

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP

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HOSPITAL WORKGROUP IN-PERSON MEETING

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FRIDAY

DECEMBER 9, 2016

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Cristie Upshaw Travis and Ronald S. Walters, Co-Chairs, presiding.

PRESENT:

CRISTIE UPSHAW TRAVIS, MSHHA, Co-Chair  
 RONALD S. WALTERS, MD, MBA, MHA, MS, Co-Chair  
 GREGORY ALEXANDER, PhD, RN, FAAN  
 ANDREA BENIN, MD, Children's Hospital  
 Association  
 AKIN DEMEHIN, American Hospital Association  
 WOODY EISENBERG, MD, Pharmacy Quality Alliance  
 DAVID ENGLER, PhD, America's Essential Hospitals  
 ELIZABETH EVANS, DNP\*  
 LEE FLEISHER, MD  
 FRANK GHINASSI, PhD, ABPP  
 KIMBERLY GLASSMAN, PhD, RN, NEA-BC, FAAN,  
 Nursing Alliance for Quality Care  
 MARTIN HATLIE, JD, Project Patient Care  
 JENNIFER EAMES HUFF, Mothers Against Medical  
 Error  
 MIMI HUIZINGA, MD, Premier, Inc.  
 JEFF JACOBS, MD, The Society of Thoracic  
 Surgeons\*  
 JACK JORDAN  
 HEATHER LEWIS, MS, MBA, Geisinger Health System  
 MARSHA MANNING, University of Michigan  
 R. SEAN MORRISON, MD  
 ALLEN NISSENSON, MD, Kidney Care Partners  
 SARAH NOLAN, Service Employees International  
 Union  
 ANEEB SHARIF, Service Employees International  
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 KAREN SHEHADE, MBA, Medtronic-Minimally Invasive  
 Therapy Group  
 BROCK SLABACH, MPH, FACHE, National Rural Health  
 Association  
 ANN MARIE SULLIVAN, MD\*  
 MARISA VALDES, RN, MSN, Baylor Scott & White  
 Health\*  
 LINDSEY WISHAM, BA, MPA  
 WEI YING, MD, MS, MBA, Blue Cross Blue Shield of  
 Massachusetts

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HELEN BURSTIN, MD, MPH, Chief Scientific Officer  
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Measurement  
ELISA MUNTHALI, Vice President, Quality  
Management  
ERIN O'ROURKE, Senior Director  
DESMIRRA QUINNONEZ, Project Analyst

**ALSO PRESENT:**

HEIDI BOSSLEY, MSN, MBA  
REENA DUSEJA, CMS  
JOANN FITZELL  
MARLIS GONZALEZ-FERNANDEZ, MD, AAPM&R\*  
ROXANNE JENSEN, Georgetown University  
JOSHUA LAPIN  
WILLIAM LEHRMAN, CMS  
TARA LEMONS, CMS  
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DANIEL POLLOCK, CDC

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BOB SHANER, American Academy of Pain Medicine

DONNA SLOSBURG, ASC Quality Collaboration\*

ASHLEY WILDER SMITH, PhD, MPH, NCI

LISA SUTER, MD

ANGEL VALLADARES, Avalere Health

PIERRE YONG, MD, CMS

\* present by teleconference

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

2 9:02 a.m.

3 CO-CHAIR TRAVIS: Well, this is  
4 Cristie Travis, for those on the phone. I want  
5 to welcome everybody back today to Day 2. If  
6 you're like me and it's your first time, it was  
7 like drinking from a fire hose yesterday.

8 (Laughter.)

9 CO-CHAIR TRAVIS: We did cover a  
10 number of different federal programs, so we got  
11 to have a variety of issues that we were able to  
12 discuss.

13 I also want to thank everybody for  
14 working through the decision matrix,  
15 understanding what we needed to do to give the  
16 proper recommendations and guidance, both to the  
17 Coordinating Committee for MAP and ultimately to  
18 CMS. And I think we got into a really good  
19 rhythm about understanding our four decision  
20 categories and really working hard to be  
21 consistent and to give the level of detail that  
22 we needed to. So thank all of you for kind of

1 working through that with us.

2 It's the first time we've had this  
3 particular decision category, and we have found  
4 it does take just kind of actually doing it,  
5 because things can look great on paper, but when  
6 you have to make decisions, you realize there are  
7 some nuances that you need to take into account.  
8 So thank you very much for that.

9 We are excited about the programs  
10 we're going to be covering today, which are  
11 primarily IQR and value-based purchasing. And  
12 then at the end of the day we will do like we did  
13 yesterday and go through the current measure sets  
14 for those two programs as well as the other two  
15 that we haven't covered yet in terms of new  
16 measures, because there weren't any new measures  
17 coming forward.

18 So with all of that, I'm going to turn  
19 it over to Ron.

20 CO-CHAIR WALTERS: Thanks again for  
21 everybody's work yesterday. We really do  
22 appreciate it. You make our job as chairs very

1 easy.

2 First thing is people that were not  
3 here yesterday that are new today filling in for  
4 someone, et cetera, et cetera, please introduce  
5 yourself and disclose any conflicts that you  
6 have. And I'm looking at Allen first.

7 MEMBER DEMEHIN: Good morning. I'm  
8 Akin Demehin. I'm the Director of Policy at the  
9 American Hospital Association sitting in for  
10 Nancy Foster. Glad to be with you. No conflicts  
11 to disclose.

12 CO-CHAIR WALTERS: Sorry. I said  
13 Allen.

14 Is there anybody else? Going around  
15 the table I don't see anybody.

16 CO-CHAIR TRAVIS: There was somebody.

17 CO-CHAIR WALTERS: Oh, yes.

18 CO-CHAIR TRAVIS: When he comes back.

19 CO-CHAIR WALTERS: Okay. We'll get  
20 him when he comes back.

21 The second thing, you got a new  
22 agenda, and that agenda is just about two minutes



1 old already. As you note on the agenda, on your  
2 prior spreadsheet there was one measure for  
3 value-based purchasing, and then it was not on  
4 the agenda you got yesterday. It is back on the  
5 agenda now, the Communication About Pain. So  
6 we'll deal with that later on after IQR. Just  
7 wanted to get you thinking about that early in  
8 the day. We also literally just found out about  
9 it.

10 The only other change I know about is  
11 that we're going to -- yesterday Nancy asked a  
12 question about the rationale of some of the  
13 design of the IQR Program. So after PROMIS and  
14 after the overview, before the public comment,  
15 Pierre is going to give a high-level response to  
16 Nancy's question. We'll still go through the  
17 measures measure by measure and not at the  
18 measure level, but kind of what they were  
19 thinking as far as IQR.

20 Okay. Not back yet.

21 All right. Well, then let's --  
22 Melissa, do you have anything you want to say?

1 MS. MARINELARENA: (No audible  
2 response.)

3 CO-CHAIR WALTERS: Okay. We'll have  
4 to catch up with the disclosure, I guess.

5 CO-CHAIR TRAVIS: We have a little bit  
6 of time because we go into the PROMIS discussion.  
7 We'll do it after PROMIS.

8 CO-CHAIR WALTERS: Yes, we'll do it  
9 after PROMIS. Always grab time when you find it.

10 (Laughter.)

11 CO-CHAIR WALTERS: Always take those  
12 -- So, Pierre, you ready to start the PROMIS  
13 discussion?

14 DR. YONG: Absolutely.

15 CO-CHAIR WALTERS: Good. Thank you.

16 DR. DUSEJA: Okay. Good morning,  
17 everyone. So we wanted to use the opportunity  
18 today to talk about PROMIS. I think yesterday  
19 there was a lot of discussion about patient-  
20 reported outcomes, and our agency has been trying  
21 to think about this. And we're really early on  
22 in the process of how to think about PROs as it

1 relates to quality measurement. So we wanted to  
2 use the opportunity with this group to get your  
3 feedback on what we've been doing and to get your  
4 input.

5 I'm going to hand off to our  
6 colleagues here from Georgetown and NCI. And so,  
7 this is Roxanne. And I'll ask you to take the  
8 floor next.

9 DR. JENSEN: Hi, everyone. Thank you.  
10 I'm -- my name is Roxanne Jensen. I'm an  
11 assistant professor at Georgetown. And so,  
12 Ashley Wilder Smith from the Outcomes Research  
13 Branch at NCI was supposed to give these first  
14 slides, but I'm going to wing it and we'll see  
15 how I do, hopefully.

16 All right. So to tell you a bit about  
17 what PROMIS is, the acronym is Patient Reported  
18 Outcomes Measurement Information System. And  
19 what it is, it's a system of patient-reported  
20 outcome selection and its way of administering  
21 PROs in a brief way that's precise, valid and  
22 reliable. And there's a lot of different ways

1       you can administer it. And the advantages are  
2       that it goes -- not my slides.

3               Okay. So some of the advantages of  
4       this type of administration of patient-reported  
5       outcomes is that PROMIS is -- it goes across  
6       diseases, it's not disease-specific and yet it's  
7       flexible and it has a lower patient burden and  
8       has electronic and paper options.

9               And so how it was developed, it was  
10      using a thing called Item Response Theory, which  
11      is taken from educational testing and applied  
12      into the health realm. And one of the benefits  
13      of this is that you can have a lot of different  
14      items in one item bank and you can build a survey  
15      that best meets the population you're trying to  
16      assess.

17              Okay. So I guess one of the main  
18      concepts of PROMIS is that it is not disease-  
19      specific, it's not setting-specific, and so what  
20      these questions are is that you develop a bank of  
21      questions that measure a construct of health.  
22      And so it's a continuum.

1                   So for example, fatigue. You have  
2 items that measure fatigue and then from there  
3 you select the items that you go into your  
4 questionnaire or your survey.

5                   All right. So IRT methodology is used  
6 to develop something called an item bank, which  
7 I've mentioned previously. And basically what  
8 happens is that you take a number of candidate  
9 items for a construct and then these are  
10 evaluated and retained as long as they can  
11 measure across continuums. So for something like  
12 physical function, you're going to have a wide  
13 range of content that goes from people who are --  
14 have difficulty getting out of bed, for example,  
15 to people that are able to run a marathon. And  
16 all of these items can be used interchangeably  
17 within the short forms that are administered.

18                   Okay. So PROMIS is a system, and  
19 there are a lot of different topics that are  
20 measured using it in physical health, mental  
21 health and social health. And so, you can see  
22 the wide range of content that is available. So

1 for example, you can get a short form in physical  
2 function, pain intensity, pain interference,  
3 fatigue, mental health. Same idea.

4 And you can see the ones kind of in  
5 dark are the ones that are more commonly used as  
6 part of a profile. And they're used to kind of  
7 map common symptoms and functional issues that  
8 patients with chronic conditions may experience  
9 to get kind of a full flavor of what's going on.  
10 And then the ones that are in the light shading  
11 are more recent additions to the PROMIS kind of  
12 library of options.

13 Okay. All right. So to reiterate --  
14 so I think one of the real benefits of PROMIS and  
15 administering it is that there are really as many  
16 options as you can imagine to administer. If you  
17 have electronic capabilities, you're able to do  
18 it electronically or using paper forms. You can  
19 use stuff that's available or you can create your  
20 own short forms that are tailored to, say, a  
21 specific population.

22 And then there's a lot of platforms

1       that are currently available. So REDCap for  
2       example has kind of the common standard off-the-  
3       shelf short forms that are available to  
4       administer. And then also what's being developed  
5       as part of the health measures. There's the API  
6       interface which allows for administration, say,  
7       within hospital systems

8               My God, I --

9               DR. SMITH: Should I just do it?

10              DR. DUSEJA: Well, okay.

11              DR. SMITH: Can I say one other thing  
12       about that?

13              DR. DUSEJA: Yes, please do.

14              DR. SMITH: First of all --

15              CO-CHAIR TRAVIS: Introduce yourself.

16              DR. SMITH: Yes, absolutely.  
17       Apologies. Metro, unfortunately.

18              So just one thing to say relative to  
19       availability, and this is going to come up at the  
20       end. First of all, there are links at the bottom  
21       of this which we can of course distribute. And  
22       just so you know, this is being updated all of

1 the time because our availability just increases.  
2 And the main thing for your purposes that would  
3 be useful for you to know is that we are actually  
4 embedding these instruments in two different EHR  
5 vendors.

6 And specifically, Epic is the roll-out  
7 for the 2016 version. It's getting updated  
8 actually spring of 2017. So anyone who had an  
9 update in 2016 will actually have both short  
10 forms. And so, the PDFs that are listed there  
11 and also will have computer adaptive testing.

12 And I'm not sure, Roxanne, if you  
13 explained what that was, but I'll say a word or  
14 two about it.

15 So, sorry if this is duplicative.  
16 What's really unique about this measurement set  
17 is that it allows for the ability to assess from  
18 a patient's perspective their health status in  
19 ways that are very low-burden. And the computer  
20 adaptive testing is something to think about  
21 moving toward in the future for assessment  
22 purposes in a variety of clinical settings



1       because as it is being rolled out again in  
2       medical record through MyChart, et cetera, and  
3       Epic -- and then also we're in conversation with  
4       Cerner, and that should happen later this year as  
5       well, too. So again, you can see that this is  
6       sort of a -- we're really in a sea change in  
7       terms of availability.

8               But computer adaptive testing allows  
9       you to ask a question based on the response to  
10      the prior question. So all of you who have  
11      children who have recently taken standardized  
12      tests or for whom you have gone back to school  
13      and taken your own standardized test recently,  
14      you've done it on the computer or they've done it  
15      on the computer. And when they get a question  
16      wrong, they get an easier question. When they  
17      get a question right, they get a harder question.  
18      And you hone in very quickly on a skill level.

19              We've adapted the same kind of  
20      methodology to health. So for example when  
21      you're talking about physical function, if you  
22      ask somebody can you walk around the block and

1       they say no, you don't ask them, can you walk a  
2       mile. You ask -- the next question is can you  
3       get out of bed? So you hone in very quickly to  
4       the person's ability level based on the responses  
5       that they had to the prior item.

6               That's an important methodology for  
7       you to know about because burden is a real issue,  
8       especially when one is thinking about rolling out  
9       questions to patients across the country.

10              So, and then the other thing I just  
11       wanted to mention is that there is the ability to  
12       -- and we can talk about this a little bit later  
13       in the last couple of slides, but the metric that  
14       I'm assuming that Roxanne covered a little bit,  
15       which is -- and she'll cover it a little bit more  
16       in some detail about some data -- is it's a scale  
17       between 0 and 100 and it has applicability across  
18       health domains so you can get scores on each of  
19       the different health domains. Regardless of the  
20       number of questions that you ask you can get a  
21       score.

22              So that computer adaptive test -- for

1       example, you could ask different questions to  
2       different people, but still get that same score  
3       because you may not want to waste their effort on  
4       questions that don't apply to them.

5               We also have the ability to actually  
6       compare those scores to other kinds of patient-  
7       reported outcome measures that have been used  
8       quite widely in the field. So those include  
9       things like the SF-36, for anybody who is  
10      familiar with patient-reported outcomes, and many  
11      others. The CESD for depression. There are a  
12      number of other instruments.

13             So what happens is even when people  
14      have been assessing using a different kind of  
15      assessment tool, they can compare it to the  
16      metric and you can actually have scores that  
17      apply to everyone regardless of what instrument  
18      they've taken. So this is another piece I just  
19      thought would be useful for you.

20             You want to go next?

21             DR. JENSEN: All right. Great. Now  
22      onto my slides, which -- thank God.

1 (Laughter.)

2 DR. JENSEN: Oh my gosh. All right.

3 Now, I'm a psychometrician, or at least a  
4 practicing one, and so basically a lot of people  
5 come to me and they say, oh, Roxanne, I want to  
6 measure physical function. So now this is how I  
7 approached these questions before when someone  
8 would come to me. I would say, okay, so you want  
9 to measure physical function. That's great.

10 All right. How detailed do you want  
11 to get into it? I mean, is this just an overview  
12 or you want to get really into like the  
13 functional ability that people have? How much  
14 space do you have on your survey? We all know  
15 that's very precious and patient burden is  
16 important. Who do you want to compare it to? I  
17 work in cancer, so do you want to compare to  
18 cancer patients? Do you want to compare to the  
19 general population? Those are different surveys  
20 and they're different items.

21 So for example, if it's a general  
22 population and it's just a wide overview, the SF-

1 12 has six items for physical function. That  
2 will do the job just for like real bare-bones  
3 stuff. If you want to get into it, the HAQ, I  
4 mean, that's 34 questions about physical function  
5 and that will really get some detailed  
6 information.

7 For cancer patients, we have some  
8 broad quality of life surveys that are disease-  
9 specific, but you can see the number of questions  
10 goes up based on kind of how people respond to  
11 these questions.

12 All right. So now here are some of  
13 the problems with using your standard paper  
14 survey, is the response burden. As mentioned  
15 before, people have to fill these out. It takes  
16 time, especially for sick people, right?

17 Comparability beyond the study sample.  
18 So I have a FACT-E score of 113. What does that  
19 mean? Well, I can compare to other studies and  
20 you can get a flavor of how my patient population  
21 compares to others, but -- there might be  
22 reference values that people have created, but

1       these don't do a great job of painting the big  
2       picture.

3                   Also sensitivity. If you administer  
4       five items of physical function on an SF-12, it's  
5       not going to be very sensitive to change or kind  
6       of the individual things that are going on for  
7       people.

8                   So moving forward, this is what Ashley  
9       was alluding to. There are these new methods  
10      that came about, and I think I mentioned this  
11      earlier, too, item response theory, educational  
12      testing, these computer adaptive tests, and kind  
13      of what you need to know. Also, just as an add  
14      on, when you're taking say the GRE and the vocab  
15      is getting easier, not harder, or the math  
16      questions are getting easier, not harder, you're  
17      in trouble. Your score is going down. Okay?

18                   (Laughter.)

19                   DR. JENSEN: And so, yes, I even  
20      remember living in fear. It was like oh, no,  
21      CATs, like I'm in trouble.

22                   (Laughter.)

1 DR. JENSEN: Fortunately, I guess it  
2 worked out.

3 (Laughter.)

4 DR. JENSEN: All right. So let's move  
5 on. So this is what happens now when people come  
6 to me to talk about PROMIS and they want to ask  
7 about physical function.

8 Well, the first thing I ask them is  
9 are you using a computer or do you need paper?  
10 This is a really big concern for people. And so,  
11 they tell me, oh, I need a paper. Oh, okay. If  
12 you have a computer, are you going to be able to  
13 actually run a computer adaptive test? Do you  
14 have programming capability, or do you just need  
15 the items to just show up, be answered? How much  
16 wiggle room? How fancy are we going to get? All  
17 right. Do you want to use something that's  
18 established?

19 Now, researchers, especially quality  
20 of life researchers, they get a little -- oh, I  
21 want to use something that's been used and  
22 validated and tested. I don't want to create my

1 own form. I want something that's available and  
2 I know is going to work because -- I just want  
3 something that's out there. So, all right. So  
4 there is a 4, a 6, an 8, a 10 and a 20-item short  
5 form for physical function that you can select.  
6 And what people generally do is they take a look  
7 at the content and they say, okay, this covers  
8 the range of my patient group. That makes me  
9 happy.

10 You can create your own and you can  
11 create -- so you can look through the item bank  
12 of 124 questions and pick any items you want and  
13 it -- you can create a score from it. And so  
14 some people do that.

15 Some people will -- I would -- and so  
16 how many items you actually put on. People say,  
17 well, how few can I get away with? That's like  
18 the number one question. And to be honest, you  
19 don't need that many. I mean, but it depends,  
20 right? But don't give someone 124 questions  
21 about physical function. That's just -- ah man,  
22 that's not very nice. So there you go.



1                   And then this is a visual  
2                   representation more about physical function and  
3                   how this works on the continuum of 0 to 100. So  
4                   people that are not able to get out of bed are  
5                   going to be more towards the zero and people who  
6                   run ultra-marathons, Ironmen, they're going to be  
7                   the other side. And so, you can see these are  
8                   some of the questions that fall across continuum.  
9                   And then they're in order from highest  
10                  functioning to lowest functioning.

11                 So you can see that on the top, are  
12                 you able to run five miles? Then are you able to  
13                 jog two miles? And bear in mind, people are  
14                 responding, they have five response options. And  
15                 so, the item response theory is taking the  
16                 probability of a response and the response  
17                 pattern together to give you a response. And so,  
18                 it's kind of taking the lid off of how we used to  
19                 do questionnaires.

20                 All right. So here's another visual  
21                 representation. I'm going to talk to you today  
22                 about some findings from physical function,

1       because quite honestly when we talk about PROMIS,  
2       we say these great things that it does. We say  
3       you can ask all the questions you want or just a  
4       few and you're going to get the same score, but,  
5       okay, in theory this is what happens, but let's  
6       take a look at what's really going on, right. I  
7       mean, let's see if it actually can do what it  
8       says it's going to do.

9               So let's go ahead and hit the next  
10       slide here. Interpretability. So something that  
11       we hit on a little bit. And just look at the  
12       colors, really. So this is a T score metric. I  
13       think what to take from this 10 points is a  
14       standard deviation, but it's also -- I think if  
15       you think about this in percentiles, because I  
16       think sometimes people think that way, too, this  
17       is -- also can be gridded that way.

18              And so, when you're up at something  
19       like 40, that's -- let's say 64 or 84, 80. And  
20       then 30 is going to be at 98th percentile. So  
21       you can see that people are really at the ends  
22       kind where as -- as these colors get more towards

1 red. So, and we're able to kind of mark out  
2 where clinically relevant differences are.

3 So a mild issue in physical function,  
4 for example, is going to be someone between 45  
5 and 40. That's half a standard deviation below  
6 the U.S. population, right? And so, we actually  
7 know where someone falls relative to the average  
8 person in the United States, and that's really  
9 cool.

10 Then moderate change is from 40 and  
11 30. So you see it's kind of in that orange zone.  
12 And that's above a standard deviation lower. So  
13 these are people that are kind of approaching  
14 that 98th percentile, or 2 percentile of physical  
15 function.

16 And then below that you have your  
17 severe functioning issues between 30 and 20.

18 Yes?

19 DR. SMITH: Just to that slide,  
20 actually. Can you go back?

21 So actually, just so you know, the  
22 bottom of the scale is for functioning. So

1 physical function, you see a higher-functioning  
2 person has a higher score. So the 80 is on the  
3 left. And essentially PROMIS scores are more of  
4 whatever it is that you're measuring, so a higher  
5 anxiety score means more anxiety. A higher  
6 physical function score means you are doing  
7 better.

8 But in terms of the interpretation for  
9 clinical purposes and other application purposes,  
10 this slide is a generic that shows you across  
11 health domains. That could be physical function,  
12 cognitive function. Symptoms are at the top;  
13 functioning at the bottom. But essentially there  
14 are fairly robust ranges for severity, meaning  
15 somebody is doing worse. And there are some  
16 individual differences for domain. And we can  
17 talk about that as well, but this is a general  
18 sort of framework for interpretation.

19 DR. JENSEN: Higher is more of. Just  
20 remember that.

21 All right. So let's take a look at  
22 what scores actually mean because we have some

1 information about that.

2 So this is from a study that we're  
3 doing validating PROMIS domains in a very broad  
4 community-based cancer sample. Seven different  
5 cancers, 5,000 people. And we asked questions  
6 about exercise and needing help with mobility.

7 And so, you can see that if someone's  
8 in a wheelchair they reported having a PROMIS  
9 physical function score of 28. Okay? With a  
10 cane it's 34. No help is 47. And these are --  
11 so these are cancer patients, so you would expect  
12 it to be close to 50, but perhaps maybe a little  
13 under. And then people who are reporting five to  
14 seven times a week of exercise is above 50. So  
15 you can see they're doing better, meaningfully  
16 better than the general U.S. population.

17 All right. Next slide. Okay. We  
18 also -- oh, can you go back one? We can keep  
19 that, I guess. There's a lot of colors.  
20 Hopefully we can see it all here.

21 On the bottom though -- and so you can  
22 see this is how these scores can work. So we

1 have an overall lung cancer physical function  
2 score. We have a colorectal cancer score. We  
3 have a prostate cancer score. And again, I don't  
4 know what you guys' background is, but prostate  
5 cancer patients on all they probably are doing  
6 pretty average, right, generally speaking. This  
7 is after treatment.

8 Colorectal cancer patients, there's a  
9 bit more of a range. And so they're at 44.

10 Lung cancer patients typically are not  
11 doing well. And you can see they're about a  
12 standard deviation lower than the U.S. population  
13 with their scores.

14 And now if you can click the slide  
15 forward. I color coded, so you can see the  
16 pretty colors, and this maps into the severity  
17 level. So people that are in a wheelchair are in  
18 the red, right? Cane, you can see -- and you can  
19 see this all goes up. So green is better. And  
20 then we have some problems.

21 All right. And then I included this,  
22 too, so you can see the range. We also are able

1 to do -- and these are U.S. reference values that  
2 we've created for cancer and by stage. And so  
3 you can see the range by stage. And this is just  
4 the level of detail we can really give. So  
5 oftentimes when people don't know how to  
6 interpret a score, I mean, the thing about PROMIS  
7 is you really can because we could create scores  
8 for different diseases. You name it and there --  
9 it -- this provides a really nice comparison that  
10 really puts things in context.

11 All right. Okay. All right. Just to  
12 look at this another way. So this is a self-  
13 report item, physical functional status. And  
14 people said they're normal. They said they had  
15 some symptoms. They were less than half the day  
16 on bed rest or more than 50 percent of the day on  
17 bed rest. And so you can see these are people  
18 that are about nine months post-diagnosis of  
19 cancer, seven different cancers. This is a  
20 really broad community-based sample that we  
21 collected at four sites in the U.S.

22 So you can see most people are feeling

1 good or normal. They don't have symptoms. And  
2 you'll see these bars. All of these colors are  
3 the different physical function surveys. And so  
4 you can see across the board these are doing  
5 exactly what we said they're going to do.

6 They're measuring exactly the same way. They're  
7 within a point, which is minuscule. And you can  
8 ask 4 items, you can ask 16 items, you could ask  
9 more than that, and you're going to get the same  
10 scores. And that's what this is suggesting.

11 And if you click it one more time,  
12 there are my colors again. And look, this is --  
13 quite frankly, you're not going to get a better  
14 slide than this one when it comes to physical  
15 function. It just makes me feel good as someone  
16 who does measurement, because it just goes down  
17 the continuum there. So you're able to really  
18 discriminate against -- for groups.

19 All right. And they left -- we left  
20 this one slide in. So part of the validation  
21 work I've done -- and we did this for eight  
22 different domains; this is physical function --



1 is we asked compared to six months ago how is  
2 your physical function. This is a follow-up  
3 survey. And then we measured the actual change  
4 and what people said. The effect sizes there are  
5 next to the response that people gave.

6 And this is quite frankly probably one  
7 of the better response graphs you're going to get  
8 when you ask this type of question. You'll see  
9 that above three is kind of what we hope -- 0.3  
10 is what we hope for for a clinically relevant  
11 difference for an effect size. And you see that  
12 when people said they were a lot better, six --  
13 between that six-month period, they improved in  
14 physical function about three points, or one-  
15 third of a standard deviation.

16 And then when you see it declines,  
17 you'll see it's much more sensitive to declines,  
18 where it's three points for a little worse and  
19 then five points for a lot worse. And this is  
20 very standard what you see for these type of  
21 metrics, and this performs absolutely like the  
22 best we could hope for.

1 DR. SMITH: So there's just two slides  
2 left. So this is some -- oh, and I guess we  
3 didn't incorporate the --

4 DR. JENSEN: No.

5 DR. SMITH: Okay. This was not the  
6 most up to date, but essentially what I had  
7 mentioned earlier -- first of all, there's  
8 increasing adoption for clinical care and  
9 treatment decision-making. And originally -- so  
10 these were developed from the NIH, which is a  
11 research organization. So we're really  
12 developing them for clinical research purposes.

13 However, in the process of this it  
14 became very clear that they were useful in  
15 clinical settings. And there have been a number  
16 of early adopters who have really, I would say,  
17 drunk the Kool-Aid themselves, and are rolling  
18 out PROMIS in fairly substantial ways.

19 The biggest early adopters are  
20 orthopedists, which is not entirely surprising,  
21 right? I mean, if you have a surgical outcome  
22 and someone either has knee pain or can't

1 function well, you want to know that from the  
2 patient. So this is the reason that you're  
3 seeing that in orthopedics. But we have it  
4 applied in a lot of other settings. Oncology  
5 Roxanne's just been discussing. And also we have  
6 in -- we've had even ICU -- surprise, surprise --  
7 the ability to ask some questions. We've seen it  
8 being used in a lot of different ways, and in  
9 some places pretty ubiquitously in health  
10 systems.

11 So the availability in -- through the  
12 EHR is obviously a huge impact in terms of the  
13 roll-out and ability to use these more across the  
14 board. And there are a lot of other ways that  
15 people can access it. And frankly, you could go  
16 to the Health Measures web site now and download  
17 any PDF you want. So that's always a  
18 possibility. And as I mentioned, the  
19 availability in Cerner in something that we have  
20 negotiated, but the roll-out and the particulars  
21 are happening in calendar year 2017.

22 If you want to go to the next slide.

1       So we've been in consideration of where this  
2       might be. This is really the last slide. It's  
3       just an example to say that, what are some of the  
4       potential uses in settings? And keep in mind  
5       that these instruments were not originally  
6       developed for setting-specific comparisons or  
7       uses, but across and within specific diseases.

8               Those diseases are treated or  
9       functional pieces are -- of health are treated in  
10      settings. One of the things that we've been  
11      considering is are there data that we still need  
12      to understand used in particular settings? We  
13      actually have quite a lot of data that we've  
14      collected across many different investigators  
15      over many, many years, so we're pooling them a  
16      little bit differently, is part of what's  
17      happening.

18             But the other thing is that some of  
19      the earliest potential uses would be -- have  
20      potentially been in post-acute care. And some of  
21      the topics associated with the IMPACT Act could  
22      be addressed fairly well and quite reasonably now

1 with many of the different PROMIS domains. So  
2 some of the ones that could be considered are  
3 cognitive function, anxiety, physical function  
4 and mobility, fatigue, sleep disturbance, social  
5 role functioning, depression and pain. So those  
6 are the different areas that we've just been in  
7 conversation about thinking through.

8 And there's the ability to determine  
9 domain-specific scores for each of those health  
10 domains that I've just mentioned. But the other  
11 piece is that -- and I don't know much Roxanne  
12 covered this -- we have profile scores available,  
13 and profile scores are basically across domains.  
14 So it might be some mental health, some physical  
15 health, and you get summaries of a person's  
16 health status.

17 One of the things that is possible to  
18 do is to calculate some profile scores on these  
19 different domain areas that have a fewer number  
20 of questions for the specific purposes, again, of  
21 evaluating, for example, the IMPACT Act or  
22 anything else related to quality programs.

1                   And the other thing is that there's  
2                   the ability to -- when I was talking before about  
3                   the ability to compare the metric to other  
4                   measures that have been used, PRO measures that  
5                   have been used, one can also use CMS items that  
6                   have already been fielded and compare them to  
7                   PROMIS scores so that there's continuity even  
8                   over time, or for those folks who've been using  
9                   other items to do that kind of comparison.

10                   So that's just sort of an early  
11                   example of one application, but there are many.  
12                   And the beauty of this is just how flexible it  
13                   is. And what it just means is that we need to be  
14                   in conversation with the people who want to use  
15                   it.

16                   So the last slide just has my contact  
17                   information if you'd like.

18                   DR. YONG: So one, thank you, Roxanne  
19                   and Ashley, for that sort of background about  
20                   PROMIS. And so I just wanted to frame it a bit  
21                   before we go into discussions, so why did we ask  
22                   Ashley and Roxanne to come down and why did we

1 stress Roxanne out to cover --

2 (Laughter.)

3 DR. YONG: -- those initial slides,  
4 which she did a great job on.

5 So I think as Reena mentioned, we've  
6 -- and yesterday, right, we heard lots of talk on  
7 the gaps in all of these programs is patient-  
8 reported outcomes. So we've been thinking  
9 internally, not just at CMS, but in collaboration  
10 with our colleagues at NIH, all the way up to  
11 Francis Collins and Patrick Conway, how can we  
12 leverage some of the resources we have within the  
13 agency at HHS? And so, there's just tremendous  
14 work, as we just heard about, with PROMIS in  
15 research settings, but also have clinical  
16 application.

17 And so, some of the things that really  
18 attracted us to PROMIS, as Ashley and Roxanne  
19 covered, right, it's not disease-specific, it's  
20 not setting-specific; it's really adaptable. It  
21 both comes in paper and e-form, just the number  
22 of questions validated and tested. But are there

1 ways to think about using PROMIS and use that as  
2 a basis to turn it into a PRO, be a performance  
3 measure that then could be incorporated into one  
4 or across programs, right, that addresses some of  
5 these issues that we talked about yesterday in  
6 terms of thinking across programs and how we sort  
7 of -- how patients move across these different  
8 providers and care settings.

9 So what we'd love to get back from you  
10 today is really your feedback and thoughts about  
11 is there an idea here? Are there -- these aren't  
12 measure concepts per se that we've brought to  
13 you, right? There would need to be additional  
14 work to bring back an actual measure for  
15 consideration by the MAP. But are we down the  
16 right path? Are there applications that we can  
17 -- you can start envisioning?

18 I will also say that we are -- Ashley  
19 mentioned at the end how there are some ideas  
20 that we have around the PAC setting. We are  
21 having the discussion across all the workgroups  
22 because we are trying to think about this



1 broadly, so not just in the Hospital Workgroup,  
2 but also in the PAC Long-Term Care Workgroup, as  
3 well as in the Commission Workgroup.

4 So happy to answer any questions, but  
5 really do want your feedback.

6 CO-CHAIR WALTERS: Well, thank you  
7 very much. Just a second. I'll get to Allen.

8 Yes, this is -- thank you very much  
9 for the presentation.

10 One -- I really happen to be a fan of  
11 the OCM, the oncology care model. That was a  
12 good move forward. One of the things I was  
13 disappointed about was in some of the original  
14 proposals it included use of a tool such as  
15 PROMIS as one of the measures. And then that  
16 fell out somewhere along the way.

17 But pertinent to our discussion  
18 yesterday that's where I think -- certainly  
19 oncology world, but in general we have to start  
20 out offering these sorts of tools, educating  
21 people, because I've got a whole bunch of health  
22 services researchers who have their own REDCap

1 databases about tool X. Ah, this is not -- you  
2 hear all of their arguments.

3 It's going to take a lot of education  
4 and discussion to get this going and support that  
5 with things like a structural measure in various  
6 programs heading towards actually the outcomes  
7 measurement, which is of course what we care  
8 about more. But to get people to use tools such  
9 as PROMIS adapted to their particular  
10 circumstance and using measure development to  
11 support that so that people can start realizing,  
12 oh, my goodness, this really does have a lot of  
13 value after all.

14 And so, we're still very early in  
15 that, I know. And I worked at MD Anderson. And  
16 so, I really support the work that you're doing  
17 and we need to continue to move forward with  
18 exactly this kind of effort, because there's a  
19 lot of inertia and I'm glad to hear that it's  
20 being built into EHRs. I think it's a little  
21 more feasible. Thank you very much though.

22 Allen?

1                   MEMBER NISSENSON: So this an area  
2                   that I have spent a lot of my career working in,  
3                   so I have particular interest in it. And I love  
4                   the PROMIS promise --

5                   (Laughter.)

6                   MEMBER NISSENSON: -- and think our  
7                   population -- I know there's been a little  
8                   dabbling in the kidney disease population, but  
9                   there -- in my view there needs to be a lot more  
10                  than dabbling. I think it's the perfect  
11                  population to apply this approach to.

12                  But I have a question. Maybe this is  
13                  more for Pierre. So as we think about using this  
14                  and possibly somehow incorporating it into  
15                  accountability metrics -- and I'll use our ESRD  
16                  example, but it may be applicable to some of the  
17                  other folks.

18                  So we currently have -- for ESRD in  
19                  the conditions for coverage for certifications of  
20                  a dialysis facility we have to administer the  
21                  KDQOL at least once a year. So KDQOL, it's an  
22                  SF-36+. So we have to do that. We now have the

1 CAP survey.

2 So my question to Pierre; and it's  
3 sort of the measure bloat issue, how kind of are  
4 you thinking about when you look at individual  
5 programs and the applicability of a tool like  
6 PROMIS in terms of PROs, not just here's another  
7 thing to add on to the other stuff we're already  
8 doing, and how we can impress this, because --  
9 and I'll use the term "burden" -- on patients is  
10 really substantial, having to administer -- and  
11 CAPS, as you know, we're actually doing CAPS  
12 twice a year. And we're doing KDQOL once a year.

13 And my final question is this sort of  
14 self-reporting, which I think is really great for  
15 patients, we have on the CAPS side a requirement  
16 that CAPS can only be administered by an external  
17 third party. So kind of how do you think about  
18 tools like PROMIS and patients just kind of doing  
19 this, or will there be requirements that we have  
20 to hire outside consulting companies to  
21 administer this, or what are you thinking from  
22 the agency point of view?

1 DR. SMITH: So the beauty is in part  
2 the metric that I was talking about relative to  
3 PROMIS. So for example, all those SF-36 items,  
4 you would not have to administer them because we  
5 would have the ability to get similar information  
6 using many fewer questions using PROMIS. The  
7 other thing is that it's self-administered. So  
8 you can hand someone an iPad and they fill it  
9 out. And you saw that that was one of the  
10 availability pieces.

11 So actually the idea behind trying to  
12 get a standard set using a measurement system  
13 that's applicable across both disease setting,  
14 etcetera, etcetera is that you have the ability  
15 to have scores that are -- that again can be  
16 interpreted across those different places and  
17 people.

18 Just to mention your comment about the  
19 need for education or training or a better  
20 understanding of interpretability, the more that  
21 you continue to use that 0 to 100 scale and  
22 people get a sense of what those scores and the

1 cutoffs mean across different areas, the easier  
2 it is to facilitate their interpretation and use.

3 So I think that -- and I'm very  
4 familiar with CAPS. We do a cancer CAPS, a  
5 linkage with our cancer registries that we  
6 provide, so I'm quite familiar with CAPS and how  
7 many questions it is. And that is not designed  
8 in the same way, so I can't really speak to that  
9 because CAPS is really more of a process measure  
10 as opposed to an outcome measure.

11 But I think that the idea of using  
12 this as a framework would actually substantially  
13 reduce the burden that you're thinking about. I  
14 don't think it would add.

15 CO-CHAIR WALTERS: I know we've got a  
16 lot of people lined up here about this, so,  
17 Karen, you're first.

18 MEMBER SHEHADE: I just wanted to  
19 mention yesterday we talked about the importance  
20 of looking at measures that are important to  
21 patients. And when you were speaking it made me  
22 think about the Stanford Chronic Disease Self-

1 Management Program, and in my past work with  
2 chronic disease management looking across chronic  
3 conditions and what are the common themes that  
4 resonate with all chronic disease? And Stanford  
5 did some of this. And I just wanted to ask you  
6 to think about how that -- the PROMIS approach  
7 could even tie into something like this, looking  
8 at things that cut across a variety of  
9 conditions. So just wanted to put that out  
10 there.

11 DR. SMITH: So just again to reiterate  
12 that the design of PROMIS was to be cross-  
13 disease.

14 MEMBER SHEHADE: Yes.

15 DR. SMITH: That as -- and actually  
16 that was part of the foundational reason for  
17 developing it. It was part of the NIH Common  
18 Fund or Road Map Initiative. That's by  
19 definition across disease for exactly that  
20 reason. And for patients frankly with multiple  
21 morbidities and diseases.

22 CO-CHAIR WALTERS: Okay. I got the

1 list going here. Don't worry. Everybody will  
2 get their chance. Helen gets priority though.

3 (Off microphone comment.)

4 CO-CHAIR WALTERS: Okay.

5 (Off microphone comment.)

6 CO-CHAIR WALTERS: Okay. Good.

7 Andrea?

8 MEMBER BENIN: This seems really  
9 fascinating to me and definitely right in line  
10 with what we've been talking about as needing to  
11 understand where patients stand and how they  
12 feel. It does seem to me that at this moment  
13 really far from an accountability metric,  
14 substantially far from an accountability metric,  
15 and even thinking about what that would look like  
16 is complex, I think. I think I can go -- if you  
17 think about how it is a one patient, one cancer  
18 look and how do you hold a hospital accountable  
19 for how that person's dealing and while risk-  
20 adjusting or whatever else needs to happen. I  
21 don't even know. So I think that it's far from  
22 an accountability metric right now.



1 I could imagine a world where there  
2 was a structural metric around using a tool like  
3 this or another kind of tool that I could  
4 imagine, but I think that is a way that if CMS  
5 felt it was wanting to support the HHS effort, I  
6 suppose. But to me this feels like a very  
7 clinical tool that should be propagated  
8 extensively in the clinical areas and -- but the  
9 payment methodology may not really be the right  
10 one for that. I'm not sure that that's -- this  
11 is the right place to put this tool right now.  
12 It doesn't feel that way to me yet.

13 It feels really valuable. It feels  
14 like it move things forward. I'm curious to fill  
15 it out myself, but -- yes, just the anxiety part,  
16 right? So anyway, thanks.

17 CO-CHAIR WALTERS: David?

18 MEMBER ENGLER: Thank you. So I'm a  
19 big supporter of PROs. I think it really goes to  
20 the point of patients and making it patient-  
21 centered. So congratulations on the work being  
22 done. And by the way, I'm not going to take it

1       today because I'm depressed as hell, so --

2                       (Laughter.)

3                       MEMBER ENGLER:  -- as are many people  
4       around the table.

5                       But so I support it.  I wonder if  
6       there's an opportunity here to place this in a  
7       category since it's not yet ready for  
8       accountability.  But I wonder if there's an  
9       opportunity for you to think about placing this  
10      in the category of emerging population health  
11      metrics.  Many of our member hospitals are moving  
12      towards more and more population health, given  
13      both our mission and where they're going in terms  
14      of their steering organizations.

15                      And it seems to me that if you  
16      broadened this just a bit and looked at the  
17      notion behind reported, self-reported measures in  
18      a population that you would be metricating and  
19      measuring something that we're not currently  
20      picking up on the clinical side.

21                      So I offer that as both a comment  
22      about the excitement and the forward thinking

1 that you're bringing to the table, but also as  
2 the opportunity to look forward in terms of this  
3 being a population health metric or consideration  
4 for population health. So thanks.

5 CO-CHAIR WALTERS: Lindsey?

6 MEMBER WISHAM: So thank you for your  
7 presentation. It was interesting and exciting  
8 all at the same time.

9 I think though when we talk about the  
10 scores and how comparable they can be, whether  
11 it's across care settings or disease-specific  
12 conditions -- is that ultimately that's  
13 beneficial perhaps to a researcher or even a  
14 provider that's giving the care. But if this is  
15 truly meant to engage the patient, the patient's  
16 going to say so what? So what I'm a 93? What  
17 does that mean? Or how does that change the care  
18 that I'm going to receive? How does that change  
19 maybe how my providers interact with each other?

20 And so I think that ultimately if this  
21 is the -- a goal is getting us started down a  
22 really good path of truly making patients engaged

1 in their care is that we have to be able to  
2 communicate what that means back to them.

3 DR. SMITH: So that is something that  
4 we are already taking up, absolutely. And in  
5 fact there are a number of -- there have been a  
6 number of studies that are about both patient  
7 communication and thinking about integrating  
8 information for decision making, dose  
9 modification or whatever it is. There are  
10 definitely both the interpretation by the patient  
11 and the clinician, and getting them in a  
12 synergistic place has been a part of using these.  
13 And I would say that patients actually have been  
14 fairly enthusiastic.

15 Do you want to --

16 DR. JENSEN: So my other hat is that  
17 I actually have been developing patient-focused  
18 symptom reports. So say a breast cancer patient  
19 who's done with treatment, 35, stage whatever.  
20 They're able to look at the scores and see how  
21 they compare to someone just like them. And  
22 people not only really wanted this information,

1 but they see like direct application, because  
2 it's very difficult in this -- my narrow setting  
3 to understand what fatigue means to them now that  
4 they're done with treatment. And just even  
5 though maybe there isn't direct applications  
6 immediately, this is something, this is  
7 information that patients seem to really want and  
8 are enthusiastic about.

9 CO-CHAIR WALTERS: The feedback's very  
10 good. Keep it up. I've got everybody on.

11 Jack?

12 MEMBER JORDAN: I completely welcome  
13 this, and it's really nice when what we're trying  
14 to do in our health system is actually aligning  
15 with where CMS is going.

16 Our associate chief medical officer of  
17 our main hospital has essentially told people  
18 that if you're doing a research study, you will  
19 use PROMIS unless you have a compelling reason  
20 not to. We're trying to really work through in  
21 our own system thinking through -- we've had this  
22 problem in the past. They have a research study;

1 and their ERB captures it there and it's lost, it  
2 just passed through there, to really try to unify  
3 this so that we're actually tracking it with one  
4 data monitor. We can reuse this for different  
5 things and not have a patient take it twice.

6 We are an early adopter. We do have  
7 it built into our patient portal in Epic prior to  
8 it being released as a complete thing. So it  
9 exists.

10 I want to agree with the population  
11 health portion, too. I think looking at  
12 populations over time -- they see a model. This  
13 is a great way to have that be kind of common and  
14 thought of. And I think we're also trying to  
15 think about is -- this is a way to look at  
16 primary care panels and kind of look at kind of  
17 the risk scoring kind of a tool for looking at  
18 panels as well. So I think there's a ton of uses  
19 for this.

20 And I think that the standardizing on  
21 something this on a large scale so we can get  
22 things marched across the country and doing that.

1       So I'm completely all for this and I think  
2       there's a lot of benefits in a lot of places if  
3       we try to commonize on this where we can. And I  
4       think what we'll lose in the specific disease  
5       things are pretty small in comparison to what we  
6       gained by being able to have comparability  
7       across.

8                 One thing I did hear that I want to  
9       make sure of is that we don't build something  
10      like this where we're officially sending it to  
11      CMS, that we don't get to keep our own data,  
12      because I think we want to use it for other  
13      purposes. If you're wanting to measure what  
14      we're doing, I would really encourage you to not  
15      set up a model where the official blessed one you  
16      trust is data then that's blinded to us and we  
17      don't get to keep. I think it's important that  
18      we get to keep and use it.

19                CO-CHAIR WALTERS: Thank you. Frank?

20                MEMBER GHINASSI: Okay. I'm going to  
21      try not to repeat anything anybody said.

22                Just first of all, this is -- I'm very

1       fond of this and I was actually part of the group  
2       that did the winnowing and thinning way back.  
3       And so it's exciting to see this one come to --  
4       so the real PROMIS is the IRT-CAT combination, so  
5       I want to really stress if you can make that a  
6       priority, because I think that's where the magic  
7       is in this.

8                 The second thing; it's just a concern,  
9       is are you thinking of this -- and you don't have  
10      to answer this. I'm just putting it out there  
11      for you to think about. Are you thinking about  
12      this as a graphic tool or a nomothetic tool? So  
13      is this a one patient kind of issue or are you  
14      really looking at this to measure large  
15      populations? Because I think it has implications  
16      both ways.

17                The third thing is, at least in my  
18      experience, within populations there are patients  
19      who consistently underreport or endorse and over  
20      report and endorse. And so, change among those  
21      populations is not the same. And when you're  
22      measuring a population, begin to think if you can



1 about ways to include individuals who restrict  
2 the range of their own self-report versus those  
3 who exaggerate the range, because it's a real  
4 phenomenon and it will affect this.

5 The next one is are you thinking about  
6 this as a treatment planning tool or are you  
7 thinking about this as a quality outcome tool in  
8 a pay-for-performance environment? Because those  
9 are two very different agencies.

10 And then the other question is are you  
11 thinking about a delta in these scores as the  
12 measure? And if so, is that a within-  
13 organization delta or some kind of national  
14 delta? Because there are problems on both sides  
15 of that. Organizations that are in different  
16 environments maybe work with different  
17 populations. Their deltas may look very good  
18 within their organization structures, but not so  
19 good across a larger one.

20 And the last point simply is I'd  
21 recommend that if you're going to do this,  
22 numbers are going to help. Millions of people

1 are going to be better. Hundreds of thousands.  
2 There may be 15,000. So for -- if you're going  
3 to do an accountability measure, it's probably  
4 going to be better if you do it at the payer or  
5 state level than at the provider level. Just  
6 thoughts.

7 CO-CHAIR TRAVIS: All feedback, aren't  
8 you?

9 Brock?

10 MEMBER SLABACH: I think prefacing my  
11 comments, I'm a hospital administrator, so I  
12 always think about things kind of operationally.

13 First of all, is Epic and Cerner going  
14 to be charging for this package to their offering  
15 to its hospitals and clinics?

16 DR. SMITH: I'm fairly certain that  
17 anyone who has the ability to -- so Cerner I  
18 don't know yet, because that's like too early for  
19 me to actually -- so the Epic piece, I'm fairly  
20 certain if you have the ability and have already  
21 selected patient reported outcomes it's part of  
22 that package. And so for those who already had

1 it, it's available.

2 And just I wanted to mention that  
3 these are also available in English and Spanish.

4 MEMBER SLABACH: It's available where?

5 DR. SMITH: In English and Spanish.

6 MEMBER SLABACH: Oh.

7 DR. SMITH: Through Epic.

8 MEMBER SLABACH: The other question I  
9 have is -- and maybe I missed it in part of the  
10 presentation, but is this administered to all  
11 patients? So upon admission to either a hospital  
12 or a clinic setting are they asked to interface  
13 with tool in all cases or just in certain  
14 disease-specific conditions of cases?

15 DR. SMITH: So you mean how is it  
16 currently being used in clinical settings?

17 MEMBER SLABACH: Yes, I mean --

18 DR. SMITH: Specifically --

19 MEMBER SLABACH: -- what do you  
20 perceive is the best way to do this --

21 DR. SMITH: Well, I --

22 MEMBER SLABACH: -- going forward and

1       how do we I guess respond to that in terms of  
2       implementation of process, because in the  
3       hospital context and the clinic context you've  
4       got to make -- you got to translate this into --  
5       we're required to have patient portal -- a  
6       certain percentage of patients accessing our  
7       portal, for example.

8               DR. SMITH: Right.

9               MEMBER SLABACH: So is this going to  
10       be a requirement that we're going to have to have  
11       so many of these forms filled out for so many of  
12       our patients in terms of population?

13              DR. SMITH: So it's a little bit of a  
14       complicated question. I can tell you what's  
15       being done now and I will also defer to Pierre  
16       and also the thinking with guidance from you all  
17       and of CMS relative to developing a performance  
18       measure, because some of the questions and  
19       comments just made were incredibly poignant and  
20       important to consider in terms of how this  
21       interpretation will happen and what kind of  
22       change in one's reported abilities or symptoms

1 for tests, whatever it is, is going to be --  
2 matter based on what the ultimate measure is.

3 But in terms of current use -- and I  
4 would say; as I mentioned, that orthopedics is  
5 the biggest starter, there are -- so for example,  
6 University of Rochester, every single orthopedic  
7 patient gets it the minute they walk in. Every  
8 time.

9 MEMBER SLABACH: Every visit?

10 DR. SMITH: Every visit. And they  
11 actually have iPads set up. And initially they  
12 thought they needed a nurse consultant or  
13 somebody to explain it, and they very quickly  
14 recognized that they did not actually need that.  
15 So they reduced that FTE burden, etcetera. The  
16 administration fees is actually pretty great.

17 So, yes, they use it. And they track  
18 patients over time and they make decision related  
19 to physical therapy, surgery, I mean, etcetera.  
20 So they're -- and now they are moving it into  
21 their oncology setting. Again, the second sort  
22 of high user group. But there are lots of

1 examples. And GI distress, for example, was one  
2 of the domain areas. That tends to be used in  
3 particular populations more. But -- and is being  
4 used in clinical settings. So there are examples  
5 all around.

6 Some -- I think for the most part in  
7 clinical practice the idea is to be tracking  
8 people either for flagging them for a particular  
9 -- the patient population in general for problems  
10 or for if there are decision points that are  
11 being made. And that depends on what the  
12 condition is and who the patient population is.  
13 Yes.

14 And the other thing is that the  
15 earliest adopters had to do a lot of their own  
16 IT-related pieces, but moving into these  
17 electronic health records, that changes that ball  
18 game completely.

19 MEMBER SLABACH: And I think that the  
20 key will be -- is to make sure; and I think I've  
21 heard it said, but just stating it another way,  
22 the benefits to the clinician and to the patients

1 have to be clearly outlined so that it will be  
2 saturated and the use of this will proliferate.  
3 Because otherwise if it's just seen as a  
4 requirement that CMS or Joint Commission or  
5 whoever requires fill this out. So that -- and I  
6 see the benefits and I see the direct outcome of  
7 the benefit, but if it's not translated in a  
8 really positive way, I think it could be seen  
9 negative.

10 Finally, the question I have is  
11 predictive ability. So I know in dealing with  
12 patients you get a certain condition at this  
13 moment in time. In terms of decision support,  
14 looking ahead in terms of the progress given the  
15 reality of where a patient is now, can you  
16 project certain characteristics or where this  
17 patient's path will go and will be planning for  
18 that in terms of reality of the situation?  
19 That's probably not a very well-asked question,  
20 but --

21 DR. SMITH: No, no, no. That's a good  
22 question.

1                   To some extent, yes, I would say that;  
2           keeping in mind that these have been tested in so  
3           many different studies, like hundreds of studies  
4           actually, the -- looking at predictive ability  
5           for every patient type in every single situation,  
6           we're not going to have that kind of information  
7           available at this point. But there are certainly  
8           indicators for -- that have been -- that have  
9           gotten more attention or more study that we do  
10          have the ability to have a general sense of  
11          someone's trajectory and that sort of thing. I  
12          wouldn't say it would -- we could assume, oh, in  
13          three months someone's going to have a three-  
14          point change. That's not going to happen.

15                   MEMBER SLABACH: Right.

16                   DR. SMITH: But a general trend is  
17          potentially possible, yes.

18                   MEMBER SLABACH: Yes, I think it could  
19          provide a real reality moment for people. And  
20          then I just think about myself and the question  
21          about filling out a form and such. It helps the  
22          feedback. Instead of denial and --



1 DR. SMITH: -- Right.

2 MEMBER SLABACH: -- avoidance, it  
3 maybe helps to craft the conversation. I think  
4 it's a really good communication tool to set up a  
5 plan of treatment that's realistic and  
6 appropriate.

7 DR. SMITH: And there are research  
8 studies on how to best provide the information to  
9 clinicians and helping clinicians action back  
10 what they are doing, and again in different  
11 settings.

12 But your comment earlier about how  
13 this gets incorporated and the sort of way in  
14 which to make it ubiquitous or such that it's  
15 easily interpreted and integrated is that if you  
16 start with; I guess the comment earlier was about  
17 structural measures, just the assessment of these  
18 and people get used to having the information and  
19 there is guidance provided just cause, here's how  
20 you can use it, and there's -- these are --  
21 here's some information, but that isn't actually  
22 evaluating the outcome piece yet. But getting

1 people used to it is sort of a stepped approach.  
2 And then the potential to look at indicators  
3 either at the population level or -- depending on  
4 what you want at the individual level, too.

5 CO-CHAIR WALTERS: Pierre's been  
6 taking copious notes. We'll get back to him  
7 after Helen.

8 But, Jennifer?

9 MEMBER EAMES HUFF: So first of all,  
10 just congratulations on all the work. It's  
11 pretty amazing. And I think we would all agree,  
12 I think we have all agreed on the importance of  
13 patient reported outcomes and can see how it's a  
14 place where many users can come together and get  
15 benefits for a variety of reasons and leads  
16 towards a more patient-centered healthcare  
17 environment.

18 I want to underscore a couple of  
19 things, one around engaging the patients in using  
20 the info and the importance that has. And care  
21 delivery, and care management, and care  
22 engagement. And I think there's also a piece of

1       -- I know -- so I've filled out surveys, too, and  
2       I get really pissed if I don't know what happens  
3       with the results or don't see that. It just --  
4       so if we're talking about doing even more  
5       surveys, we need a way to actually get the  
6       patients to buy in to doing that.

7               And I think one of the ways -- so I  
8       don't know if you're doing research on  
9       smartphones and apps and how those can play a  
10      role. And I'm thinking more of it's not the  
11      solution for everybody. And we know there are  
12      population differences, but there was a time when  
13      there was like a standard model of you mail out  
14      the survey once, twice and then you do a phone.  
15      Is there a way that we can move to apps being a  
16      part of the multi-modal way in which you reach  
17      patients? And it's not the be-all-end-all, but  
18      it serves as a really important point for a  
19      variety of reasons.

20             And then the other thing I want to say  
21      to CMS is I think you've done a great job already  
22      starting to create momentum in terms of using

1 PROs in healthcare, the voluntary option in the  
2 CJR Program. And I actually even like CPC+  
3 because it becomes a part of the package. You  
4 get to choose the track, you choose the PROs. So  
5 I think that's really important to getting  
6 engagement and comfort with using that as  
7 starting to have it.

8 And I do think I find one of the  
9 challenges -- particularly as we're talking about  
10 different disease states, and if you're looking  
11 at doing aggregate comparisons across  
12 organizations, is the numbers challenge, right?  
13 Some of these places it's just small numbers to  
14 even get to the point of creating reliable and  
15 valid. It's kind of challenging. So I'd  
16 strongly encourage you to engage with the private  
17 sector in doing this towards the beginning. Is  
18 there a way in which the private sector can also  
19 be in alignment? One, for a variety of reasons  
20 it just creates having multiple signals of what's  
21 important; but two, in working together on the  
22 measure development so you're creating the

1 volume.

2 And I know that requires a lot more  
3 front-end work, but I think this is one of those  
4 places in measurement we have a key opportunity  
5 to get people on board and sort of driving in the  
6 same direction instead of having lots of  
7 different measures about the same thing. I think  
8 that's something we'd really want to avoid. So  
9 there really needs to be a lot of care from the  
10 get go in terms of having very early  
11 conversations about what people can and cannot  
12 do. From the registries to healthcare systems to  
13 the payers there's a variety of opportunities  
14 around that.

15 DR. SMITH: Just one quick  
16 clarification. The app is already available. So  
17 one of the things in the early slides was about  
18 that there's a PROMIS app and -- but it's  
19 available for iPad. It has not been developed  
20 for smartphone use yet. And that's where again  
21 the University of Rochester, everybody's using an  
22 iPad, distributing it, and that's how it's

1 specifically done.

2 I think one of the things -- I don't  
3 know if the iPad -- if it's in sort of an office  
4 space use, but I think as we're seeing some of  
5 the things that you're doing, we wouldn't want it  
6 tied to an office visit. It does not have to be.  
7 It can be done remotely. It can be done  
8 anywhere. I just more mean that if a hospital  
9 is, for example, doing it for every patient that  
10 walks in the door, you can do it on -- buy five  
11 iPads and you're -- and, but, yes, it can be done  
12 remotely, and that is used and can be integrated  
13 directly.

14 CO-CHAIR WALTERS: Wei?

15 MEMBER YING: Actually this year will  
16 be the third year our organization will be  
17 receiving the patient reported outcome data from  
18 our physician organization, so I can share some  
19 of the experience and the lessons learned from  
20 this exercise.

21 It's very exciting to hear that  
22 they're now -- PROMIS has kind of integration

1 with other two, but one question that we  
2 encountered when we tried to negotiate this  
3 contract is physicians are receptive to using the  
4 PROMIS tool, especially the physical function and  
5 the global tool, but they're hesitant on the  
6 mental health side. The main issue there is PHQ-  
7 9 has been out there for such a long time and  
8 they're so familiar with it. So they'll usually  
9 shy away from the mental health part.

10 And also another thing is a lot of  
11 times these things are -- specialist societies  
12 didn't want to use it, and we developed their own  
13 specialist-driven app. So usually, while we  
14 engage with orthopedists or oncologists, it's  
15 always PROMIS -- we offer PROMIS as one of the  
16 options, but they always want to couple it with  
17 another tool that they're more familiar.

18 So my question is, in terms of  
19 collaboration do you mean the collaboration was a  
20 more general standardized health status tool, SF-  
21 36, or do you mean the collaboration with some  
22 kind of the specialty society development tool?

1 DR. SMITH: So I should have had a  
2 slide on this. And there's actually web site  
3 about it. It's called PROsetta Stone. Very  
4 cute. It was --

5 (Laughter.)

6 DR. SMITH: It was a grant that was  
7 funded by the NCI, the National Cancer Institute,  
8 and it was specifically to develop these  
9 crosswalks between what we call legacy measures  
10 -- so SF-36 is one, PHQ-9 is also one, the CSD,  
11 etcetera, etcetera. And there's actually a list  
12 there. And we are planning additional ones in  
13 the current grant that NIH is funding now for  
14 use.

15 In terms of any -- and an oncology  
16 fact, for example, Roxanne had -- is used  
17 extensively. Many fact items are actually the  
18 same in PROMIS because the development of PROMIS  
19 actually came from both the identification of  
20 specific legacy measures that could be -- items  
21 could be pulled in directly from them. Then we  
22 have agreements with the authors of those



1 instruments to do that. And then we added  
2 additional items where there were gaps. So some  
3 of that crosswalking is fairly direct, actually.

4 And if there are little-used -- so the  
5 other thing I always tell the patient we  
6 understand there are many assessment tools that  
7 are -- people are very comfortable and familiar.  
8 Go ahead and use it. We can compare it to the  
9 PROMIS metric and get you a PROMIS score. If you  
10 want to change over, it's seamless. And if you  
11 want to stick with the PHQ-9 because you know it,  
12 that's fine, too.

13 So if there are specialty society-  
14 driven assessment tools that are more -- narrower  
15 use, I don't know that we would have crosswalking  
16 available now. It sort of depends on what it is.  
17 We've been trying to go with the most used ones  
18 first, obviously. Yes, but the methodology is  
19 there.

20 MEMBER YING: Oh, great. And another  
21 lesson learned we -- that we learned from this  
22 exercise is the actionability. So PHQ-9, the

1 reason we ran out with PHQ-9 the first two. The  
2 reason for that is there is -- I want to call it  
3 clinical guideline, but physicians sort of know  
4 if a patient gets scored within this score range,  
5 it means this. We think that's working. They  
6 know how -- what to do about it.

7 For the other two their argument is,  
8 yes, it's nice. I know it's 80. But what does  
9 that mean? What's the difference between 80 and  
10 85? So they're -- if they don't know what to do  
11 about it, it's very hard to persuade physicians  
12 to actually adopt a tool into their work flow.

13 And another thing about PHQ-9 is there  
14 are two PHQ-9 measures that's out there. I've  
15 seen at least one of them. Maybe both of them  
16 are endorsed by NQF. Again, when we go out with  
17 these measurements, we still get a lot of  
18 pushback. So we don't use it for payment  
19 purpose. We use it sort of as a monitoring  
20 purpose. But again, there is something there  
21 that we can monitor what's going on and we can  
22 look to claims data to see what is the treatment

1 has that leads to different kind of improvement  
2 pre and post the survey.

3 So for these other choose if there is  
4 no actionability so the physician doesn't know  
5 what to do about it, it's very hard to push  
6 forward.

7 CO-CHAIR WALTERS: Take home  
8 assignment, everybody should visit PROsetta just  
9 to look through it.

10 (Laughter.)

11 CO-CHAIR TRAVIS: Sean?

12 MEMBER MORRISON: So, Ashley, you've  
13 heard this from everybody, but just to  
14 reemphasize what an extraordinary body of work  
15 the PROMIS people have done over the years. And  
16 the amount of psychometric work to get a measure  
17 set like this is extraordinary, so thank you for  
18 that. I think it's probably one of the most  
19 pragmatic things that NIH has ever done.

20 (Off microphone comment.)

21 (Laughter.)

22 MEMBER MORRISON: Please do not. I

1 still rely on you for funding.

2 I wanted to make really three  
3 comments. The first is that what we've seen is  
4 CMS evolve from really essentially a big  
5 insurance company to an organization that has  
6 really focused on the health and quality of life  
7 of people in this country. And that is a very,  
8 very important change. And all of the work that  
9 we have done around this table has really focused  
10 on the goal of how do we improve health and  
11 quality of life for people who sit under CMS, and  
12 all the measures that we have done are really  
13 surrogates in that.

14 But as healthcare has moved forward  
15 and becomes more fragmented and more personalized  
16 and we get individual treatment options, all of  
17 these multiple measures that we have are going to  
18 become obsolete because either we're going to be  
19 spending all of our time measuring every single  
20 specific small outcome or process that goes with  
21 every single individualized treatment, or we're  
22 going to have to rethink how we're doing that.

1 And I think what this does is really focus on --  
2 this set of measures as what are -- what is  
3 important for the nation's health? It is the  
4 patient reported outcomes. It is what's  
5 important to know.

6 They don't -- my 90-year-old doesn't  
7 care what his or her glycosylated hemoglobin is.  
8 She really doesn't. What she cares about is how  
9 she's feeling. And I think that we really need  
10 to think very, very hard about how we push this  
11 forward extremely quickly, that the opportunity  
12 is here to have a set of measures that goes  
13 across diseases. It goes across settings, it  
14 goes across plans and it goes across providers in  
15 a way that's very meaningful to the people we're  
16 taking care of.

17 And I would love in five years to be  
18 sitting here and thinking about what are the  
19 PROMIS measure sets or what are the measure sets  
20 rather than when I'm going to be looking at is 25  
21 different items such as alcohol use and brief --  
22 if you provided or offered an alcohol use brief,

1 and multiple measures like that.

2 So thank you for doing that. And,  
3 Pierre, thank you for the opportunity for us to  
4 hear about it. And thank you for CMS considering  
5 this as a move forward. I think it is the right  
6 direction.

7 CO-CHAIR WALTERS: Okay. We're  
8 drawing near, but we'll get to Lee, then Dan and  
9 then Lindsey and then Helen and then Pierre.

10 Lee?

11 MEMBER FLEISHER: Yes, another kudos.  
12 We actually do use it on every visit for our pain  
13 practice. And one of the key questions is --  
14 particularly we don't know in pain what works at  
15 all for many of our treatments. In fact, I would  
16 question a lot of what we do, as do my own  
17 people, which is why they've done it in 3,000  
18 patients longitudinally with other scores. It  
19 would be great to somehow use this to actually do  
20 a comparative effectiveness trial within certain  
21 areas, because I think; Sean, I think would  
22 agree, some way to marry up payment with research

1 to find --

2 DR. SMITH: We at NIH welcome  
3 applications all the time. There are multiple  
4 receipt dates for January --

5 (Simultaneous speaking.)

6 MEMBER FLEISHER: Yes, between you and  
7 PCORI, right.

8 DR. SMITH: Right, yes.

9 MEMBER FLEISHER: So I think --

10 DR. SMITH: No, but really actually we  
11 do support a grant portfolio that would be very  
12 enthusiastic. I'm in a healthcare delivery  
13 research program. We're very much focused on how  
14 can we use tools like this. So additional  
15 studies, NIH funds, yes.

16 CO-CHAIR WALTERS: Dan?

17 MEMBER POLLOCK: And to that end and  
18 thinking in terms of moving this from where it is  
19 now to the measurement world for quality  
20 improvement, one of the most important dimensions  
21 of quality measures is to establish that there's  
22 a performance gap and to establish how the metric

1 can be used to close that gap. So I would just  
2 encourage keeping those very important parameters  
3 in mind as you move forward. Where is the  
4 performance gap? This is a vital sign. What you  
5 are developing is another vital sign. So how  
6 does that vital sign get used to actually improve  
7 patient care and where are the gaps?

8 CO-CHAIR WALTERS: Lindsey?

9 MEMBER WISHAM: So kind of having  
10 grown up through electronic clinical quality  
11 measures, I tend to look back at what are the  
12 lessons learned, what maybe we could have done  
13 differently to make that a smoother process. And  
14 I think that this is a new frontier, just as  
15 ECQMs have been as well.

16 I think one thing to consider from an  
17 implementation perspective is though while it  
18 seems it's very positive that it's configurable  
19 and there are so many questions that you could  
20 put together to hopefully achieve a very light  
21 score, depending on the questions you ask of  
22 course, but is it -- how do we get this data back



1 out of the systems? So I'd be very interested to  
2 talk with and Epic or a Cerner to see how they  
3 would potentially get the data back out in some  
4 sort of meaningful way for reporting so that  
5 initial benchmarking could be done, so that  
6 performance metrics could be developed, that it  
7 could begin to look at what these benchmarks may  
8 drive.

9 CO-CHAIR TRAVIS: Thank you, all. And  
10 before I turn it to Helen, there are just kind of  
11 three observations I've made about things that  
12 were interesting to me about this.

13 One was the whole discussion about is  
14 this for individual treatment decision making and  
15 how that may not align really very well  
16 necessarily with looking at performance measures.

17 I was in a conversation earlier this  
18 year around oncology actually, and the whole  
19 concept that this type of information could be  
20 used as part of the work flow and to the point  
21 about making it important to patients. I mean,  
22 if they see that what they're giving you actually

1 changes the treatment decisions that are being  
2 made, I think that's a significant piece. So  
3 whatever -- I would hate to think it only becomes  
4 a performance measure and is still not there for  
5 individuals treatment decisions along the way  
6 that need to be made.

7 Another thing I kind of picked up on  
8 -- and I'm -- I work with employers on their  
9 health, I don't work out in the industry per se,  
10 just as background -- is that there may be in  
11 other regulations, in other pieces of licensure  
12 or other regulatory processes for people who are  
13 required to do other types of patient reported  
14 outcomes. So I think being sure that as CMS  
15 looks at how do we use this that it's not just  
16 CMS programs that you're looking at, but that you  
17 understand what are the other pieces? And I  
18 think to Jennifer's point, working with others  
19 now to figure that out, whether it's an  
20 accreditation requirement, whether it's a  
21 regulatory requirement, whether it's a state  
22 requirement, so that there can be some kind of

1 consensus on how we move forward.

2 But the whole idea that we could  
3 actually have performance measurement be part of  
4 work flow versus this added thing that happens  
5 over on the side I think would be exciting, and I  
6 can kind of see how this could do that as long as  
7 it still continues to meet both needs.

8 And with that, I think I'll turn it to  
9 Helen.

10 DR. BURSTIN: Great. Thanks so much.  
11 I want to thank both of you. It was great. And  
12 Ashley and I have talked about this in the past.  
13 Just so you know, PROPMS has been a major purpose  
14 of NQF for the last several years, since very  
15 generous funding from HHS that allowed us to  
16 actually create a pathway for how do you go from  
17 the tool -- and this was a brilliant tool we  
18 talked about this morning where a series of item  
19 banks were essentially a PRO. How does that make  
20 the transition to a PRO-based performance measure  
21 is where I think a lot of our emphasis has been  
22 and I think a lot of the work is going to need to

1 go.

2 For those of you who haven't done it,  
3 I would really recommend going onto PROMIS and  
4 doing a couple of the item banks. There's  
5 nothing more instructive than actually doing  
6 itself, and we'd be happy to send those links  
7 out. And since Ashley mentioned the University  
8 of Rochester, I actually have the video from Judy  
9 Blumenauer that she shared and she allowed me to  
10 share with anyone of the work they've done of --  
11 literally a patient sitting with their clinician  
12 looking at their PROMIS results and seeing how  
13 well they did compared to where they could be.

14 And what's really extraordinary is  
15 they're also using it to get at appropriateness.  
16 So they can figure out based on somebody's pre-op  
17 score how far they would actually have had to  
18 move to make sufficient improvement that surgery  
19 is every worth doing. And they can actually tell  
20 people based on what your PROMIS physical  
21 functioning score is you're actually too well  
22 off. Surgery wouldn't get you enough benefit to

1 take the risk on. So this is really clinically  
2 transformative in a way we're just beginning to  
3 scratch the surface of.

4 So as part of our PROPM work funded by  
5 HHS there was a monograph developed, which is on  
6 Amazon; I think we shared the link with you, or  
7 free paper versions of it, that explain that  
8 pathway. The lead author is David Sella, who  
9 works very, very closely with Ashley and her team  
10 at PROMIS. And again, this pathway is where I  
11 think we really need to think about how do we  
12 move from having a structural measure -- and we  
13 talked about this yesterday. Is that really  
14 satisfying enough just that you checked that to  
15 the other extreme of did you demonstrate  
16 sufficient improvement like we have with our  
17 depression measures?

18 And I think part of what we have to  
19 figure out is there something in between those  
20 two poles that in the interim we could move  
21 towards -- is that you used it in a clinically  
22 meaningful way might be another way to help us

1 get closer to actually your point about being  
2 able to use it in practice, with being able to  
3 use it for measurement and what that looks like  
4 and the promise of -- it's very easy to do that,  
5 isn't it?

6 (Laughter.)

7 DR. BURSTIN: Redact. The promise of  
8 putting it in the HR means, with all the caveats  
9 we heard from Lindsey -- it's actually in there  
10 and I hope that it actually gets used clinically  
11 beyond a check box measure. Yes, I checked that  
12 somebody has an annual KDQOL, to Allen's earlier  
13 point.

14 We also have some incubator work we're  
15 doing as part of the NQF incubator, developing  
16 some new PROPMS. And David Sella is working very  
17 closely with is on those as well. And there is  
18 an interesting model to Wei's earlier comment  
19 about using a generic tool like physical  
20 functioning as we're doing for a multiple  
21 sclerosis project, but then adding on a series of  
22 more disease-specific kind of items to get sort

1 of the best of both worlds, but not get just the  
2 addition of multiple and multiple tools. And  
3 we'd be happy to share that as well.

4 Since Lindsey also -- I'm sorry, since  
5 Ashley also mentioned the PROsetta Stone work, we  
6 actually have been working closely with both  
7 developers, Minnesota Community Measurement and  
8 NCQA, to actually consider moving away from the  
9 measure requiring a PHQ-9, but to allow the full  
10 range of tolls that have been covered by the  
11 PROsetta Stone analysis to show that you can do  
12 that equivalence.

13 There's still some work ongoing, but  
14 from our vantage point the idea of being able to  
15 have a set of tools that you don't have to force  
16 hospitals to say I've been using this for years.  
17 Well, sorry, you now going to have to switch to  
18 this. That's not what we want to do. So we're  
19 actually very excited about what could be done  
20 here.

21 And just lastly -- there's one other  
22 thing I wanted to say. Now I can't remember what

1       it was. Oh, the last thing just in terms of the  
2       private sector, since both Jennifer and Cristie  
3       brought it up, we're actually doing a joint  
4       convening in -- I think it's now scheduled for  
5       February or March with ICHOM, the International  
6       Consortium for Health Outcomes Measurement;  
7       PROMIS is part of those discussions, being co-  
8       convened by NQF and the Healthcare Transformation  
9       Task Force. So David Lansky and I are leading  
10      those efforts with the folks at ICHOM.

11               So again, very much trying to see  
12      whatever we can to bring all of these different  
13      forces together. This is such a remarkable  
14      approach. There's just -- we spent so much time  
15      trying to harmonize at the back end and banging  
16      our head against the wall and it's just very  
17      exciting to see opportunities to very highly  
18      upstream harmonize before these measures even  
19      kind of hiccup. So thanks.

20               CO-CHAIR WALTERS: And a sincere thank  
21      you for everybody's thoughts and comments. You  
22      can tell people are quite energized about this.



1 Pierre, did you get enough feedback?

2 (Laughter.)

3 DR. YONG: We could spend the rest of  
4 the day. We can just skip the measures, right?

5 (Laughter.)

6 DR. YONG: No, I -- this has been --  
7 I mean, wow, right? I mean, I think I loved the  
8 engagement and didn't expect anything less, but  
9 really the discussion here in the past hour I  
10 think has been tremendously valuable, not just  
11 for us, but also for our NIH colleagues as we  
12 continue to sort of think and think about the  
13 potential next steps in this. So really do  
14 appreciate that and so want to thank Ashley and  
15 Roxanne for coming and providing their expertise,  
16 and also their additional CMS staff in the room,  
17 but also back at CMS who've been working with  
18 Roxanne and Ashley closely on this.

19 DR. SMITH: One thing just for synergy  
20 purposes, we are also working with the FDA and  
21 they are currently evaluating PROMIS as a -- for  
22 use as a PRO in drug development trials, and

1 specifically they're looking at physical  
2 function. And at their request they were  
3 interested in physical function in oncology. But  
4 that's an earliest place where; speaking of  
5 industry, other side of industry, will be using  
6 these as part of their comparisons in their arms  
7 to better understand the effects of the drugs  
8 that they're testing.

9 CO-CHAIR WALTERS: Thank you. This is  
10 what MAP and NQF is about right here. You just  
11 saw a great example.

12 We have one thing to take care of  
13 first. Aneeb, would you introduce yourself and  
14 disclose any conflicts you have?

15 MEMBER SHARIF: Aneeb Sharif with SEIU  
16 and there are no conflicts.

17 CO-CHAIR TRAVIS: Okay. Well, thank  
18 you all for a warm-up. It obviously was a very  
19 engaging conversation, and I think for me is very  
20 optimistic and very hopeful for where we can go.  
21 And I do want to echo Sean's opening comments  
22 about the role that CMS is playing and really

1 thinking about the health of our nation and not  
2 just being a payer and how you've aligned those  
3 two things together, which brings us to our next  
4 set of federal programs that we're going to talk  
5 about today.

6 The first program that we're going to  
7 address today is the Hospital Inpatient Quality  
8 Program, one of the ones that is nearest and  
9 dearest to all of our hearts. It also includes  
10 the Medicare and Medicaid EHR Incentive Program  
11 for Eligible Hospitals and Critical Access  
12 Hospitals. And I am going to turn it over to  
13 who? Melissa.

14 (Laughter.)

15 CO-CHAIR TRAVIS: I can't read and  
16 talk at the same time. It's like chewing gum and  
17 walking.

18 So, Melissa, thank you for kicking us  
19 off.

20 MS. MARINELARENA: Thank you, Cristie.  
21 Okay. Let's keep that positive attitude that we  
22 just had while we go through these last programs.

1 (Laughter.)

2 MS. MARINELARENA: So as we all know,  
3 IQR, this is a pay-for-reporting and public  
4 reporting program. Hospitals that do not  
5 participate or do not meet the program  
6 requirements are -- can receive up to a quarter  
7 reduction of the annual payment update and the  
8 program rules are to progress towards paying  
9 providers based on the quality rather than the  
10 quantity of care that they give patients. And  
11 there's also a goal of interoperability between  
12 EHRs and CMS data collection, which is where you  
13 see the integration of IQR and the EHR Incentive  
14 Programs, which are separate and; I think I got  
15 the EHR Incentive Programs right, to provide of  
16 course consumers information about hospital  
17 quality so that they can make informed decisions.  
18 And I'll look to my CMS colleagues to see if I  
19 got this right.

20 So the Medicare and Medicaid EHR  
21 Incentive Program for eligible hospitals and  
22 critical access hospitals, which is -- was

1 meaningful use -- it was three different  
2 programs. So the Medicare EHR Incentive Program,  
3 that is for eligible hospitals and critical  
4 access hospitals that do not successfully  
5 demonstrate meaningful use. They receive reduced  
6 Medicare payments.

7 For the Medicaid EHR Incentive Program  
8 those eligible hospitals and critical access  
9 hospitals that only participate in the Medicaid  
10 EHR Incentive Program, which is state-based, and  
11 do not bill for Medicare are not subject to any  
12 kind of payment adjustments.

13 Then there's the Medicare and Medicaid  
14 EHR Incentive Program. I think I got this right.  
15 So hospitals, eligible hospitals and critical  
16 access hospitals that participate in both and do  
17 not meet meaningful use, they are subject to  
18 payment adjustments, is that correct? I think  
19 so, yes.

20 Okay. And of course the goal is to  
21 promote the adoption and meaningful use of  
22 interoperable information, technology and

1 qualified EHRs and to accelerate the adoption of  
2 HIT and utilization of qualified EHRs. So we  
3 have measures that were -- are introduced into  
4 the program for both IQR and the EHR Incentive  
5 Program, and then some are just for IQR. We have  
6 separated them out.

7 Here's a slide provided to us by our  
8 colleagues from CMS. And we have again the NQF's  
9 priorities on the left. And you have -- all  
10 these measures on the right that were introduced  
11 in the MUC. The ones in the parentheses are the  
12 ones that are just the EHR Incentive Program, but  
13 we will -- those are the ones that we're voting  
14 on last, so we'll make that every clear when we  
15 go through them.

16 This is the current state of the IQR  
17 EHR Incentive Program, and we have it lined out  
18 where there's the ECQM only measures. And you  
19 can see the progress of the IQR Program over  
20 time. There used to be -- like when I started  
21 all of this there was a lot of chart-abstracted  
22 measures. There's very few left.

1                   The slide that you have now, I did  
2                   update it with the measures that are slated to be  
3                   removed within in the next couple of years, but  
4                   we start off with your COTIs, COPSIs, your  
5                   claims-based measures.

6                   If we go to the next slide, these are  
7                   more the claims-based measures, and I tried to  
8                   like lay them out my mortality or the  
9                   readmissions measure, excess days in acute care  
10                  measures. So these again are all based on sort  
11                  of themes.

12                  Keep going. We have a whole lot. So  
13                  here's your ECQMs. Those are the ones that are  
14                  -- can qualify either in the EHS Incentive  
15                  Program or some of the ones that the IHR IQR  
16                  Program can use as part of meaningful use.

17                  Now the ones that are highlighted in  
18                  purple; and I have it, those are finalized for  
19                  removal. So the original slides that you saw  
20                  back during the web meeting, I did include those,  
21                  but now I've put those back in so you could see  
22                  what CMS has scheduled to move out. So those are

1 scheduled to move out, so we don't look at those  
2 as gaps. They've been taken out. And you have  
3 it in your handout as well.

4 So these are the only chart-abstracted  
5 measures that are left. So CMS is really moving  
6 towards either the ECQMs or claims-based  
7 measures. And we have your patient surveys and  
8 some structural measures. And then there's two  
9 that are scheduled to be removed as well.

10 And there's a quiz afterwards --

11 (Laughter.)

12 MS. MARINELARENA: -- to name all the  
13 measures.

14 CO-CHAIR TRAVIS: Thank you. That  
15 will take a while.

16 (Laughter.)

17 CO-CHAIR TRAVIS: Before we go to  
18 public comment, Pierre, I know you wanted to make  
19 some comments based on some feedback you got  
20 yesterday. So if you would like to make some  
21 comments, or to -- whatever you're prepared  
22 comments are, those are the right ones.



1 DR. YONG: Thanks, Cristie.

2 So just wanted to offer just some  
3 general context for the measures we're about to  
4 discuss for IQR, so hopefully that will be  
5 helpful for you all as you're thinking about why  
6 we put these measures on the MUC list for IQR.  
7 And I'm just going to cover this at a very high  
8 level. Obviously if you have specific questions  
9 during individual measure discussions, we can  
10 certainly cover that.

11 But, so one of the things that folks  
12 have been -- I know many folks around the room do  
13 follow closely our regulations, but in last  
14 year's IPPS rule for the Inpatient Quality  
15 Reporting Program one of the questions we did ask  
16 for feedback on was -- generally we noted that  
17 based on some MedPAC analyses about a third of  
18 psychiatric hospitalizations for Medicare  
19 beneficiaries actually occur not in inpatient  
20 psychiatric facilities specifically, but in acute  
21 care general hospitals. So there's a substantial  
22 amount of psychiatric-related conditions that are

1 taken care of in general hospitals.

2 And so one of the questions we asked  
3 for feedback in last year's rule was -- or  
4 earlier this year was should we consider more  
5 behavioral health-specific measures in the IQR  
6 Program? And we did get a variety of responses  
7 that were quite supportive of that concept, but  
8 then also got some comments just cautioning again  
9 you needed us to consider general implications  
10 for work flow and effort, if you will.

11 But so what we did in this year's --  
12 when putting together this year's MUC list is we  
13 looked at -- as you know, yesterday we discussed  
14 the measures for the IPF Program, the Inpatient  
15 Psychiatric Facility Program. So we looked at  
16 the measures there that may be applicable to the  
17 Inpatient Quality Reporting Program. So for  
18 example, acute care hospitals.

19 And so you'll see a number of those  
20 measures on the MUC list, and they are all  
21 implemented into the IPF Program. So that's what  
22 was generating that and driving those decisions

1 to put those on the MUC list. And so we want  
2 your feedback on those. And are those the right  
3 measures? And so that's what we're here to  
4 discuss.

5 I think yesterday we also had a robust  
6 discussion and expect that we will have another  
7 robust discussion, as I'm sure Sean will lead the  
8 way on -- in certain terms of pain and opioid  
9 questions, but as we all know the opioid epidemic  
10 in this country is something that's garnered a  
11 huge amount of attention. And so we do have a  
12 couple of questions relating to pain management  
13 and opioid use. And so that's what's driving  
14 those particular questions being -- or measures,  
15 excuse me, being on the MUC list, and we'll have  
16 a discussion around that.

17 And then we also look generally across  
18 general gaps, so nutrition for example, there's a  
19 collection of four -- a set of four questions  
20 relating to patient nutrition and malnutrition  
21 status that are on there. There are some  
22 questions around tobacco use and other sort of

1 questions along those lines to fill those kind of  
2 gaps. So hopefully that will provide some  
3 general high level context for the decision  
4 making that went around measures that went onto  
5 the MUC list. So thank you.

6 CO-CHAIR TRAVIS: Well, thank you.  
7 That's very helpful for us to really think about  
8 how we go through these measures when we do.

9 So before we get started with the  
10 measures I'm going to open it up for public  
11 comment.

12 Operator, will you see if there's any  
13 public comment on the phone?

14 OPERATOR: Thank you. At this time if  
15 you would like to make a comment, please press  
16 star then the number one on your telephone  
17 keypad. We'll pause for just a moment.

18 (Pause.)

19 OPERATOR: And there are no public  
20 comments at this time.

21 CO-CHAIR TRAVIS: Public comment in  
22 the room? You may go ahead.

1 DR. SUTER: Can you hear me? Okay.  
2 Hi, my name is Lisa Suter. I'm the -- oversaw  
3 director -- I was -- directed measure development  
4 for the informed consent measure that you're  
5 actually going to be hearing about later, but the  
6 NQF staff indicated that we had new information  
7 relevant to today's discussion. They had new  
8 information relevant to the MUC 16-262 measure,  
9 the informed consent measure, and the NQF staff  
10 asked me as the developer to present during  
11 public comment.

12 So we have information relevant to the  
13 hospital level measure result reliability  
14 testing. We performed split sample test/retest.  
15 I'm happy to share documents if people want to  
16 see this in front of them. But this is where we  
17 took hospital level data for the informed consent  
18 measure, which we'll discuss later. We split the  
19 patients at each hospital randomly into two 50  
20 percent samples. We ran the measure results in  
21 both 50 percent samples and then calculated  
22 interclass coalition coefficients to determine

1 measure result at the hospital level reliability.

2 If you're looking just at the mean  
3 score, the ICC is 0.94. If you're looking at the  
4 proportion of informed consent quality scores at  
5 that hospital that were over a quality threshold  
6 of 5, a score of 5, the ICC was 0.73. And if  
7 you're looking at the proportion of informed  
8 consent quality scores over a threshold of 10,  
9 the ICC was 0.95. So I'll be happy to discuss  
10 this later, but the staff asked me to present  
11 this early during public comment. Thank you.

12 CO-CHAIR TRAVIS: Thank you.

13 MS. BOSSLEY: Hi, Heidi Bossley. I'm  
14 speaking on behalf of AMA. Their staff  
15 unfortunately couldn't make it today; asked me to  
16 read a couple comments for them.

17 Specifically, I believe the two HCAHPS  
18 pain measures are for discussion, not for votes.  
19 Or is one for vote and one's -- okay. Either way  
20 we're going to provide some comments on both.

21 (Laughter.)

22 MS. BOSSLEY: Pain is a high priority

1 when treating a patient and should be assessed  
2 frequently, but the measures and questions as  
3 drafted imply that it is the first and foremost  
4 topic of conversation. The questions still only  
5 highlight prescription medications as a sole  
6 option for managing pain when alternatives may  
7 also be effective such as physical therapy, non-  
8 prescription medications and so forth.

9           The questions associated with  
10 specifically the 263, the Assessing Pain During  
11 the Actual Stay, seemed very open-ended. And the  
12 second and third questions that are associated  
13 with that same MUC number, the ones dealing with  
14 has the hospital talked to you about how much  
15 pain you've had and then have they actually  
16 talked to you about how to treat that pain are  
17 not realistic since the scoring aspect is -- be  
18 always by patients?

19           We also suggest that instead of asking  
20 whether hospital staff explained side effects of  
21 any prescribed pain medications the question  
22 should ask if the hospital staff explained how to

1 safely use the medications. Therefore, there is  
2 a need for CMS to complete testing and bring the  
3 measures back to the MAP for careful review after  
4 the testing results and revised measures are  
5 developed to ensure the measures are valid and  
6 they do not lead to unintended consequences.

7 Second measure, the Safe Use on  
8 Opioids. They just wanted to briefly comment as  
9 well that they support the intent of the measure,  
10 but are very concerned that it will lead to  
11 unintended consequences that patients that  
12 legitimately need concurrent opioids prescribed  
13 will have an access issue primarily due to the  
14 fact that physicians might be penalized for  
15 prescribing those. Thank you.

16 CO-CHAIR TRAVIS: Thank you both very  
17 much. Oh, we have another one.

18 MR. SHANER: One more. Thank you.  
19 Hi, I'm Bob Shaner. I'm here on behalf of the  
20 American Academy of Pain Medicine, which is the  
21 AMA-recognized specialty society in pain  
22 medicine. And we want to say us, too.



1           I think we endorse the comments that were  
2           just made on behalf of the AMA. We think it  
3           would be a terrible mistake to change the  
4           existing measures and adopt a new set of measures  
5           that simply puts more focus on medication.  
6           Quality pain control in the inpatient setting is  
7           a lot more complicated than a yes/no choice on  
8           opioids.

9                     And in fact, there's been tremendous  
10           progress in the last 20 years on inpatient pain  
11           control, and much of it has very little to do  
12           with opioids. Sometimes it's opioids in  
13           conjunction with other therapies. Sometimes it's  
14           other therapies instead of opioids. But to come  
15           back with five questions, two of which now  
16           basically focus on did you get medication or  
17           didn't you get medication, and did they talk to  
18           you about side effects or didn't they talk to you  
19           about side effects? Just vastly oversimplifies a  
20           complicated part of quality inpatient care.

21                     So we would urge you as the AMA has to  
22           hold off on the five that you have proposed, do

1 more work, gather more input, and our academy  
2 would be more than happy to participate in that.  
3 We submitted a very lengthy statement to CMS in  
4 connection with the de-linkage of the quality  
5 measures for pain for payment purposes, and I'd  
6 like to make that available to you and hope  
7 you'll have a chance to share that among your  
8 colleagues. So thank you very much for the  
9 opportunity to weigh in on this.

10 CO-CHAIR TRAVIS: Well, thank you.

11 Are there any other comments in the  
12 room?

13 DR. GONZALEZ-FERNANDEZ: Hi, yes. I  
14 am Marlis Gonzalez-Fernandez. I'm a physiatrist,  
15 Johns Hopkins School of Medicine, and I'm here  
16 today to give comments representing the American  
17 Academy of Physical Medicine and Rehabilitation.

18 CO-CHAIR TRAVIS: Okay.

19 DR. GONZALEZ-FERNANDEZ: We also --

20 CO-CHAIR TRAVIS: Yes, I'm sorry. Go  
21 on.

22 DR. GONZALEZ-FERNANDEZ: We also agree

1 with the comments that AMA and AAPM just put  
2 forward. We further suggest that expanding the  
3 scope of the options for managing pain is  
4 incredibly important, especially, as we mentioned  
5 before, the opioid epidemic is upon us.

6 So those things that are beyond  
7 medications include activity, behavioral  
8 modifications, mindfulness, medication  
9 counseling, psychological support, physical  
10 occupational therapy. So and the measures are  
11 not addressing any of those interventions.

12 Further, we would suggest that MUC 16  
13 -- the 263 and 264 should better represent the  
14 intent of testing the communication of pain,  
15 rather the treatment of pain. So we would  
16 suggest that changing the how often questions in  
17 HP-2 and HP-3 to, for example, quote, "During the  
18 hospital stay did the hospital staff discuss ways  
19 to treat your pain with treatments other than  
20 medication," and perhaps saying, for example,  
21 "During this hospital stay did the hospital staff  
22 ask about the effectiveness of your pain

1 treatment" would be a little bit more open and  
2 help patients tell us if pain has been in the  
3 forefront, not just in the medicational realm,  
4 but overall.

5 So thank you for your consideration.

6 CO-CHAIR TRAVIS: Thank you. Are  
7 there any other comments on the phone, operator?

8 OPERATOR: There are no comments at  
9 this time.

10 CO-CHAIR TRAVIS: Okay.

11 MR. LAPIN: I believe I have a  
12 comment, if I'm able to right now.

13 CO-CHAIR TRAVIS: Sure.

14 MR. LAPIN: So, I'm Joshua Lapin. I'm  
15 at the Society of Hospital Medicine and I just  
16 wanted to I guess forward the comments from the  
17 AMA on the 263 and 264, the HCAHPS measures.  
18 Hospitalists are frequently in the position of  
19 treating pain for hospitalized patients, and we  
20 strongly appreciate that CMS has been working to  
21 address some of the unintended consequences and  
22 pressures around the HCAHPS questions.

1                   And similarly, to the AMA's comments,  
2                   we think that there's an opportunity to continue  
3                   working on the measures to be able to focus more  
4                   on the communication of pain and the wide range  
5                   of non-opioid options available for pain  
6                   management for hospitalized patients and for pain  
7                   management post-discharge.

8                   CO-CHAIR TRAVIS:   Okay.   Thank you  
9                   very much.

10                  I'm going to pause one moment to see  
11                  if there's anybody else out there before we close  
12                  public comment.   Any other comments?

13                  OPERATOR:   And there are no further  
14                  comments.

15                  CO-CHAIR TRAVIS:   Thank you, operator.

16                  All right.   Well, thank you to all of  
17                  those who made comments and we really appreciate  
18                  your perspectives as we begin to look at these  
19                  particular measures.

20                  The first set of measures that we're  
21                  going to be looking at address alcohol use and  
22                  drug use as well as one smoking prevalence

1       measure. I didn't get any notification ahead of  
2       time as to whether anyone wanted to pull these  
3       measures, but we will go measure by measure to  
4       see if anybody would like to pull them.

5               The first one is Alcohol Use  
6       Screening, which is MUC 16-179. It was  
7       originally and is being recommended to support a  
8       rulemaking. Is there anyone that would like to  
9       pull that measure? Okay. Akin says yes. Okay.  
10      That's great. So that measure's pulled.

11             The second one is Alcohol Use Brief  
12      Intervention Provided or Offered and Alcohol Use  
13      Brief Intervention. The recommendation on the  
14      consent calendar is support. Would anybody like  
15      to pull that? Mimi. Okay.

16             The third one is Alcohol and Other  
17      Drug Use Disorder Treatment Provided or Offered  
18      at Discharge and Alcohol and Other Drug Use  
19      Disorder Treatment at Discharge. And the  
20      recommendation is do not support. Would anybody  
21      like to pull that measure for discussion?

22             (No audible response.)

1 CO-CHAIR TRAVIS: Okay. Seeing none,  
2 it stays on the consent calendar.

3 And the final one is Patient Panel  
4 Smoking Prevalence IQR, which is MUC 16-68.  
5 Recommendation of do not support on the consent  
6 calendar. Anyone want to pull it?

7 (No audible response.)

8 CO-CHAIR TRAVIS: Okay. So we have  
9 two measures that are remaining on the consent  
10 calendar. They are MUC 16-180 and MUC 16-68.

11 Are there any general comments that  
12 anyone would like to make about these measures  
13 before we see if we can just accept the consent  
14 calendar? Akin?

15 MEMBER DEMEHIN: Since we pulled this  
16 I did want to give a --

17 CO-CHAIR TRAVIS: Oh, no, we're not  
18 there yet.

19 MEMBER DEMEHIN: Oh, okay.

20 CO-CHAIR TRAVIS: Sorry about that.  
21 We're just considering -- we'd like to offer an  
22 opportunity for people to say something about the

1 consent calendar measures in case there's a  
2 burning desire to do so. So that's where we  
3 still are.

4 Okay. I don't see anybody based on  
5 their card to do that. So are there any  
6 objections to accepting the consent calendar with  
7 those two measures on there?

8 (No audible response.)

9 CO-CHAIR TRAVIS: I don't see any  
10 objections. So now we will move to looking at  
11 the particular measures that have been pulled for  
12 discussion. And the first one is Alcohol Use  
13 Screening, MUC 16-179.

14 And, Akin, if you'd like to open us up  
15 with your rationale for why you had it pulled.

16 MEMBER DEMEHIN: Thanks, Cristie. So  
17 it was helpful to hear from Pierre some of the  
18 rationale for putting measures on the IQR list,  
19 one of which was looking at the IPF measure set  
20 and seeing if there was an opportunity to  
21 incorporate measures from that.

22 I'll be pretty blunt and say that we



1       aren't a fan of this measure in the IPF measure  
2       set and we're not particularly big fans of it in  
3       the IQR measure set either.

4               In raising concerns about this I  
5       certainly don't want to convey the impression  
6       that we don't believe alcohol abuse is an  
7       important public health topic, because it most  
8       certainly is. I just think we question the  
9       extent to which a measure like this, which is  
10      really offering a brief intervention during a  
11      hospitalization, during a time when a lot is  
12      happening for a patient -- just how much of a  
13      downstream impact this has on overall rates of  
14      alcohol abuse.

15             It seems to us that this is kind of a  
16      process measure. It's more of a check-the-box  
17      thing that something that has a strong linkage to  
18      outcomes. So from our perspective the effort to  
19      collect the measure doesn't seem to pay off  
20      downstream. So our recommendation on this would  
21      be do not support.

22             CO-CHAIR TRAVIS: Thank you, Akin.

1 And just as a clarification we do have several  
2 alcohol measures here. This particular one is a  
3 screening measure, but we will get to the brief  
4 intervention measure in a moment. So thank you  
5 for that.

6 And so his thoughts are do not  
7 support. Are there other comments on this  
8 measure? Mimi?

9 MEMBER HUIZINGA: We agree with the  
10 AHA that the effort required to submit and  
11 collect the information for this particular  
12 measure doesn't seem to be paying off, I guess,  
13 in actionable and proven evidence.

14 Again, like the AHA, we don't like  
15 this measure in the current program that it's  
16 being used in and think that better understanding  
17 of the impact across a broad range of different  
18 types of acute care settings is needed before  
19 going forward.

20 CO-CHAIR TRAVIS: Thank you.

21 Sean?

22 MEMBER MORRISON: Oh, I just want to

1 offer a counter-argument. Alcohol screening is  
2 something that is not done well in hospitals.  
3 The risk of not identifying it is acute alcohol  
4 withdrawal syndrome, which is often missed and  
5 can be deadly. And one of the reasons actually  
6 to keep this in is to ensure that people with  
7 a history of heavy alcohol use are screened and  
8 appropriately targeted, not to develop a brief  
9 alcohol intervention while they're in the  
10 hospital. I would just urge consideration to  
11 keep it for that reason, not for a brief alcohol  
12 intervention.

13 CO-CHAIR TRAVIS: Thank you, Sean.  
14 Marty?

15 MEMBER HATLIE: Just to reinforce  
16 that, there were comments made by the Joint  
17 Commission and public comments about how  
18 important this is because the problem is very  
19 real. So I'm just supporting Sean's analysis.

20 MEMBER SULLIVAN: This is Ann on the  
21 phone. I just want to echo what the last two  
22 individuals have said. There's a high use of

1 alcohol in the elderly especially and often not  
2 noticed, not asked, not pursued, and I think  
3 causes lots of trouble actually in their ongoing  
4 medical care, and even as was mentioned the  
5 possibility of missing it and having a severe  
6 outcome.

7 But I really do think you need to be  
8 screening for this like you would for anything  
9 else that you're concerned about the elderly,  
10 especially since it's so unidentified. So I  
11 would support particularly the screening measure.

12 CO-CHAIR TRAVIS: Thank you, Ann.  
13 Nice to hear your voice this morning.

14 Are there other comments? Ron?

15 CO-CHAIR WALTERS: I agree with Sean  
16 and Ann, and I do distinguish between the  
17 screening measure and the intervention measure.  
18 There obviously are a subset of people who come  
19 into the hospital, either their first time or  
20 without direct connection to other outpatient  
21 programs.

22 I believe this is -- this underlies

1 the Joint Commission's stewardship of the measure  
2 that it's an important place of capture. The  
3 attribution in that sense can only be to the  
4 facility for doing it. The Joint Commission is  
5 obviously going to keep this as a belief that  
6 they have that it is a responsibility; I'm not  
7 speaking for them, by the way, of hospitals to do  
8 as a potential point of marking people for  
9 intervention, I would say. And I would urge that  
10 we support this, the preliminary analysis of  
11 supporting for rulemaking.

12 CO-CHAIR TRAVIS: Thank you, Ron.

13 Yes, David?

14 MEMBER ENGLER: Can you hear me now?

15 Great. Thanks. Sounds like a commercial.

16 So with respect to Ron's comment, I'd  
17 like to support that, on 178 in particular. A  
18 number of hospitals have a significant burden of  
19 drug and alcohol abuse, a disease burden in our  
20 particular populations. I'll give you a number.  
21 It's over 30 percent of patients that we're  
22 serving that have underlying drug and alcohol

1 issues affecting their conditions, and chronic  
2 conditions at that.

3 I did have a question on -- and I'm  
4 glad the developer is on the line today. I did  
5 have a question because I'm pretty much  
6 encouraged by what I see in terms of the ability  
7 of brief interventions to have some sort of  
8 impact on alcohol use in the long term. And if  
9 in fact that is the case and if in fact we can do  
10 brief interventions and have these opportunities  
11 to reduce the burden of disease in the  
12 population, which by the way is a horrible  
13 disease, then I think it's up to us to support  
14 178 as we go forward. So those are my comments.  
15 Thank you very much.

16 CO-CHAIR TRAVIS: Well, thank you.  
17 And let's please keep David's thoughts in mind  
18 when we do address 178. It's a little confusing  
19 here I know because we're kind of doing both of  
20 these, but they've both been pulled. So we will  
21 have the opportunity. So if we can, let's think  
22 about the screening component so that our vote is

1 clean at the end of this conversation.

2 So, Mimi?

3 MEMBER HUIZINGA: Thank you. I forgot  
4 to add that we would be much more interested in  
5 this measure if it was eSpecified. So we feel  
6 that if -- right now this is a manual extraction  
7 measure and the effort required to manually  
8 extract this is what we're concerned about from  
9 the screening perspective. However, if it was  
10 eSpecified, that would alleviate some of those  
11 concerns.

12 CO-CHAIR TRAVIS: Well, thank you for  
13 that. Just as a question I had had in my own  
14 mind was where's the burden? Is it on finding  
15 out whether you did the screening or is it on the  
16 screening, because there appears, at least from  
17 my perspective, to be support for doing the  
18 screening from a clinical standpoint. So, Mimi,  
19 am I interpreting you correctly that it's maybe  
20 more burdensome from the data collection  
21 standpoint?

22 MEMBER HUIZINGA: It's burdensome on

1 both. So in this standpoint -- but particularly  
2 on the data collection. So in this case it  
3 required it to be an approved measure, so you  
4 need to ensure that from a work flow standpoint  
5 that you built out the process to collect that  
6 information and to prompt that.

7 But when -- then when you're going  
8 back through as an abstractor and trying to --  
9 you have to find what note it was performed in.  
10 It could be a nursing note or a physician note.  
11 So it's in multiple places in the EHR, because  
12 it's not eSpecified.

13 Then the reviewer must know whether or  
14 not the tool that was used is a validated tool.  
15 And you could use different tools for different  
16 age groups and what qualifies as validated versus  
17 not validated could be debated.

18 And then lastly, what happens if the  
19 tool is not completed? Maybe the patient  
20 answered or the person recorded only a few parts  
21 of the question.

22 So these are some of the very really



1 challenges that we have with abstraction of the  
2 screening tool in the current program. And we  
3 don't feel that those have been adequately  
4 resolved to move this to a broader program. Even  
5 though we totally understand and agree with what  
6 everybody said that alcohol screening is  
7 critically important, we would be more in favor  
8 of this if this were eSpecified and maybe further  
9 delineated.

10 CO-CHAIR TRAVIS: Thank you. That's  
11 helpful.

12 Okay. Any other comments before we go  
13 to a vote? Yes?

14 MEMBER JORDAN: Well, I would like to  
15 propose then for No. 2 that we have the ability  
16 to vote to say -- the clarification would be to  
17 develop a new measure as the -- what we're voting  
18 for with conditional support, the condition of an  
19 eMeasure be developed and --

20 CO-CHAIR TRAVIS: Okay. And I'm going  
21 I thank you for that, Jack. I'm going to look to  
22 staff around that as to whether that would be a

1 refine and resubmit or whether that would be a  
2 conditional support.

3 MS. MARINELARENA: That would be a  
4 different measure. So you have to vote on the  
5 measure.

6 CO-CHAIR TRAVIS: We're going to vote  
7 on the measure. We're trying to decide if we  
8 vote one, two, three or four.

9 MS. MARINELARENA: Right.

10 CO-CHAIR TRAVIS: So the question is  
11 would refine and resubmit -- if we wanted it to  
12 be an eMeasure would it fall under refine and  
13 resubmit? So it doesn't even fall under that?

14 MS. MARINELARENA: Well, that's --

15 DR. FITZELL: Hi, I'm Joann Fitzell.  
16 I'm one of the nurses that works at CMS. I'm one  
17 of the measure leads on this. So this is  
18 currently being eSpecified by SAMHSA, and TJC is  
19 consulting with them.

20 (Off microphone comment.)

21 DR. FITZELL: Well, for -- right, for  
22 one of the measures we actually have quite a bit

1 of data. The two -- sub two and sub three, the  
2 time frame is not -- well, not yet. We're --

3 CO-CHAIR TRAVIS: We're early use. I  
4 mean, the screen.

5 DR. FITZELL: Right. So -- pardon?

6 (Off microphone comment.)

7 DR. FITZELL: Yes. Yes, it is.

8 CO-CHAIR TRAVIS: I'm sorry. I  
9 couldn't hear Helen's question. So I --

10 (Off microphone comment.)

11 DR. FITZELL: On, not it's not. It is  
12 not complete yet, no.

13 CO-CHAIR TRAVIS: And when we says is  
14 it done yet, meaning toward eSpecification, is  
15 that --

16 DR. FITZELL: Right.

17 CO-CHAIR TRAVIS: -- the content? I  
18 wanted to be sure. There are all these sub-  
19 conversations going on so it's difficult for us  
20 to all year.

21 So I'm going to go back to the same  
22 question: The fact that there may be an interest

1 in an eSpecified measure would not therefore be  
2 anything that could get you into two or three?

3 MS. MARINELARENA: It can capture that  
4 you -- if you support this measure now and then  
5 make -- and capture the report that you strongly  
6 support the eSpecification of this measure that  
7 is in process.

8 DR. BURSTIN: So that would be yes.

9 MS. MARINELARENA: Right. So the  
10 recommendation for this one now is support for  
11 rulemaking, this measure now. And then know that  
12 the workgroup really wants the eMeasure, which is  
13 in process.

14 CO-CHAIR TRAVIS: That's great. I  
15 can't read the whole room, but what if the answer  
16 is -- I guess we could make that comment no  
17 matter what we voted on. So if we voted -- it  
18 can't be a condition or a refine and resubmit is  
19 what you're telling us? Okay. That's what I  
20 wanted to give clearly since that was the  
21 question Jack brought up.

22 Okay. We've still got some cards

1 going up. So I know this has been a little  
2 confusing and I want to be sure we get there.

3 Marty?

4 MEMBER HATLIE: Just given the  
5 magnitude of the problem that several of us have  
6 spoken to today, I would urge us to support this  
7 measure and not wait for the eMeasure with the  
8 strong comments that we've talked about, the  
9 importance of how an eMeasure would reduce  
10 burden, but I think this is one of those areas  
11 where we really have the opportunity to make a  
12 difference by using that hospitalization  
13 opportunity to address this national problem. So  
14 please let's support this one.

15 CO-CHAIR TRAVIS: Thank you, Marty.

16 Brock?

17 MEMBER SLABACH: I would probably say  
18 it the other way, that we need to not support but  
19 strongly recommend that this be eSpecified and  
20 brought back for inclusion in the program.

21 CO-CHAIR TRAVIS: Right, I mean, I  
22 think we've got that. I think that whatever we

1 say people are going to -- might to put a strong  
2 urging that an eMeasure be associated with this.  
3 So that can be kind of a side comment. It won't  
4 come into the voting, but it'll come in as a side  
5 comment.

6 Mimi?

7 MEMBER HUIZINGA: Well, thank you, and  
8 I agree with Brock. Of course, I mean, I want  
9 people to understand that if you put this measure  
10 in now, and even if we get conditional support,  
11 there is a history that CMS would take that  
12 forward and put that into a payment program. And  
13 so hospitals would build an entire abstracting  
14 team and program, train people, invest lots of  
15 money in making this happen. And then maybe it  
16 sounds like next year we would be talking about  
17 an eMeasure. So I would strongly support people  
18 not to support this and just do it right the  
19 first time and not have a runabout process.

20 MEMBER SULLIVAN: This is Ann.

21 CO-CHAIR TRAVIS: Yes, Ann?

22 MEMBER SULLIVAN: Could I just get

1 some clarification here? They said the eMeasure  
2 is in process. I mean, does that mean that it's  
3 going to be done very, very soon, or not?

4 And the second thing is I don't know  
5 the -- I would still vote for approving this and  
6 then saying that we strongly support getting the  
7 eMeasure. Because again, putting it off is  
8 something -- it interferes with the -- now you  
9 can be a long time before you do alcohol  
10 screening.

11 And I would just like to echo what  
12 other people have said. We have used taught  
13 processes. I know they can be difficult. I know  
14 they're a little burdensome, but this is a big  
15 issue. And I don't think it's very wise of us to  
16 not approve it now, but maybe with a very, very  
17 strong recommendation that the eMeasure move  
18 along. And I'm not so sure that CMS would put  
19 this out as an eMeasure. We're almost ready, I  
20 would assume, although maybe I shouldn't, that  
21 they would then do it as an eMeasure.

22 CO-CHAIR TRAVIS: Thank you. We'll

1 get clarification again. Can you all speak to  
2 the eMeasure?

3 DR. YONG: I mean, the eMeasures we're  
4 working with SAMHSA on this and eSpecifying it.  
5 That's -- I don't have a specific timeline.

6 CO-CHAIR TRAVIS: Oh, so there's no  
7 specific timeline on when the eMeasure would be  
8 available.

9 So unless it's something different  
10 than has already been said, Akin -- because I  
11 think we're being a little repetitive. So I want  
12 to be sure it's additive.

13 MEMBER DEMEHIN: This is a slightly --  
14 this is more a question especially for the  
15 clinicians in the room. So this particular  
16 measure has as time window of three days within  
17 admission to screen for problem alcohol use.  
18 Does it make it -- and I know one of the points  
19 that was made was around this could be helpful in  
20 terms of identifying alcohol toxicity and its  
21 downstream impacts on patients, but does that  
22 three-day window make it any more or less useful



1 for that purpose?

2 CO-CHAIR TRAVIS: Sean?

3 MEMBER MORRISON: Yes, speaking as a  
4 clinician, the -- if you're looking at alcohol  
5 withdrawal syndrome, the window is 48 to 72  
6 hours. And unlike opioid withdrawal syndrome,  
7 alcohol withdrawal syndrome kills. Opioids,  
8 typically withdrawal doesn't kill. Alcohol does.

9 CO-CHAIR TRAVIS: Okay. Well, I think  
10 that we have kind of addressed -- and we see the  
11 two issues that are before us. So I think it's  
12 time to move to a vote. As a realistic issue,  
13 our vote really is support and do not support at  
14 this point because the eMeasure development is  
15 not suitable for conditional or refine and  
16 resubmit.

17 Just to I guess -- I'm looking at  
18 whether we should just vote on those two, or  
19 should we include -- okay.

20 So we're going to just give you the  
21 option, unless I hear differently from you all,  
22 because I want to give you a chance to vote in

1 any category. But it looks like it's going to be  
2 support or do not support. And unless there's an  
3 objection, those are going to be the two options.

4 MS. MARINELARENA: Before you vote I  
5 just want you to take a look at the measures that  
6 are in the current set now. There's only six  
7 chart-abstracted measures, so I don't know if  
8 that makes a difference. I remember the days  
9 when there was a whole lot. So if CMS is moving  
10 towards -- there's less chart-abstracted  
11 measures. So I don't know if that makes a  
12 difference in decreasing the burden, but I was  
13 there when you were doing --

14 (Simultaneous speaking.)

15 CO-CHAIR TRAVIS: Well, thank you.  
16 No, I think that is helpful. So thank you very  
17 much for adding that.

18 (Laughter.)

19 CO-CHAIR TRAVIS: Okay. I think we'll  
20 go on and move -- and we're only going to vote  
21 one and four.

22 MS. QUINNONEZ: Yes, before you cast

1 your votes I just want to do a quick reminder for  
2 the sake of those who may not have been with us  
3 yesterday. When you cast your vote, everyone, I  
4 want to make sure everyone who is voting has  
5 their voting clicker, yes, in the room? Okay.  
6 If you -- when you are ready to vote, when we  
7 open the vote, if you could just point your  
8 clicker towards me.

9 And also to remind you that your last  
10 click that you do make will be your vote. Okay?  
11 So you can click as many times as you want, but  
12 the very last click that you do make will be your  
13 final vote.

14 And we may have to do this more than  
15 once. Hopefully not. But thank you for your  
16 patience. Okay?

17 So we are now voting on Hospital  
18 Inpatient Quality Reporting for Consent Calendar  
19 No. 6. This is Measure -- the Alcohol Use  
20 Screening measure, and that's MUC 16-179.

21 You have two options. For those who  
22 are on the phone, you can cast your ballots

1 through our chat system. Option No. 1 is  
2 support. Option No. 4, do not support. So you  
3 have two options for MUC 16-179, the Alcohol Use  
4 Screening measure. And Option No. 1 is support;  
5 Option 4, do not support.

6 (Voting.)

7 MS. QUINNONEZ: Thank you, Marisa and  
8 Ann.

9 Okay. Voting is now closed. Okay.  
10 Wow.

11 (Laughter.)

12 MS. QUINNONEZ: For the results of  
13 Alcohol Use Screening measure, MUC 16-179, the  
14 results are 61 percent voted for support, 39  
15 percent voted do not support. This moves forward  
16 with support.

17 CO-CHAIR TRAVIS: Well, the only thing  
18 I can say from a project -- I mean, a meeting  
19 management standpoint, I'm relieved that we at  
20 least came down one way or the other on this  
21 measure --

22 (Laughter.)

1 CO-CHAIR TRAVIS: -- because we were  
2 going to have to go back and talk about this even  
3 more. So, but thank you. And I do hope that  
4 those who voted do not support understand that  
5 your thoughts were heard and they will be -- they  
6 are being communicated directly, but also will be  
7 considered as we move forward. So thank you all  
8 for that.

9 The next measure that's been pulled is  
10 the Alcohol Use Brief Intervention Provided or  
11 Offered and Alcohol Use Brief Intervention. I  
12 think it means happening. But anyway, and this  
13 is MUC 16-178. We've had a little bit of  
14 discussion because these things are so close  
15 already, but I know that Mimi pulled this.

16 So if you would like to talk with us  
17 about the rationale behind pulling it.

18 MEMBER HUIZINGA: I think that the  
19 rationale has already been well-stated, so I'll  
20 just review at a high level. Offering a brief  
21 intervention during the hospital stay is already  
22 a measure in another program and we haven't

1 necessarily seen the payoff from having that  
2 measure as we would like to see.

3           There is a tremendous amount of effort  
4 that goes both into implementing this  
5 intervention, tracking it, even determining if  
6 it's been offered. The amount of training, which  
7 I feel like maybe I didn't spend enough time  
8 speaking on, and the cost to a hospital of  
9 training abstractor -- first developing the  
10 process, defining the protocol, developing the  
11 abstraction tools, training all the abstractors,  
12 having to fill in the abstractors when somebody  
13 can't be there is a tremendous amount of time and  
14 effort and money. And so every time we put in a  
15 chart-abstracted measure, even if there's only  
16 six, is still -- just maintaining them on an  
17 annual basis is a phenomenal amount of time and  
18 effort.

19           This not only -- even if this was  
20 eSpecified, we would still have concerns about it  
21 due to several of the comments that David and  
22 Akin both made earlier about just the overall

1 benefit of having the brief intervention compared  
2 to the effort that is required to capture this  
3 particular measure.

4 CO-CHAIR TRAVIS: Okay. And I  
5 apologize for this. I did not do this earlier.  
6 It gets confusing up here, believe it or not.  
7 But we do have some lead discussants that were  
8 engaged with this set of measures. David is one  
9 of them and has raised his card, so I'll probably  
10 start with you. But either Marsha or Jennifer  
11 want to add any comments, we would like to hear  
12 from you, if you can, regarding what your  
13 thoughts were.

14 So, David?

15 MEMBER ENGLER: Thank you. Thank you.  
16 And thank you, Mimi, for your comments  
17 as well.

18 My -- I had as a lead discussion I had  
19 -- hopefully the developer is on the line today.  
20 Am I thinking correctly? Are they --

21 CO-CHAIR TRAVIS: I don't --

22 MEMBER ENGLER: Are they not with us

1 today?

2 CO-CHAIR TRAVIS: No, they're not with  
3 us today.

4 MEMBER ENGLER: Oh, okay. Because I  
5 was hopeful for a little bit more conversation  
6 about whether or not the interventions in  
7 hospitals, these brief interventions have been  
8 proven to impact alcohol abuse in patients that  
9 are being served. And it's a question that I  
10 have that was raised by some of my staff and some  
11 of my members, whether or not that has been  
12 tested on the inpatient side. My notes suggest  
13 that it has been effective in primary care  
14 settings, but I do not know. And this is a  
15 question that I'd be interested -- and perhaps  
16 Mimi can chime in on this. I'd be interested in  
17 knowing it hasn't had any impact on the use in  
18 inpatients; that is, does brief interventions  
19 have any impact on long-term use of alcohol?  
20 Thanks.

21 CO-CHAIR TRAVIS: Well, why don't we,  
22 if that's okay, go on and try to see if we can



1 get some additional information on that, and then  
2 we'll go to the other lead discussants if they  
3 have any additional comments.

4 I'm looking at CMS. Do you all know  
5 what the evidence is related to the brief  
6 intervention in an inpatient setting in terms of  
7 the effectiveness?

8 (Off microphone comment.)

9 CO-CHAIR TRAVIS: Okay. I don't know  
10 if any of the Committee members on the phone have  
11 any comments. Ann, I don't know if you have any  
12 work in this area or know of any that might be  
13 helpful.

14 MEMBER SULLIVAN: I think the major  
15 studies have been done in primary care. To tell  
16 you the truth, I'm not sure if they've looked at  
17 absolute outcomes from individuals who are  
18 actually in the hospital and get brief  
19 interventions. So I'm sorry I can't really help  
20 with that issue.

21 CO-CHAIR TRAVIS: No, that's fine.  
22 Thank you.

1           It's my understanding there may be  
2           some additional information in our detailed  
3           summaries of this measure, but I don't have that  
4           in front of me. So would somebody who's looking  
5           at it like to read what it says? I don't know if  
6           that's Helen, Melissa, Ron.

7           CO-CHAIR WALTERS: So, yes, I'm  
8           reading in the measure description itself and  
9           down in the -- it's actually called the  
10          Endorsement and Public Comments. And what it  
11          says is, "The Committee noted that the majority  
12          of the evidence generally is related to the  
13          outpatient setting, however, following  
14          substantial discussion Committee members agreed  
15          that certain evidence could be generalizable from  
16          the primary care setting to the inpatient setting  
17          and that sufficient evidence was presented  
18          related to the inpatient setting based on the  
19          USPSTF and Cochrane Review evidence to support  
20          the measure."

21                 We don't have the actual data, but  
22          that's the statement that's made.

1 CO-CHAIR TRAVIS: Okay. I think  
2 that's helpful. Is that helpful to you, David?

3 (Off microphone comment.)

4 CO-CHAIR TRAVIS: Yes. Is that  
5 related to this, Sean? Okay.

6 MEMBER MORRISON: So a brief PubMed  
7 search found two RCTs in the inpatient setting of  
8 the effectiveness of a brief alcohol intervention  
9 in the hospital with highly statistically  
10 significant results.

11 CO-CHAIR TRAVIS: So to us non-  
12 researchers does that mean it is working?

13 MEMBER MORRISON: I'm sorry. What it  
14 means is, yes, there are two randomized control  
15 trials that have shown that a brief alcohol --  
16 oh, man.

17 (Laughter.)

18 (Simultaneous speaking.)

19 MEMBER MORRISON: A hundred and  
20 twenty-four large confidence intervals, but  
21 statistically significant.

22 CO-CHAIR TRAVIS: Okay. So I guess

1 one thing -- I mean, there's two things that I'm  
2 taking away from that: There are some PubMed  
3 results that show that it was effective, albeit  
4 people may be looking at the numbers, but that in  
5 the standing committee they did feel that the  
6 evidence from primary care -- they felt after  
7 looking at it would also apply in this setting.  
8 So I think we've given you the answers that we  
9 can give you relative to David's concerns.

10 I do want to give a moment, if any of  
11 the other lead discussants had any comments that  
12 they wanted to make relative to this particular  
13 measure, MUC 16-178. And it's okay to say no.  
14 Okay. I just didn't want to not honor the work  
15 that may have been done in advance.

16 Okay. So because I have been thinking  
17 and not looking, I'm just going to start down at  
18 the end of the table with Marty and work my way  
19 up on this side. And then those of you over  
20 there can start thinking about whether you want  
21 to have any comments.

22 So, Marty?

1                   MEMBER HATLIE: Okay. Since we don't  
2 have the Joint Commission with us on the phone,  
3 they did file a very significant and strongly-  
4 worded comment. Clinical trials have  
5 demonstrated that brief interventions, especially  
6 prior to the onset of addiction, improved health,  
7 but also reduced cost. So there's a cost element  
8 here that I wanted to highlight that we haven't  
9 really talked about except for the effort side of  
10 the equation. Thank you.

11                   CO-CHAIR TRAVIS: Thank you, Marty.  
12 We're glad you're looking at those comments, so  
13 thank you very much.

14                   Brock?

15                   MEMBER SLABACH: This measure I think  
16 illustrates, and Mimi talked about the very  
17 important parts of data collection, but I'm going  
18 to move upstream now and suggest to you that  
19 there's about 1,500, 1,800 small and rural  
20 hospitals that have a very difficult time in  
21 terms of staffing to be able to provide this  
22 intervention. So the first question I ask is

1       who would do this in a particular facility?

2                   And usually, like in the tobacco  
3       cessation requirements, it's respiratory therapy.  
4       We say you go up to talk to the patient. This is  
5       even more difficult I think in terms of a  
6       conversation, especially if family is involved  
7       and they're in the room and you're in a two,  
8       three, four-day acute care stay dealing with  
9       important acute care issues that are going all on  
10      at the same time. And now you're trying to talk  
11      with them about some systemic issue that is going  
12      to go on well beyond that short stay. And it  
13      needs to be done well, I guess is my point.

14                   And then this becomes a check-the-box  
15      program. And then the value of it I think  
16      diminishes despite some of the evidence to the  
17      contrary. I just know how this is  
18      operationalized in a facility.

19                   CO-CHAIR TRAVIS: Thank you.

20                   Mimi?

21                   MEMBER HUIZINGA: Thank you. So I  
22      wanted to clarify the points about the data that

1 we were looking for, and then also because I'm an  
2 epidemiologist and I can't -- I feel like I can't  
3 let Sean's comments go unspoken to.

4 The first piece of it, what we were  
5 specifically talking about was evidence of the  
6 use of this measure. So not a randomized control  
7 trial. But this measure has been in use and  
8 we're very interested how this measure has  
9 impacted long-term alcohol use, and we don't feel  
10 that that has been publicized. And if it has,  
11 CMS, we would love to see that information and  
12 data and I would love to be corrected.

13 Second, when we look at this measure  
14 and how it aligns to just the Cochrane study, the  
15 Cochrane Review was a 14 randomized control  
16 trial. Cochrane does a great job. It only shows  
17 a benefit for heavy alcohol users, which is not  
18 what this measure is. This measure is anyone  
19 with unhealthy alcohol use. There are multiple  
20 studies that show -- randomized control trials  
21 that show that use and light drinkers or at-risk  
22 drinkers does not show benefit.

1                   And so we've taken a population where  
2                   there is evidence for -- we've expanded in this  
3                   measure creating additional work and effort that  
4                   again doesn't have the support. I know this  
5                   isn't our place to debate the scientific merits  
6                   of the study; and Helen's shaking her head at me,  
7                   but it was opened up and there was a question  
8                   that was asked, so I felt that it's worthwhile to  
9                   respond then to you.

10                  CO-CHAIR TRAVIS: Thank you, Mimi.

11                  Brock, anymore comments or --

12                  MEMBER SLABACH: No.

13                  DR. BURSTIN: Operator, could you  
14                  please open the line for Ann Watt from the Joint  
15                  Commission?

16                  (Pause.)

17                  DR. BURSTIN: Ann, are you with us?

18                  (Pause.)

19                  DR. BURSTIN: Operator, are you with  
20                  us?

21                  OPERATOR: Ann has not dialed in. We  
22                  do have Alvera Ryan on with the Joint Commission.



1 DR. BURSTIN: Okay. Maybe they  
2 switched. Go ahead.

3 (Pause.)

4 DR. BURSTIN: Good morning.

5 MS. RYAN: Hi, this is Alvera Ryan.

6 DR. BURSTIN: Wonderful. Are you able  
7 to speak to the questions that have been raised  
8 about the alcohol intervention measure?

9 MS. RYAN: I can't really speak in  
10 terms of studies about how the measure has  
11 impacted long-term alcohol use.

12 With the work that we have done we  
13 have looked at studies that have spoken to brief  
14 interventions being done in the hospital and  
15 during hospitalization being a prime time to  
16 approach the patients, and that at that point in  
17 time they are more amenable to interventions, and  
18 that the impetus is to get that process started  
19 during the hospitalization. And studies have  
20 shown that patients who have that initiated while  
21 they're inpatients have a greater tendency to  
22 follow through with treatment in the outpatient

1 setting.

2 CO-CHAIR TRAVIS: Thank you very much  
3 for that information.

4 I'm going to go back to Mimi, and then  
5 I'm hoping that we'll be ready for a vote.

6 MEMBER HUIZINGA: Okay. I promise  
7 this is the last thing I'm going to say.

8 So the Cochrane Review actually showed  
9 that there was a difference in alcohol use at  
10 three and six -- I'm sorry six and nine months,  
11 but not at one year. So clearly this -- even --  
12 and that was only in the population of heavy  
13 alcohol drinkers.

14 So I appreciate everyone's comments  
15 that this has an impact, but we should understand  
16 what the impact is. We're asking for a lot of  
17 effort to have some improvement in a small piece  
18 of denominator population that's currently  
19 defined in the measure. It is not a long-term  
20 life changing intervention. According to the  
21 evidence it does have impact in a period after  
22 the hospitalization for a subset of the

1 denominator.

2 CO-CHAIR TRAVIS: Okay. Thank you.

3 And just because we can go through rebuttal and  
4 everything back and forth every time, if the  
5 Joint Commission person would like to make any  
6 statements; and it's okay not to --

7 (Laughter.)

8 CO-CHAIR TRAVIS: -- I do want to give  
9 you an opportunity to. But if I don't hear, I'll  
10 assume you would not like to make a follow-up  
11 comment.

12 While you're thinking, Frank?

13 MEMBER GHINASSI: This is more of a  
14 question. I don't know if I'm looking at the  
15 same 127-person study you are. Was it South  
16 Africa? No, it wasn't?

17 So it's a similar thing. It was a  
18 randomized trial, three-month follow-up. About  
19 30 of the 127 they looked at showed improvement  
20 at 3 months. It was self-report, not -- there's  
21 no concurrent evidence on it. And of the 60  
22 people that referred to treatment, only 30 of

1       them actually went. So it was a positive study  
2       and significant, but if you read it a little more  
3       closely, the significance is not how it would  
4       initially sound.

5               My second question is a technical one.  
6       This is NQF-endorsed, so I have to assume that it  
7       met a standard for scientific acceptability.

8               PARTICIPANT: Yes.

9               MEMBER GHINASSI: And that  
10       acceptability was based on primary care  
11       effectiveness or inpatient effectiveness?  
12       Because that would be my question. That's all.

13              MEMBER ENGLER: That was my question,  
14       too.

15              CO-CHAIR TRAVIS: We're looking it up  
16       so we can read it to you.

17              DR. BURSTIN: I recall it was a very,  
18       very lengthy discussion about what would be  
19       translatable and what was uniquely inpatient-  
20       based. We're just looking at the submission  
21       again. I don't know if the person; sorry I  
22       missed your name, on the phone has any

1 information to shed while we look this up,  
2 specifically on the evidence for the inpatient  
3 brief intervention.

4 (Simultaneous speaking.)

5 CO-CHAIR TRAVIS: Yes, and she did  
6 mention some of that.

7 DR. BURSTIN: They did actually cite;  
8 let's see, three different studies, the first of  
9 which had 12 trials, the second of which had 11  
10 trials. And there's also a DoD guideline review  
11 that had 1,177 studies. So they did have a  
12 pretty significant number. Each of the studies  
13 was rated in terms of the quality of the evidence  
14 as well. And ultimately we felt this was  
15 evidence-based. We're happy to share the  
16 specific submission form if you'd like to see it.

17 CO-CHAIR TRAVIS: Okay. This is going  
18 to hopefully be our last comment. Well, we've  
19 got -- Mimi, is your card still up?

20 (No audible response.)

21 CO-CHAIR TRAVIS: Okay. So, Brock,  
22 you get to bring it home.

1                   MEMBER SLABACH: Well, I just wanted  
2 to quickly follow up on the data that was  
3 suggested on the effectiveness.

4                   How was the structure of the  
5 interventions made in those studies? And is it  
6 done under such a fashion that it could be  
7 replicable in terms of the content of those  
8 interventions across 4,000-plus acute care  
9 hospitals in the United States? And is each of  
10 those going to be the same in terms of the  
11 quality? And that's the real question I think  
12 that I have a concern about in terms of being  
13 able to meet this, the intent of what this is  
14 trying to achieve versus what the reality will  
15 be.

16                  CO-CHAIR TRAVIS: So I'm going to  
17 probably take that as a rhetorical question since  
18 I don't think we have anybody here who can answer  
19 that, but I really failed to see that Marty's  
20 card was up before Brock's, so now, Marty.

21                  MEMBER HATLIE: So the evidence gap  
22 for me here is really the cost of the burden that

1 we hear about from hospitals for investing and  
2 addressing this real issue, and I don't have that  
3 data. I come from a rural part of the country  
4 where I know this is a real issue where families  
5 who need an intervention, if they're going to get  
6 it anywhere, that they can't do themselves, it's  
7 going to be at the hospital.

8 I think it is a huge issue, and I just  
9 want to see hospitals stepping up and doing this.  
10 If it's a huge or prohibitive cost burden, I  
11 guess that needs to be considered, but I don't  
12 know that it is. We're talking about a brief  
13 intervention for an important national problem.

14 CO-CHAIR TRAVIS: Okay. Well, thank  
15 you so much, Marty.

16 I think that for the second time in a  
17 row we've kind of had a broad discussion and  
18 gotten rather deep into some of this, which I  
19 think it's worth. So I thank you all for your  
20 thoughtful comments.

21 I think we will go to the vote and I  
22 think we'll just go with the vote that's on the

1 screen. I have not heard any conditions or  
2 refine and resubmit, but we will -- like we did  
3 yesterday, we'll just kind of go through all  
4 those options.

5 MS. QUINNONEZ: Okay. We are now  
6 voting on the IQR Program measure, Alcohol Use  
7 Brief Intervention Provided or Offered and  
8 Alcohol Use Brief Intervention. And this is MUC  
9 16-178. Option No. 1, support; Option No. 2,  
10 conditional support; Option No. 3, refine and  
11 resubmit; and Option No. 4, do not support.

12 I'll go over those options one more  
13 time for those on the phone. Option No. 1,  
14 support; Option No. 2, conditional support;  
15 Option No. 3, refine and resubmit; and Option No.  
16 4, do not support.

17 (Voting.)

18 MS. QUINNONEZ: Thank you, Ann.

19 (Voting.)

20 MS. QUINNONEZ: Okay. All votes are  
21 in and voting is now closed. For MUC 16-178  
22 Alcohol Use Brief Intervention Provided or



1       Offered and Alcohol Use Brief Intervention the  
2       results read 48 percent voted for support; 0  
3       percent for conditional support; 4 percent voted  
4       for refine and resubmit; and 48 percent voted do  
5       not support.

6                   CO-CHAIR TRAVIS:   Okay.   So I'm going  
7       to huddle over here --

8                   (Laughter.)

9                   CO-CHAIR TRAVIS:   -- and see what we  
10      need to do.   I'll be back with you in a moment.

11                   (Pause.)

12                   MS. QUINNONEZ:   The verdict for MUC  
13      16-178 is do not support.

14                   CO-CHAIR TRAVIS:   And the rationale is  
15      we didn't have 60 percent or above to go, so it  
16      fails.   So see, we've now had an experience with  
17      that and we know what to do on the next time, if  
18      and when that ever happens.   But thank you all  
19      very much.

20                   Before we leave this consent calendar,  
21      it has been brought to my attention that although  
22      it was part of the consent calendar that we

1       accepted, the recommendation for do not support  
2       for the Patient Panel Smoking Prevalence, there  
3       is a desire that we hear some discussion around  
4       that so that there can be an understanding for  
5       why we as a group decided to accept the do not  
6       support. That would be helpful to CMS for us to  
7       -- for them to understand our rationale.

8               So I can maybe start to see if any of  
9       the lead discussants have anything they would  
10      like to bring up relative to this particular  
11      measure. Oh, yes. Sorry. Thank you, Pierre.

12             MEMBER YONG: So thank you. I know it  
13      wasn't proper. We just wanted to get some  
14      feedback about this. This folks who are on the  
15      MAP Committee last year may remember we had a  
16      similar type measure. There was a very robust  
17      discussion about the Tobacco Prevalence measure,  
18      which I think got 61 percent also. I think it  
19      was last year. It got support and continue  
20      development.

21             And so we wanted to bring back -- this  
22      was brought back and to adjust some of the

1 concerns that were raised and some discussion  
2 that was raised last year in that. And so  
3 Tiffany McNair from the Innovation Center at CMI  
4 is going to talk a little bit about this. But  
5 the feedback would be helpful to us.

6 DR. MCNAIR: Thanks so much, Pierre.  
7 And thank you all. Thank you to NQF and thank  
8 you to the MAP for this opportunity to present  
9 today. We really appreciate it.

10 I just want to start off by saying as  
11 a practicing OB/GYN and preventive medicine  
12 physician myself I'm especially enthused about  
13 the opportunity the outcomes-based measures  
14 present, especially the one that we're presenting  
15 and proposing to you, to the IQR today really to  
16 achieve shared accountability across our  
17 healthcare system. This opportunity represents a  
18 future state I think in which the people that I  
19 and all you in this room serve are able to  
20 receive the most effective evidence-based care,  
21 one in which disease is not only prevented, but  
22 really help us promote it, and that's the framing

1       that we are trying to achieve.

2               It's in that vein that we are  
3       proposing MUC 16-68, which is the Patient Panel  
4       Smoking Prevalence measure to the Hospital IQR.

5               You can go to the next slide. Thank  
6       you. This measure is collected to be a hospital  
7       records and captures the percentage of adult  
8       hospital patients who are current smokers. And  
9       as Pierre said, we at CMS did submit a related  
10      geographically defined measure to the IQR last  
11      year during the 2015 MUC cycle. That measure was  
12      assessing smoking prevalence at the county level  
13      among household dwelling adults in the U.S.

14              After robust discussion, as you said,  
15      the measure was supported for continued  
16      development. And one key reaction that we did  
17      received concerned this issue around  
18      accountability in the hospital for the smoking  
19      behavior of individuals not directly served in  
20      the inpatient setting.

21              And so we took this feedback to heart  
22      in response to that and several other responses

1       that you all provided to us. We did refine the  
2       measure, still with an eye towards outcomes, as  
3       you'll see, that's really within the boundaries  
4       of the hospital, so the patient panel.

5               Next slide. I just -- I know that all  
6       of you know this already, but at HHS and CMS we  
7       really are committed to realizing this healthcare  
8       system that delivers better care, practices  
9       smarter spending and at least to help their  
10      people. And so we are trying to focus more and  
11      more on quality as opposed to quantity and value  
12      over volume.

13             Next slide. And do as this framework  
14      depicts, which some of you may be familiar with,  
15      our reform efforts really are shifting toward  
16      altering the payment models and population-based  
17      payments. And it's in light of this movement  
18      towards a value-oriented outcomes-based system  
19      that we believe this is the right opportunity for  
20      the measure we're presenting to you today.

21             Next slide. You may also be asking  
22      why smoking? Well, number one, we all know this

1 is expensive. Smoking is the leading cause of  
2 preventable death and disease in the U.S. and  
3 costs nearly \$170 billion annually in direct  
4 medical costs. So tackling this particular  
5 problem we believe is ideal in terms of improving  
6 health and reducing the cost to the system.

7 But number two, we know that hospitals  
8 can do something about it. There's a really  
9 strong evidence base that shows that a  
10 coordinated multi-modal community-wide and  
11 patient-centered approach improves the success of  
12 smoking reduction efforts. And I might add that  
13 with eight percent of the population being  
14 hospitalized each year, there really are repeat  
15 opportunities for hospitals to have an impact  
16 beginning with the inpatient stay.

17 In fact, there's already a growing  
18 number of hospitals that are already engaged in  
19 the types of efforts that we think that our  
20 measure incentivizes. This is everything from  
21 using EHR prompts to prompt physicians to ask  
22 about smoking; improving combined approaches to

1 treatment like behavioral and pharmacotherapy  
2 therapy interventions, which is consistent with  
3 the Joint Commission recommendations; referring  
4 patients upon discharge to outpatient smoking  
5 cessation treatment, right, and quit lines.

6 And then of course strengthening those  
7 linkages with local primary care providers and  
8 other community partners in order to improve  
9 coordination of care and care management. This  
10 in the end not only helps people to quit, but  
11 helps to sustain quitting.

12 We also know of a number of hospitals  
13 across the U.S. that are using community-wide  
14 policies like smoke-free campuses, which have all  
15 been shown to be effective approaches to  
16 promoting and sustaining smoking cessation.

17 So these approaches we believe not  
18 only fall within the scope of the hospitals'  
19 sphere of influence, but also ultimately move the  
20 needle on the outcome that we care most about,  
21 which is reduced smoking.

22 Next slide. Finally, we would add

1       that we can actually measure the fruits of our  
2       labor in this space, the outcome. Until now  
3       really smoking and other tobacco use measures  
4       utilized in CMS quality programs have focused  
5       primarily on process as opposed to outcomes and  
6       often without an orientation towards primary  
7       prevention, which is perhaps the biggest cost  
8       saver.

9               And so we recognize that this kind of  
10       broader outcomes measure used in conjunction with  
11       clinical process measures actually could do two  
12       things: One is expand the reach of the process  
13       measure, right? So incentivize folks to do even  
14       more of that, as well as improve our  
15       understanding of the magnitude of the impact of  
16       our clinical care services such as cessation  
17       counseling on the specific health behavior like  
18       smoking.

19               So just taking together those three  
20       elements that I described: cost, the evidence  
21       base and the opportunities for measuring our  
22       success, we believe that this smoking prevalence



1       measure, as refined since last year, offers the  
2       logical next step in terms of assessing the  
3       quality of the care furnished in hospitals.

4               So last slide. Just want to -- a  
5       point of clarification based on the analyses that  
6       we received from NQF. Please note that we did  
7       perform internal reliability and validity testing  
8       on this measure utilizing eligible provider data  
9       from the PQRS electronic health record. It was  
10      shown to have higher liability and moderate  
11      validity including demonstrating an association  
12      between provider screening practices and smoking  
13      prevalence in the subsequent reporting year.

14              So we actually found that with an  
15      absolute 10 percent increase in screening  
16      practices in one reporting year we saw a two  
17      percent absolute decrease in smoking prevalence  
18      in the subsequent reporting year. And this  
19      finding was significant and it's critical.

20              As previously described, there is a  
21      strong evidence base showing that hospitals,  
22      similar to individual clinicians, can really

1 influence the smoking behavior of their patients.  
2 So while our initial testing was not performed  
3 realizing hospital-based data, we expect  
4 comparable results among hospitals given the  
5 availability of the similar prevention tools and  
6 the repeated opportunities for impact.

7 The last point that I'll make is that  
8 CMS has also proposed a tobacco process measure  
9 which is on the slate for later on today, MUC 16-  
10 60, to this year's MUC list. And although  
11 useful, we believe standing alone it captures  
12 just a clinical process rather than an outcome.  
13 We would propose that using these two measures in  
14 tandem would actually achieve the most  
15 comprehensive end. It would encourage hospitals  
16 to advance best practices to reduce smoking, but  
17 it would also promote the formation of critical  
18 partnerships that embrace a more coordinated  
19 multi-modal and patient-centered approach to  
20 care.

21 So it's in that spirit of shared  
22 accountability and coordination across the system

1       that we're exploring the potential for smoking  
2       prevalence measures, not only in the hospital  
3       IQR, but also across several other quality  
4       programs including the Medicare Shared Savings  
5       Program and MIPS. And we think this is a great  
6       opportunity for us to think more about this  
7       shared purpose and to encourage accountability  
8       across our entire healthcare system.

9               So I'll stop there. I know that I  
10       speak very quickly, but I knew that I didn't have  
11       a ton of time. If you have any feedback, we look  
12       forward to the discussion. And again, I really  
13       do thank you for this opportunity today.

14              CO-CHAIR TRAVIS: Well, you may be  
15       quick, but you're very organized --

16              (Laughter.)

17              CO-CHAIR TRAVIS: -- and logical. So  
18       thank you for that. We do appreciate the  
19       overview.

20              I am, as I indicated, going to kind of  
21       go to our lead discussants to see if they have  
22       any comments.

1 Marsha?

2 MEMBER MANNING: My comment -- and I  
3 didn't have the benefit obviously of last year's  
4 discussion. I knew to this workgroup. I am just  
5 very focused on data that's very actionable at  
6 the patient level, and so I have concerns about a  
7 population health metric. While I totally  
8 support the need for us to develop interventions  
9 at the population level for smoking interventions  
10 or smoking cessation interventions, a population  
11 level doesn't feel actionable to me at the  
12 patient level when somebody's there in the  
13 hospital. And so that is why I'm supporting  
14 NQF's recommendation.

15 CO-CHAIR TRAVIS: Thank you, Marsha.

16 David or Jennifer, any comments?

17 (No audible response.)

18 CO-CHAIR TRAVIS: Okay. All right.

19 So I think Jack might have done his card first,  
20 so we'll start with Jack.

21 MEMBER JORDAN: Okay. I actually  
22 think this is a measure that is a dangerous

1       mistake for CMS to make, and that is that I think  
2       it carries a very real risk of kind of  
3       undermining their credibility. This is something  
4       that I can see the cynical physician in the  
5       health system just puking on with the how can we  
6       be responsible, the fact that our hospital sits  
7       in a place where lots of people smoke?

8               The community around us choosing to  
9       smoke or not, the best lever for that is not  
10      really a hospital. And I think it almost gives a  
11      sense of learned helplessness to the people that  
12      are trying to do the right things in hospitals  
13      because it's -- the connection between the  
14      smoking in your community and what you're doing  
15      in the hospital seem so disconnected, or at least  
16      so indirect, even if you do have some evidence of  
17      this. The perception of it alone I think really  
18      will hurt your credibility. So I think that it's  
19      very problematic for this kind of a measure to go  
20      forward.

21              I know my own health system did send  
22      in comments on this, that it just seems like

1 something that you have very little control over  
2 when you list the hospitals of who's good and  
3 bad. If your hospital's in Kentucky, you're  
4 going to look bad because lots of people smoke in  
5 Kentucky versus Vermont. But then that isn't  
6 something you should interpret as a good or bad  
7 hospital, though maybe over time that might have  
8 sense. But I think that it really would carry a  
9 huge burden to the hospitals of feeling a learned  
10 helplessness kind of a thing, that they have no  
11 control over this.

12 CO-CHAIR TRAVIS: Mimi?

13 MEMBER HUIZINGA: I echo Jack's  
14 comments, although I probably wouldn't have been  
15 quite as colorful.

16 (Laughter.)

17 MEMBER HUIZINGA: We are extremely  
18 supportive of actionable measures. And you  
19 listed a slew of potential actionable measures.  
20 And so I guess I don't understand why you would  
21 go for a measure that hospitals and the providers  
22 within the hospitals have no control over versus

1 all of the different options that you guys did,  
2 that they can do and that do have impact. So we  
3 would encourage you to rethink your entire  
4 approach to this and move away from a population-  
5 based measure.

6 In addition, there are issues that we  
7 would have with this measure. So this is --  
8 shows the value of going through the NQF  
9 endorsement process. What is a hospital panel?  
10 What if somebody visits from -- is visiting from  
11 Kentucky in Florida? Are they part of that  
12 panel? Is there going to be a Kentucky panel?  
13 There's just a lack of definition and  
14 understanding about what you mean here that would  
15 benefit through the resolution of the NQF  
16 process.

17 In addition, you have an exclusion  
18 criteria for an EP, which is an eligible  
19 professional. It looks like you took this  
20 measure from PQRS and moved it over. I would not  
21 say that you should make that assumption that you  
22 could do that. There's a lot of things that go

1       into attribution and thinking through those. All  
2       of these highlight the importance of going  
3       through the NQF process, which again you  
4       shouldn't do this measure, but if you develop  
5       actionable structure measures or clinical process  
6       measures, they would still need to go through the  
7       NQF process.

8                   CO-CHAIR TRAVIS: Thank you, Mimi.

9                   MEMBER HUIZINGA: We would recommend  
10       that. I shouldn't say they need to go. We would  
11       recommend that they go through.

12                   (Laughter.)

13                   CO-CHAIR TRAVIS: Thank you.

14                   Sean?

15                   MEMBER MORRISON: I'll be brief and I  
16       will say this again; and I was here for the  
17       discussion last year, I -- it really distresses  
18       me when CMS comes with a measure that has not  
19       gone through the NQF endorsement process. I know  
20       the law says that you guys can do that, but the  
21       NQF endorsement process exists for a reason. I  
22       don't represent any organization or stakeholder.



1                   So send it back. That was the  
2                   recommendation last year. Do the right process  
3                   work and then bring it back to us, please.

4                   CO-CHAIR TRAVIS: Akin?

5                   MEMBER DEMEHIN: I really echo the  
6                   comments that have already been made about  
7                   actionability, about some of the technical  
8                   aspects of the measure.

9                   I think there's kind of a broader  
10                  conceptual issue here, too. I think by boiling  
11                  what is a complex multi-faceted societal problem  
12                  into a single measure -- I think it almost has  
13                  the effect of trivializing what is a very  
14                  important effort, and that is the joint effort to  
15                  address smoking prevalence.

16                  And hospitals recognize the need to  
17                  play a role in that activity. Part of what  
18                  hospitals do, using their community health needs  
19                  assessment process, is to identify things like  
20                  smoking rates in their community and develop some  
21                  interventions that they can work on jointly with  
22                  the community to affect it.

1                   So I really agree with what's been  
2                   said. This doesn't seem like a very fruitful  
3                   path and it could actually end up being really  
4                   quite a dangerous path if it becomes something  
5                   that's the basis of public reporting, Star  
6                   ratings, pay-for-performance, and so forth.

7                   CO-CHAIR TRAVIS: Okay. Any comments  
8                   from Committee members on the phone?

9                   (No audible response.)

10                  CO-CHAIR TRAVIS: Okay. Yes?

11                  DR. McNAIR: Yes, quite briefly.  
12                  Thank you very much.

13                  First I will say thank you all for  
14                  your comments and for your feedback. Definitely  
15                  appreciate it.

16                  Number one, I will say that an NQF  
17                  submission package is currently underway, so we  
18                  appreciate that feedback, and we'll continue to  
19                  work on all of the suggestions that you've  
20                  provided.

21                  The other piece I would say again is  
22                  this emphasis around shared accountability. For

1       that reason we certainly see hospitals as the  
2       only locus of that, and so we are looking for  
3       opportunities and ways that we can begin to push  
4       forward that type of an agenda, which is I think  
5       a very important one to all of our quality  
6       programs.

7               But I would actually argue against the  
8       response that said that this is not actionable.  
9       At the end of the day you're correct that all of  
10      these different best practices are available, but  
11      as opposed to having this kind of disparate  
12      approach where we focus on the individual  
13      screening processes or a specific intervention  
14      we're basically saying you have all -- you have  
15      this menu, this potpourri of opportunity in order  
16      to move the needle on the specific outcome, and  
17      they're all available to you. And we are  
18      beginning to demonstrate at least that there is a  
19      correlation between including all of that in your  
20      practice and seeing an effect on the outcome.

21             The other piece that I would just say  
22      is that we have more work to do. We want to

1 continue to hear your perspectives and we will  
2 continue to move forward in this space. We  
3 definitely appreciate it.

4 CO-CHAIR TRAVIS: Well, thank you very  
5 much. And I always feel a huge sense of  
6 responsibility when we said support continued  
7 development and then to be where you are today.  
8 So I do appreciate you giving us the opportunity  
9 to kind of share with you what people's current  
10 thinking is.

11 And I think we're sitting right now in  
12 a place of tension. We know that we need to do  
13 population health management, but our structures  
14 are not quite there yet and that you don't  
15 necessarily -- the whole panel description, you  
16 don't necessarily have an assigned group of  
17 people that you're responsible for, and it could  
18 be randomly different every year. And so to a  
19 certain extent I think that -- at least my  
20 concern around the accountability issue is that I  
21 don't have a defined group of people that I'm  
22 accountable for. It changes in the way we're

1 currently situated. And I think if the delivery  
2 system structure changes over time, then I think  
3 we could see maybe more comfort with that type of  
4 a measure.

5 So I hope you won't give up on  
6 thinking about it because it's a critical issue  
7 for us. I just think we're in kind of a -- in  
8 that in between stage in some of the tensions  
9 here. But I thank you for your continued work,  
10 and we will look forward to seeing it through the  
11 endorsement process as well. So thank you very  
12 much.

13 You know, guys, we're running about 45  
14 minutes behind, and one of the concerns I have  
15 today is that I am sure we all have flights out  
16 this afternoon. So as much as I hate to say  
17 this, we are not going to take a formal break  
18 right now. If you do need to take a personal  
19 break, please do so, but make it as quickly as  
20 possible. But we're going to move ahead so that  
21 we can make up for some of the time. It's been  
22 all well worth it, but we do want to be sure that

1 people get out of here. In fact, I know you'll  
2 get out of here. I just hope we're through with  
3 our work by the time you get out of here.

4 So I'm going to turn it over to Ron.

5 CO-CHAIR WALTERS: Thank you. So  
6 we're on Consent Calendar 7 now, which has three  
7 measures. I'm going to go through them briefly.  
8 MUC 16-165 is the Follow-Up After Hospitalization  
9 for Mental Illness. The preliminary analysis was  
10 refine and resubmit because the NQF measure 576  
11 was specified and tested at a health plan level,  
12 and therefore it required more study about  
13 attribution to a facility. Also there were some  
14 problems noted with the results in the IPFQR  
15 Program and should be resolved prior to  
16 implementing the measure in an additional  
17 program. So that was a refine and resubmit.

18 The next measure was 16-262, MUC 16-  
19 262, which was the Measurement of the Quality of  
20 Informed Consent Documents for Hospital Performed  
21 Elective Procedures. That was a refine and  
22 resubmit prior to rulemaking basically to see the

1 reliability and validity. And you heard some  
2 testimony about that during the public commenting  
3 period. So we'll be interested to see what you  
4 do with that.

5 And then the final one is MUC 16-263,  
6 which is Communication about Pain During the  
7 Hospital Stay. That was also a refine and  
8 resubmit originally. It was pulled and then put  
9 back on the agenda. And the discussion -- you  
10 heard a lot of discussion about that earlier  
11 during the public commenting.

12 So what I'm going to ask now is  
13 specifically about 16-165, which is on the  
14 consent calendar as refine and resubmit. Is  
15 there anybody who wishes to pull that measure for  
16 discussion? Okay. Frank.

17 And now for the next measure, 16-262,  
18 which was the Measurement of the Quality of  
19 Informed --

20 (Off microphone comment.)

21 CO-CHAIR WALTERS: Yes, the team.  
22 I'll put team again. Frank and team.

1 Two-sixty-two, which is the  
2 Measurement of the Quality of Informed Consent.  
3 Is there anybody that wishes to pull that from  
4 the consent calendar?

5 (Simultaneous speaking.)

6 CO-CHAIR WALTERS: Oh, okay. Frank  
7 and then team. Yes, okay. Got it.

8 And finally, 16-263, which is  
9 Communication About Pain During the Hospital  
10 Stay, which again was refine and resubmit. Who  
11 would like to pull that? Okay. Good. Okay. So  
12 all three are pulled from the informed consent  
13 calendar. Got it.

14 So let's start at the beginning with  
15 Frank's comments. Just a second. I got to make  
16 sure I got that right now. One-sixty-five. Yes.  
17 Frank's comments about MUC 16-165. Why did you  
18 pull it?

19 MEMBER GHINASSI: I'll make this brief  
20 because I know we're trying to move ahead.

21 So this is again one of these measures  
22 where it is impossible to argue with the critical



1 importance of this. I agree with it completely.  
2 I think it's a prime directive of the hospital to  
3 try to deliver that person to the next level of  
4 care. I'm on board completely.

5 The challenge is that the ability to  
6 make that happen is impacted by a number of  
7 variables: How important the hospital takes it,  
8 the measures they take in place to do evidence-  
9 based treatment to make it happen, how they  
10 prioritize it, the people they assign to it to  
11 deliver that treatment, all of which is within  
12 their span of control. The other difficulty is  
13 that although you can throw a perfect spiral, if  
14 a person catching that ball doesn't have good  
15 hands, then you have a problem.

16 Now the other piece of this is; and  
17 not that I'm a football -- so the other piece of  
18 this is that if you're going to move toward a  
19 measure like this, we need to take into account  
20 the prevalence and availability of access in the  
21 individual community within which that hospital  
22 is sending that individual.

1                   So a frontier state who's held to a  
2   30-day and 7-day follow-up period is going to be  
3   in a very different place than somebody's who's  
4   in an environment-rich resources. And even if  
5   you call agencies and say do you have access, the  
6   reality on the ground is if they say yes to you,  
7   that they give an appointment on Tuesday at 3:00,  
8   and that's their yes, and there's no flex in  
9   that, for many people that's a no.

10                  So I think the problem with this is --  
11   I'm totally in favor of the intent of the  
12   message. I think the measure doesn't take into  
13   account the full system within which that measure  
14   exists. I'm done. Thank you.

15                  CO-CHAIR WALTERS: What is your  
16   recommendation?

17                  MEMBER GHINASSI: That if -- at the  
18   very least that the measure include -- and I  
19   think CMS has the capacity to do this -- that it  
20   includes an assessment of that region's access,  
21   capacity and standards and that institutions are  
22   judged based on that access, not solely on does

1 it happen?

2 CO-CHAIR WALTERS: And to pin you down  
3 just a little step further, is that a --

4 MEMBER GHINASSI: Please.

5 CO-CHAIR WALTERS: -- conditional  
6 support or is that a refine and resubmit, or is  
7 it a do not support?

8 MEMBER GHINASSI: I would make it --

9 CO-CHAIR WALTERS: Yes, I'm sorry.  
10 It's already -- well --

11 (Simultaneous speaking.)

12 CO-CHAIR WALTERS: Yes, that would be  
13 a refine and resubmit.

14 MEMBER GHINASSI: If it's --

15 (Simultaneous speaking.)

16 CO-CHAIR WALTERS: Which way is the  
17 recommendation?

18 MEMBER GHINASSI: Yes, if it added  
19 that component, if they built into it the access  
20 capacity and they benchmark institutions on that  
21 marriage, then I think this has more capacity.

22 CO-CHAIR WALTERS: So it's an

1 agreement with the initial assessment, but you'd  
2 like to see some additional -- comments on it?

3 MEMBER GHINASSI: Yes.

4 CO-CHAIR WALTERS: You've given some  
5 comments on it?

6 Okay. Marty?

7 MEMBER HATLIE: Well, I am always  
8 happy when I see measures like this because of  
9 the prime importance that's been identified. I  
10 think this gets to one of the priorities that we  
11 tailor service to every year, which is person and  
12 family engagement, follow-up after hospital to  
13 engage patients and families. And patients  
14 getting the care they need is a really important  
15 thing.

16 I know there's a philosophical divide  
17 here, and I'm on the side that really sees  
18 hospital accountability being to community as  
19 well, to work with the community to work after  
20 someone leaves the hospital to really advance the  
21 overall journey across transitions to a safe  
22 result. So that's really where I'm coming from,

1 and for that reason I think this is the  
2 appropriate place in the category that it's in.

3 I like all of the suggested  
4 considerations that were made about what CMS  
5 should consider as they refine this and resubmit  
6 it. Thank you.

7 CO-CHAIR WALTERS: Do you have a  
8 recommendation?

9 MEMBER HATLIE: I have a  
10 recommendation that it stay right where it is.

11 CO-CHAIR TRAVIS: Which is refine and  
12 resubmit?

13 MEMBER HATLIE: Yes.

14 CO-CHAIR WALTERS: Okay. Mimi was the  
15 other lead discussant. Mimi?

16 MEMBER HUIZINGA: Sorry. So in this  
17 measure we support the idea of having better  
18 follow-up after mental health, but we actually  
19 are a do not support for this particular measure.

20 I wouldn't say that we have a  
21 difference in philosophy from Marty. We do think  
22 that the hospital should be working with their

1 communities, but as Frank said, this is a matter  
2 of access. I mean, yesterday we talked about how  
3 we have hospitals who have patients sitting in  
4 their ER for days just because they can't find a  
5 bed. So those same places struggle with access.

6 The other issue that we have with this  
7 measure is that is difficult for the hospitals to  
8 drive action on it. They don't receive this  
9 data. So this measure was initially developed  
10 for a health plan and makes sense for someone who  
11 has that data and maybe can influence access more  
12 than hospitals can.

13 So ACOs, health plans, this type of  
14 measure that goes cross-continuum, those are the  
15 payment models that are focused on that, and  
16 those are the payment models that actually have  
17 the tools and resources available to potentially  
18 drive change on them.

19 I like the suggestion that Frank made,  
20 and that would certainly make this measure more  
21 palatable, but without having the data source to  
22 drive improvement efforts we would still be do

1 not submit.

2 CO-CHAIR WALTERS: Okay, so we have a  
3 do not submit and a refine and resubmit. Akin?

4 MEMBER DEMEHIN: I echo the concerns  
5 that both Frank and Mimi have articulated, and  
6 this really is a measure where the -- the core  
7 idea behind it is sound. You do want hospitals  
8 to take action to connect patients with the next  
9 level in the continuum of care. But as Frank  
10 pointed out, that continuum of care is often a  
11 patchwork in a lot of communities, and so we're  
12 kind of on the fence between a refine and  
13 resubmit and a do not support.

14 I just don't know if it is technically  
15 feasible to do the kind of -- the kind of  
16 adjustment that Frank is talking about around  
17 looking at access within communities and trying  
18 to account for that in comparing performance, so  
19 just not sure if the frame of this -- of this  
20 particular measure is quite right to achieve the  
21 goal we want to achieve.

22 CO-CHAIR WALTERS: Before we get to

1 Brock, I'd like to hear some thoughts, or be  
2 thinking about, so, it is a currently endorsed  
3 measure in the Inpatient Psychiatric Program, and  
4 this is for the Inpatient -- Hospital Inpatient  
5 Quality Program. Is that two standards of care  
6 or not? Yes, yes.

7 MEMBER SULLIVAN: This is Ann. Can I  
8 just talk to this a bit?

9 CO-CHAIR WALTERS: Sure.

10 MEMBER SULLIVAN: I realize --

11 CO-CHAIR WALTERS: Ann, go ahead.

12 MEMBER SULLIVAN: Now there are big  
13 problems with access, I agree, but we've had this  
14 one in the Psychiatric Hospitalization Program  
15 for years, and when someone is psychiatrically  
16 hospitalized, even in some of the most  
17 disadvantaged communities, they are able to  
18 arrange for some degree of follow-up, because you  
19 have to understand, this is not just a regular  
20 psychiatric appointment, this is someone who has  
21 been in the hospital, who has been very very ill,  
22 and usually -- I mean, maybe in some very poor



1 rural communities, you may have to defer to the  
2 primary care doctor.

3 But that has not been the experience  
4 in the psychiatric hospital situation. We have  
5 been able to do this for these seriously ill  
6 patients in terms of getting them care, and there  
7 is usually some availability as an intensive  
8 outpatient or partial because we're not totally  
9 bereft of any psychiatric services in these  
10 communities, but often, these guys are  
11 prioritized, and that's what hospitals kind of  
12 have to work at.

13 The second thing is I think that you  
14 should not have two standards of care. These are  
15 hospitalizations that happen to occur in a  
16 general hospital versus a psychiatric hospital,  
17 but if you're not going to get a follow-up within  
18 seven -- within 30 days, you're going to get a  
19 readmission, so I think it behooves the hospitals  
20 to really recognize that most of them are pretty  
21 close to getting this kind of already because how  
22 could you in good faith discharge people with no

1 follow-up? I sincerely doubt that that is  
2 happening.

3 This is just a way of keeping track  
4 and making sure that those connections are made.  
5 You know, there is not always primary care  
6 capacity. Sometimes, there is no cardiology  
7 capacity. Sometimes, there's other problems with  
8 capacity. That doesn't stop us from saying there  
9 has to be good care after hospitalization, or  
10 having impacted on some of the readmission  
11 indicators that have been there.

12 So I think it is a little bit  
13 overstating the facts because these are such  
14 high-priority patients, even in New York, which  
15 has some of the most rural areas, equal to  
16 anyplace else, we manage to find places for these  
17 individuals because they're such high priorities.

18 So I think it is perfectly worth  
19 refining and resubmitting. I think that's a good  
20 idea just to kind of get it -- make sure that it  
21 can work within these facilities, but I do think  
22 -- I wouldn't overstate that with very high-

1 priority people, that there is no way to get  
2 access, and that it would be such a burden on the  
3 hospital to arrange it.

4 CO-CHAIR WALTERS: Thank you very  
5 much, Ann. Brock, you took your card down?

6 MEMBER SLABACH: Well I was going to  
7 put it back up as soon as she finished.

8 I -- I would like to reiterate that  
9 one of the most difficult problems in rural areas  
10 around the country, maybe New York probably is an  
11 exception, is referrals to mental health follow-  
12 up, and if this is going to be a measure, as  
13 Frank said, that is going to point out the access  
14 issues and not be a penalty for the hospital in  
15 terms of doing what it is supposed to do, then I  
16 would be in favor of it. In other words, it is  
17 indicating that we need to invest more resources  
18 in mental health and we need to have better  
19 networks of care, you know, in rural and more  
20 underserved communities.

21 But if this is going to be, say I'm  
22 holding the hospital responsible for the fact

1       that the patient didn't follow up to a mental  
2       health provider following the discharge, then I  
3       find this to be somewhat offensive to 2,000  
4       hospitals in the United States who are doing  
5       their best to try to make this happen, so -- .

6                   CO-CHAIR WALTERS:  You are which side  
7       of the fence?

8                   MEMBER SLABACH:  Oh, I do not support  
9       --

10                  CO-CHAIR WALTERS:  Okay.

11                  MEMBER SLABACH:  -- unless -- unless  
12       the things that Frank talked about earlier were  
13       introduced into it.

14                  CO-CHAIR TRAVIS:  I just -- this is  
15       Cristie.  I have just a clarifying question, in  
16       that this -- the way this measure looks is that  
17       you were actually treated for selected mental  
18       illness diagnoses, and then whether or not you  
19       have the follow-up afterwards, so that your  
20       hospitalization included, or was for, treatment  
21       of mental illness.

22                  And I think the other piece that -- I

1 wanted to be sure I was reading it right, but the  
2 other piece I was trying to understand -- and I  
3 really don't mean to introduce a competition  
4 here, and I really apologize -- but the Inpatient  
5 Psychiatric Facility Program, does it include  
6 psychiatric units in general acute care  
7 hospitals, or is it -- and it does, doesn't it?  
8 Okay. So it's not just freestanding psychiatric  
9 hospitals.

10 DR. YONG: No, the facilities included  
11 in the program include both freestanding  
12 psychiatric facilities as well as psychiatric  
13 facilities embedded in general acute care  
14 hospitals.

15 CO-CHAIR TRAVIS: Okay. So the reason  
16 that I wanted to confirm my understanding is, you  
17 know, I am trying -- I am not saying there  
18 wouldn't be some people who were admitted to a  
19 hospital for mental illness that didn't have a  
20 psychiatric unit, because I assume that could  
21 happen, but that is who this really ends up  
22 applying to that it doesn't already apply to.

1                   In other words, if a general acute  
2                   care hospital has a designated psychiatric unit,  
3                   assume they're participating in your program  
4                   under that, so they're already reporting it for  
5                   that. So this would be patients outside of that  
6                   unit?

7                   DR. YONG: Right.

8                   CO-CHAIR TRAVIS: I mean, I am trying  
9                   to figure out how these two things work together.  
10                  Maybe I should just say it that way.

11                  DR. YONG: So we do know that -- but  
12                  there are also patients who have -- are  
13                  hospitalized for mental illnesses that aren't  
14                  hospitalized for the psychiatric ones, and so  
15                  that I think would be the population that would  
16                  additionally be captured.

17                  CO-CHAIR TRAVIS: That's -- that's  
18                  what I'm trying to -- so the only reason I bring  
19                  this up is that it -- it is not all -- I mean,  
20                  some people are already having to report on this,  
21                  even from general acute care hospitals if they  
22                  have a designated psychiatric, so we're talking

1 about expanding that in that those patients then  
2 that fall outside that psychiatric unit, or are  
3 in a hospital that doesn't have a psychiatric  
4 unit, are the ones we're talking about.

5 But the other piece is, I mean, these  
6 people were in the hospital for mental health  
7 issues, not that they were in for a cardiac issue  
8 and needed follow-up care.

9 CO-CHAIR WALTERS: Lee.

10 MEMBER FLEISHER: So I am sort of torn  
11 because I actually -- at my own hospital, until  
12 the measures existed for readmission and for  
13 appointments, we didn't have people who were  
14 actually dedicated and going out and asking the  
15 patient, when can you actually get to an  
16 appointment? So that having something like this  
17 would drive the right thing.

18 It's NCQA, so it is not Yale CORE, and  
19 I'm just thinking if you can't do what Frank  
20 suggested, some sort of SES look in this  
21 population would tell us a lot as a surrogate for  
22 -- because I don't know the data that would exist

1 to look -- do you have it, where, I mean, to --

2 MEMBER GHINASSI: I mean, there's a  
3 variety of studies on this, and I can send you  
4 data. But the --

5 MEMBER FLEISHER: No, I am talking  
6 about -- I am not talking about the -- what --  
7 what exists in easily accessible data because it  
8 is CSAC --

9 MEMBER GHINASSI: Oh, that would be --  
10 that would be from -- my hope would have been  
11 that there would be a way for them to assess the  
12 availability and access within a community before  
13 you judge one part of the system.

14 MEMBER FLEISHER: Right, but I am not  
15 sure that that data exists in an easy way, so as  
16 a first pass, if -- it would be great to see if  
17 regions that had different SES sort of by -- had  
18 different rates of this to start, and even  
19 getting better some of those regions would be an  
20 important different way of looking at it because  
21 I think improvement might be a -- a different way  
22 of scoring better over time than just rates



1 looking between individual hospitals.

2 CO-CHAIR WALTERS: Andrea?

3 MEMBER BENIN: I just wanted to -- I  
4 think Cristie your question was helpful to me for  
5 understanding this because frankly, my  
6 understanding is that if you can't have a CON for  
7 a psych bed, you cannot admit someone with a  
8 principal diagnosis of a psych problem to -- to  
9 anywhere. And so if you are being admitted to a  
10 regular bed, that means you have to have some  
11 other diagnosis, so it is overdose, whatever that  
12 is, it's suicide attempt that has an injury  
13 remaining, so that, your principal diagnosis  
14 actually is a medical diagnosis. It has to be or  
15 else you cannot go forward. I mean, you couldn't  
16 have a patient there.

17 I mean, Pierre or Ann Marie might  
18 understand this better than I do, but so I am not  
19 actually sure then if that is the group that  
20 we're trying to capture who those patients are at  
21 this point because you have to be in a psych --  
22 unless it is psych facilities with -- with sets

1 of CON -- you know, with beds within hospitals  
2 that are not freestanding psych hospitals, but  
3 not -- it can't -- it's not just like every  
4 hospital admitting patients who have a mental  
5 illness. That is -- there just is a principal  
6 diagnosis, just --

7 CO-CHAIR TRAVIS: Right.

8 MEMBER BENIN: -- I am trying to make  
9 sure I am super clear on your --

10 CO-CHAIR TRAVIS: And I don't know,  
11 yes, I mean that was kind of my -- and that was  
12 trying to be sure we were clear. Now I will say  
13 that CON is not in every state, but I don't  
14 understand the -- there could be licensure  
15 requirements. You know, I -- but that is -- that  
16 is kind of what I was trying to say.

17 These people are not in a psychiatric  
18 unit, I mean, because if they were in a  
19 psychiatric unit, they would already be reporting  
20 this information through the other measure of  
21 psychiatric hospitals that we talked about  
22 earlier, because even units within general acute

1       care hospitals are covered under that other  
2       program.

3                   CO-CHAIR WALTERS:   Let me not put  
4       words in your mouth, but you're saying do not  
5       support because it's not needed and not  
6       necessary?

7                   MEMBER BENIN:   I mean, I was fine with  
8       the revise and resubmit, let people think about  
9       it some more.

10                  CO-CHAIR WALTERS:   Okay.

11                  MEMBER BENIN:   I mean, if it needs  
12       more --

13                  CO-CHAIR WALTERS:   Okay.

14                  MEMBER BENIN:   -- thinking or figuring  
15       out, I am not --

16                  CO-CHAIR WALTERS:   I got you.

17                  MEMBER BENIN:   -- I don't have any  
18       sort of stake in this.

19                  CO-CHAIR WALTERS:   Mimi?

20                  MEMBER HUIZINGA:   So I had a question  
21       for clarification, and then a point to make, but  
22       my question first: so if we look at QPS, the NQF

1       measure that is currently being used in the  
2       inpatient psych program, it says the level of  
3       analysis is health plan or integrated delivery  
4       system, so were there any modifications made? I  
5       mean, it seems like it's kind of like an off-  
6       label use to use it just in a psychiatric  
7       facility and not at the health plan level, where  
8       it is endorsed, so did it go through a  
9       modification process in order -- it didn't.

10                   But it says endorsed here. I don't  
11       know --

12                   MS. MARINELARENA: It's endorsed at  
13       the health plan or IDS level.

14                   MEMBER HUIZINGA: Okay. It is -- do  
15       you know if in their maintenance, they will --  
16       are there any plans to resubmit it to --

17                   MS. MARINELARENA: I do believe it is  
18       going through maintenance now in our Behavioral  
19       Health Project, I believe. I can check right  
20       now. If you read the preliminary analysis, that  
21       was one of the -- that's the refine and resubmit  
22       to specify it, test it at the inpatient hospital

1 level.

2 CO-CHAIR WALTERS: Wei? And then I  
3 think we'll try to see if everybody has enough  
4 information --

5 MS. MARINELARENA: But let me -- let  
6 me --

7 CO-CHAIR WALTERS: -- to vote.

8 MS. MARINELARENA: -- confirm that  
9 it's going to be --

10 CO-CHAIR WALTERS: For the inpatient  
11 --

12 MS. MARINELARENA: That -- right, yes.

13 MEMBER HUIZINGA: And so then my point  
14 was, you know, going along with kind of what  
15 Frank says, how this might be modified to be more  
16 appealing to hospitals or useable by hospitals,  
17 so I as a primary care provider, I would spend  
18 many hours on the phone trying to get  
19 appointments for patients. I would get them, and  
20 then they wouldn't go for various reasons that  
21 were all outside of my control, so could there be  
22 a way that in order, if you can't measure access

1 or adjust for it, that this measure could try to  
2 be more structural or process to assess intent to  
3 get scheduled or actually scheduling the measure,  
4 not -- those are the things that the hospital can  
5 gather data on and can develop programs for and  
6 act upon. Whether or not a patient actually goes  
7 is a little bit separate.

8 CO-CHAIR WALTERS: So I have heard a  
9 lot of discussion that basically is around refine  
10 and resubmit, or do not support, for the  
11 Inpatient Quality Reporting Program. I think  
12 we're ready for a vote?

13 (Pause.)

14 CO-CHAIR WALTERS: So what we're  
15 talking about up here is from a practical  
16 purpose, even though we can't stop you from  
17 voting for option 2, the options we -- the  
18 options in reality are number 1, number 3, and  
19 number 4. That's what the discussion hung  
20 around.

21 MS. QUINNONEZ: Okay. Voting is now  
22 open for Follow-up After Hospitalization for

1 Mental Illness. This is MUC16-165 of the IQR  
2 program. Option number 1, support. Option  
3 number 2, conditional support. Option number 3,  
4 refine and resubmit. And option number 4, do not  
5 support.

6 I will read those options one more  
7 time. Option number 1, support. Option number  
8 2, conditional support. Option number 3, refine  
9 and resubmit. And option number 4, do not  
10 support.

11 Thank you, Marisa. Thank you, Ann.  
12 Okay. Voting is now closed.

13 (Pause.)

14 MS. QUINNONEZ: Okay. We're going to  
15 ask you to vote one more time.

16 (Laughter.)

17 MS. QUINNONEZ: Oh, here we are, okay.  
18 We actually have our totals now. Thank you.

19 All right. For the -- I will read the  
20 results for the IQR Measure 16-165. 0 percent  
21 support, 0 percent conditional support, 72  
22 percent for refine and resubmit, and 28 percent

1 for do not support. This stands at a refine and  
2 resubmit.

3 CO-CHAIR WALTERS: And as we said  
4 yesterday, even though that was the preliminary  
5 analysis recommendation, I think input by the  
6 comments given to CMS would be very helpful.

7 Now proceeding on with MUC16-262 -- I  
8 am going according to the agenda list -- which is  
9 the measure The Quality of Informed Consent  
10 Documents for Hospital-Performed Elective  
11 Procedures, and again, the preliminary analysis  
12 was refine and resubmit, and basically, the whole  
13 right side of the room said they recommended  
14 pulling it.

15 So would you put your cards up? Not  
16 the whole side, just half of it or so.

17 (Laughter.)

18 CO-CHAIR WALTERS: Mimi?

19 MEMBER HUIZINGA: Thank you. So we  
20 don't support this for several reasons. Informed  
21 consent is a process covered in other mechanisms,  
22 namely the Conditions of Participation, and the



1 Joint Commission of course has standards. There  
2 is a high level of effort required for this  
3 measure.

4 There is some ambiguity. I realize  
5 that we heard a little bit about reliability and  
6 validity testing, but we would argue that there  
7 is still a great deal of training and development  
8 that would need to happen in order to achieve  
9 those numbers, and further testing would be  
10 needed, but we don't recommend that either  
11 because we think that CMS should just stop here  
12 with this.

13 And if you were ever going to consider  
14 a measure like this, it should definitely go  
15 through the NQF process so that it could be  
16 assessed for the reliability and validity as  
17 needed. And most importantly, we feel that  
18 informed consent is not an outcome. It's a  
19 structural measure, and the way that the points  
20 are structured in this measure, if you read what  
21 you get points for, it really is just a yes or  
22 no, did they write a different language? It

1 doesn't say anything about was the language used  
2 actually understood by the patient in the intent  
3 that it needed to be so that the patient was  
4 really receiving an informed consent process.

5           So informed consent can't be judged by  
6 a chart review. It is really -- or the quality  
7 of it, I would argue, is judged by what the  
8 patient understands. So we think, just in  
9 summary, CMS has other mechanisms in place to  
10 check off structural measure yes or no for  
11 informed consent. The measure doesn't really  
12 address an outcome, nor does it do much to drive  
13 the quality of informed consent, as there is some  
14 -- a lot of variation that could be allowed  
15 within the language as it is structured, and we  
16 think that if you wanted to understand this  
17 better, it really should be based on both the  
18 patient, their preferences, and what they  
19 understand to be the procedure that they are  
20 undergoing and the risks that are associated with  
21 it.

22           CO-CHAIR WALTERS: Marty, you were

1       there to lead discussion?

2                   MEMBER HATLIE:   So I was delighted to  
3       see this on the MUC list --

4                   (Laughter.)

5                   MEMBER HATLIE:   -- because it really  
6       does address a problem, and that is I see the  
7       informed consent process as one of the main ways  
8       in which we can reach shared decision-making, the  
9       costs of shared decision-making, and it has  
10      become a check-the-box kind of thing in  
11      hospitals, or -- at best. At worst, a risk  
12      management strategy that has almost no shared  
13      decision-making content anymore.

14                   It is a priority because shared  
15      decision-making is a content. It is a priority  
16      not only for NQF, but in the CMS quality strategy  
17      now.

18                   I do think also I was impressed by the  
19      analysis and the way in which hospitals who used  
20      this seemed to find -- to get information that  
21      they would find useful in improving their --  
22      their informed consent processes. It just seemed

1       like the testing was surprisingly creative and  
2       interesting in pointing out ways in which things  
3       can be done better, which I -- I do think  
4       hospitals need.

5               I am sympathetic, I mean, to the  
6       burden issue here. I think this could be one  
7       that does take additional training, but I think  
8       it is needed because this is just such a broken  
9       process throughout the healthcare system, so for  
10      all those reasons, I -- I want to just support  
11      where it is, continue to look at it in the  
12      refinement and resubmit category, but I also want  
13      to compliment CMS for actually taking this step,  
14      CMS and NQF.

15             It's kind of a next step. It was  
16      positioned nicely in the decision guide as a next  
17      step in really looking at this key, key process  
18      and taking it to the next level. Thank you.

19             CO-CHAIR WALTERS: Lee?

20             MEMBER FLEISHER: So I am -- I am glad  
21      the lawyer was supportive because -- correct,  
22      it's the lawyer? -- because in fact the people

1 who have caused this to occur in my hospital are  
2 actually the lawyers all around malpractice  
3 suits.

4 To put this in perspective, the  
5 underlying issue is that is this a conceptual  
6 model according to which informed consent  
7 happens, or is this the legal document at the end  
8 of that conceptual model that leads to the  
9 support when you end up in court whether or not  
10 informed consent happened?

11 So my concern, and I did actually  
12 comment privately, which they -- I didn't see  
13 your responses, so I have to be accurate, that  
14 were supposedly put up on the web, to some of  
15 these concerns that a lot of the elements --  
16 reliability is great, but if it doesn't -- if the  
17 reliability is whether or not you time it and  
18 date it, which are requirements by Joint  
19 Commission, et cetera, and whether or not it is  
20 legible, which are requirements by our lawyers,  
21 that is different than whether or not the patient  
22 actually understood everything.

1           So while I commend them for taking a  
2 first step, I think along the continuum of what  
3 is shared decision-making and where we get to,  
4 starting with a legal document is the wrong  
5 place. And again, I would say what you have done  
6 is created a great structure for every hospital  
7 in this country to think about how to defend  
8 their process because when you look at this, what  
9 happens is patients do not read it. So while  
10 highly educated patients read it, and while sort  
11 of the people who need it potentially the least  
12 read it, it -- it won't get to the achieved goal.

13           So getting back to I think it's Allen  
14 who previously said utility of a measure, I think  
15 this does not rise to a utility. Put in the  
16 Joint Commission participation, let your legal  
17 team say how great a job Yale did at defending  
18 what the process occurred.

19           CO-CHAIR WALTERS: So I interpret that  
20 as a do not support?

21           MEMBER FLEISHER: Do not support. And  
22 lastly, I really do believe I agree with Mimi

1 entirely. This needs to go through the NQF  
2 process where it is truly vetted and by the  
3 appropriate panel gets to CSAC, and then we'll  
4 see what happens there too.

5 CO-CHAIR WALTERS: I -- I am just --  
6 I am just thinking a second. So with that last  
7 sentence you made, which is what the initial  
8 recommendation was, refine and resubmit, and  
9 everybody agrees it should go through the  
10 process, so is this measure as you read it  
11 refinable --

12 MEMBER FLEISHER: No, I --

13 CO-CHAIR WALTERS: -- and --

14 MEMBER FLEISHER: -- I actually -- I  
15 would be -- I would be curious what happens in  
16 the process, but I do not support this measure.

17 CO-CHAIR WALTERS: Got you.

18 MEMBER FLEISHER: I do not believe it  
19 achieves the goals of improving the care of our  
20 patients.

21 CO-CHAIR WALTERS: Okay. I just  
22 wanted to clarify that. Akin?

1                   MEMBER DEMEHIN: We have a number of  
2                   significant concerns about this measure, many of  
3                   which both Mimi and Lee have articulated very  
4                   well, so I won't rehash them.

5                   But I did want to underscore one  
6                   particular aspect of this that has us troubled.  
7                   There absolutely are standards from the Joint  
8                   Commission and under CMS Conditions of  
9                   Participation around informed consent, there are  
10                  often state-level laws that dictate what goes  
11                  into a -- an informed consent. This to me has a  
12                  very real risk of just adding to the confusion,  
13                  and it really is focused more on the piece of  
14                  paper than it is on sort of the real issue to  
15                  address here, and that is making the informed  
16                  consent process meaningful to patients. So we  
17                  absolutely do not support this measure.

18                 CO-CHAIR WALTERS: Marty, did you have  
19                  another comment?

20                 MEMBER HATLIE: Yes. I mean, informed  
21                  consent documents are unreadable because the  
22                  lawyers have put them together. I mean, we are



1 talking really about a paradigm here where no one  
2 could understand it, or else they are so  
3 meaningless. I mean, I have been asked to give  
4 informed consent now on a computer screen, you  
5 know, that makes me feel like I'm in a department  
6 store.

7           So -- so this is an opportunity  
8 actually to get out of that old paradigm that the  
9 lawyers are defending because of defense worries.  
10 Actually, there would be less litigation, in my  
11 belief, if we had better communication at this  
12 stage in the process, where people really did  
13 understand the risks they were undertaking, and  
14 what -- and I totally agree with you though that  
15 this needs to go through a thorough vetting  
16 process. The NQF process I think would be a  
17 great, great step to really bring out all the  
18 potential of -- of this opportunity to kind of  
19 create a better practice here that might have  
20 some influence on the bar, in saying, you know,  
21 it's not just about defending the hospital, it's  
22 actually about communicating and choosing risks

1 and making better decisions. So I love the idea  
2 of this actually going through the NQF process in  
3 a really thorough way.

4 CO-CHAIR WALTERS: I am trying to  
5 avoid rebuttal, rebuttal, rebuttal number two,  
6 rebuttal number three, rebuttal number four.  
7 Mimi, do you have anything else to add that is  
8 different from what has already been said?

9 MEMBER HUIZINGA: I do, and then this  
10 will be the last time I speak on it.

11 The -- so the first thing is that  
12 there is no evidence that implementing this would  
13 in any way change what currently exists. It  
14 would only -- it would likely, although I don't  
15 have evidence, but I feel that if we were to  
16 gather a group of hospital lawyers, this would  
17 add to what's in an informed consent document,  
18 not take away, and it wouldn't do much to improve  
19 the clarity or understandability by the patient.

20 However, if the CMS would like to  
21 collect information on that or the measure  
22 steward and bring that back for NQF through the

1 process to evaluate, that would be the  
2 appropriate place to handle that, and then we  
3 could have actual backing instead of conjecture.

4 I would say that I think that Lee  
5 hinted at this earlier: we are strongly  
6 supportive of shared decision-making, but that  
7 should happen well before you are ever into a  
8 consent document. There should be a long,  
9 thought-out process when an initial diagnosis is  
10 made, and that conversation or guiding that  
11 shared decision-making process should not try to  
12 be captured in a document that really exists for  
13 more legal purposes than the actual conversation  
14 and documentation of how the patient arrived at  
15 the decision to proceed with the procedure.

16 CO-CHAIR WALTERS: Akin, incremental  
17 information?

18 MEMBER DEMEHIN: More sort of on the  
19 more constructive side. You know, we've talked  
20 about this measure, we talked about the smoking  
21 measure, to a certain extent the follow-up for  
22 mental illness measure, and I think part of the

1 struggle we have is we are talking about what can  
2 be put into a quality measure versus what is an  
3 important improvement area that should be  
4 addressed.

5 To me, something like informed consent  
6 could be really, really nice to include in the  
7 efforts through the TYO. Maybe it is something  
8 that the HIMSS take a look at downstream.

9 I also think that gives an opportunity  
10 to see if there is anything in the context of  
11 that improvement where it lends itself to a nice  
12 measure that could be used in a national program,  
13 but to me, this sort of feels like we're going to  
14 boil it down to the measure to solve the  
15 overarching problem, and I think it has to be  
16 looked at in a much more holistic way.

17 CO-CHAIR WALTERS: Okay. I am going  
18 to open it up for voting. I did -- oh, sorry,  
19 yes?

20 DR. SUTER: Hi, this is Lisa Suter.  
21 I directed the measure development. I would like  
22 to respond to some of the comments made. I very

1 much appreciate this opportunity to speak.

2 The first thing I would like to just  
3 clarify is that this is -- definitely goes beyond  
4 just having a document or dating a document. I  
5 think it is important to recognize that this  
6 measure was developed in a very innovative way,  
7 with patients involved from the very beginning.  
8 They were brought in at every step. They were  
9 involved in every step of testing. We have heard  
10 positive results from the hospitals that we're  
11 working with to test, including premier hospitals  
12 that have found it beneficial.

13 So I think important to recognize that  
14 we've heard the hospital perspective. We've  
15 heard a legal perspective. But we have not heard  
16 the patients' perspective. The patients that  
17 were involved in this measure feel it is very  
18 valuable.

19 They also, as well as the patient  
20 advocates who commented during public comment and  
21 participated on our TEP, acknowledged that it  
22 does not go far enough, and we acknowledge that

1 as well. This is a first step, but it takes us a  
2 very long way. Can we all imagine what it might  
3 be like as a patient regardless of their  
4 socioeconomic status to have a piece of paper  
5 that actually describes the procedure that they  
6 are having before an elective procedure well  
7 before the actual procedure, before they are  
8 under anesthesia?

9 This is the information that this  
10 measure conveys. It is a potentially very  
11 powerful document. Mimi is right. We do not  
12 have data prospectively that indicates that this  
13 has changed anyone's life at this point, but we  
14 know from deep investment and collaboration with  
15 patients organized through the National  
16 Partnership for Women and Families working  
17 collaboratively with us that this is a meaningful  
18 measure to them. They see it as important even  
19 in addition to a shared decision-making as a  
20 first step, that this is critical information to  
21 anyone going forward with an elective procedure.

22 It is low-burden. We anticipate it

1 would be a very minimal burden on hospitals. It  
2 takes only a few minutes to abstract. We are  
3 working -- as you heard earlier, our reliability  
4 estimates are exceptionally high. We ought to be  
5 able to drive the sample size per hospital down  
6 to minimize hospital burden.

7 So we think that there is a tremendous  
8 amount of short-term benefit, right? This is  
9 something we could get -- we could get every  
10 hospital in America to a point where they could  
11 offer information to patients about elective  
12 procedures, or every physician, or every  
13 outpatient surgical center, to get to a minimum  
14 standard, and we hear again and again from  
15 patients that this is a minimum standard, but it  
16 exceeds what is legally required.

17 The legal requirements are vague, and  
18 they vary from state to state. We do not  
19 envision any incompatibility with existing state  
20 laws. For example, Louisiana has a lot of  
21 requirements for their informed consent  
22 documents. Hospitals we have tested from

1 Louisiana actually rate very well, so they are  
2 working to improve, and what the states are doing  
3 is in complete alignment with what this measure  
4 shows.

5 I will also acknowledge that in terms  
6 of the NQF endorsement, there has not been an NQF  
7 call for measures relevant to this measure. We  
8 are eager to have it in front of NQF. I think it  
9 is important for the MAP to recognize that the  
10 process of getting a measure out into use is a  
11 several-year process, so when this meeting  
12 decides in December of 2016 to revise and  
13 resubmit a measure, that is probably a three- to  
14 four-year delay for implementation in federal  
15 programs because of the -- if we move out next  
16 year, putting it in rulemaking, it gets signaled  
17 in rulemaking in 2018, and it gets implemented in  
18 2019, we'll for 2020 report it, so that -- I am  
19 just recommending caution when you're on the  
20 fence about measures to recognize that it is a  
21 12-month delay when you guys make decisions that  
22 may -- you may be on the fence about.



1                   So I don't know if I covered all of  
2                   the concerns, but I really appreciate the  
3                   opportunity to speak. Thank you.

4                   CO-CHAIR WALTERS: Thank you, Lisa.  
5                   I am sorry I didn't see your card up before.

6                   Okay. I'm going to call for a vote.  
7                   I think you've heard all the considerations. The  
8                   one you did not hear discussed by anybody was  
9                   option 2, conditional support. Any of the other  
10                  three options I think were brought up. So let's  
11                  vote.

12                  MS. QUINNONEZ: Voting is now open for  
13                  IQR program measure Measure of Quality of  
14                  Informed Consent Documents for Hospital-Performed  
15                  Elective Procedures, and this is MUC16-262.

16                  Option number 1, support. Option 2,  
17                  conditional support. Option 3, refine and  
18                  resubmit. Option 4, do not support.

19                  I will repeat those one more time for  
20                  those on the phone. Option 1, support. Option  
21                  2, conditional support. Option 3, refine and  
22                  resubmit. And option 4, do not submit -- do not

1 support.

2 (Pause.)

3 MS. QUINNONEZ: Okay. Thank you,  
4 Marisa. Voting is now closed. The results of  
5 IQR MUC16-262, 17 percent voted to support, 0  
6 percent conditional support, 46 percent refine  
7 and resubmit, and 38 percent do not support.  
8 This yields a refine and resubmit.

9 CO-CHAIR WALTERS: It's refine and  
10 resubmit.

11 Okay. The last measure in Consent  
12 Calendar 7, which was pulled, is MUC16-263,  
13 Communication About Pain During the Hospital  
14 Stay. We will start with Kim, who asked that be  
15 pulled.

16 MEMBER GLASSMAN: Thank you, Ron.

17 CO-CHAIR WALTERS: About -- I am  
18 sorry, you want to do about the measure first?  
19 Okay.

20 DR. YONG: Thanks Ron, I appreciate  
21 it. Just wanted to give you some context for  
22 this measure as we undertake this discussion. So

1 folks who have been following the program and the  
2 regulations relating to the Hospital Value-Based  
3 Purchasing Program may have been aware that in  
4 this past year's rule, we did propose and  
5 finalize to move the domain relating to the pain  
6 component in HCAHPS given -- even though we do  
7 acknowledge and do firmly believe that, you know,  
8 the pain is a critical component of a patient  
9 experience, it does need to be addressed that it  
10 may have -- we don't want to confuse the  
11 situation given the concerns around opioid  
12 overuse, and so that's why we finalized taking it  
13 out of the HVBP calculations for HCAHPS.

14 So as we have done that, we have  
15 continued to do work, and I wanted to give Bill  
16 Lehrman, who has been working as a steward of  
17 this measure, a chance to speak about our  
18 continued thinking and evolution of thinking  
19 around sort of how do we potentially address pain  
20 as part of the HCAHPS survey?

21 MR. LEHRMAN: Thank you, Pierre. As  
22 Pierre mentioned, in the outpatient rule this

1 year, we propose removing the pain management  
2 dimension from the VBP formula, beginning in the  
3 fiscal year 2018 program.

4 This stems from concerns raised by  
5 healthcare providers, physicians, et cetera that  
6 they believe the current pain management items in  
7 the HCAHPS survey and especially their inclusion  
8 in the VDP program was encouraging overuse of  
9 opioids. This happened to coincide with the  
10 opioid epidemic. CMS carefully considered the  
11 comments and commentary and decided to remove  
12 that measure from the -- the payment program.  
13 However, it remained on the survey because we  
14 believe that proper patient care should be a  
15 routine part of good quality hospital care.

16 However, we had the opportunity to  
17 investigate alternative questions for the HCAHPS  
18 survey that tapped into the same dimension about  
19 pain. Given the concerns about the current  
20 questions, the new items that we tested focused  
21 on communication about pain rather than patients'  
22 need for pain medication or belief that their

1 pain was well-controlled or that hospital staff  
2 did everything they could.

3 So the items that we tested and the  
4 items that we are putting forward today focus on  
5 communication about pain with the patient during  
6 the hospital stay. We have tested this earlier  
7 this year. We have good empirical support for  
8 the three items we would like to propose in the  
9 new composite measure, which is 263.

10 We also tested the cognitive testing  
11 with patients, inpatients and emergency  
12 department patients, about the new items. We  
13 also had a number of interviews, informative  
14 interviews with hospital administrators,  
15 physicians, and nurses about the content and  
16 direction of the current items and the proposed  
17 new items.

18 We feel that these empirical and  
19 cognitive informative interviews support the  
20 items in the composite that we are -- we have  
21 proposed in the MUC list, and with that, I will  
22 close.

1 CO-CHAIR WALTERS: Thank you. Okay,  
2 Kim?

3 MEMBER GLASSMAN: Okay. And I can  
4 kill two birds as both a puller and a discussant.

5 So we would commend CMS for being  
6 directionally appropriate in the changes that you  
7 are proposing to these questions, and  
8 particularly, I am pleased to see more plain  
9 language in the HCAHPS survey and would urge you  
10 to consider that for other questions, but also  
11 feel that this is very premature in testing. We  
12 are not aware of any of these data and therefore  
13 do not recommend including this at this time.

14 I would also add that I believe we're  
15 discussing questions 1, 2, and 3, which are  
16 directionally better than questions 4 and 5,  
17 which I believe generated a lot of comment this  
18 morning, so as these questions are being  
19 considered, we would urge CMS to also not focus  
20 so much on pharmacologic measures, but allow a  
21 wider range of treatment for people for pain.

22 CO-CHAIR WALTERS: Pierre is going to

1 respond to the question about the questions.

2 DR. YONG: Yes, just to make sure  
3 we're all on the same page, but yes. So for the  
4 committee's considerations, just HP1, 2, and 3,  
5 which are part of MUC16-263, so we're not talking  
6 about the other measures.

7 CO-CHAIR WALTERS: Akin?

8 MEMBER DEMEHIN: I think Kim covered  
9 a lot of the salient points already, so first  
10 just want to commend CMS for your willingness to  
11 take another look at these questions and really  
12 try to improve them in such a way that we are  
13 striking that right balance between treating  
14 pain, which we absolutely have to do because of  
15 the enormous negative consequences it can have,  
16 along with the concerns around the spread of the  
17 opioid abuse epidemic.

18 Definitely for us, this falls pretty  
19 squarely into the refine and resubmit category.  
20 We would strongly urge you to bring this through  
21 the NQF endorsement process before it goes into  
22 the program to really make sure we get a deeper

1 look at how this was tested and how this was  
2 developed.

3 I -- I -- we do have some questions  
4 too around making sure that there are some  
5 questions that target not just use of pain --  
6 pain medications, which I think is fair game to  
7 ask, but some of the non-pharmacological  
8 interventions as well, so look forward to  
9 continuing to work with you on the development of  
10 this measure. It is really important to get it  
11 right, and we're -- we're glad that you are going  
12 down this path.

13 CO-CHAIR WALTERS: I forgot to ask,  
14 what was your recommendation?

15 MEMBER DEMEHIN: To leave it where it  
16 is, refine and resubmit.

17 CO-CHAIR WALTERS: And Kim?

18 MEMBER GLASSMAN: I had indicated my  
19 recommendation of do not support at this time.

20 CO-CHAIR WALTERS: Are there any other  
21 people who wish to make a comment about this  
22 measure for the IQR?



1 (No audible response.)

2 CO-CHAIR WALTERS: Okay. I did not  
3 hear anything resembling a condition for  
4 conditional support, so we'll open it for voting.

5 MS. QUINNONEZ: We are now voting --  
6 before we vote, we'll have one more response.

7 CO-CHAIR WALTERS: Yes.

8 MR. LEHRMAN: Okay. In response to a  
9 couple of the comments, we did the testing of the  
10 items earlier this year. We tested the new  
11 survey items in 50 hospitals from around the  
12 country. We had about 16,000 surveys. We have  
13 -- we can reveal here a few items that we learned  
14 from that testing.

15 We found that the new items in the  
16 three-item composite that Pierre mentioned,  
17 that's just the three items, HP1, 2, and 3, in  
18 MUC-263, they weren't subject to floor or ceiling  
19 effects. They have excellent reliability at the  
20 hospital level at the recommended sample size,  
21 which is 300 completes per hospital per year.

22 They are not redundant with any of the

1 current items in the survey. They were related  
2 in a predictable manner with the standard patient  
3 mix characteristics that we use when we adjust  
4 the HCAHPS scores with public reporting. They  
5 are predictive of hospital rating and recommend.  
6 A lot of hospitals want to know that. They do  
7 not -- they do not vary systematically by survey  
8 mode -- that is, telephone, mail, IBR, or mixed  
9 mode -- or by patient race, ethnicity, or by  
10 hospital characteristics, after we adjust for  
11 patient mix. And they have a higher internal  
12 consistency as composite, a Kronbeck offer of  
13 0.81.

14 So we were encouraged by the empirical  
15 results. That was part of our decision to put  
16 these three items in particular into the new  
17 composite to replace the current items. We  
18 probably will go through the NQF. Timing was  
19 such that the MUC list came first.

20 Oh, and of course, I should indicate  
21 that quite deliberately, the new items do not  
22 mention medication. They ask if the hospital

1 staff talked to the patient about treating their  
2 pain. We do not limit what "treat" might mean,  
3 and we know from cognitive interviews that  
4 patients interpret "treat" as medicines and other  
5 therapies and methods for relieving pain.

6 CO-CHAIR WALTERS: Sean?

7 MEMBER MORRISON: I'm sorry, Ron, I  
8 just can't let this one go by. I think you guys  
9 really need to look not at the research in the  
10 past five years but the research what was done 20  
11 to 25 years ago that looked at these line of  
12 questioning and demonstrated that there actually  
13 wasn't a link between patient experience and  
14 outcomes and all it did was generate nurses  
15 talking to patients about their pain but there  
16 was no change in the experience. There was no  
17 change in outcome. And there actually wasn't a  
18 change in practice. And I think that has been  
19 forgotten because those data were done almost  
20 three decades ago.

21 So, please take a look at that before  
22 you -- I would strongly encourage you to look at

1 those data before you bring it through  
2 endorsement.

3 CO-CHAIR WALTERS: Kim.

4 MEMBER GLASSMAN: Just a clarifying  
5 question, then. Because it is included in the  
6 materials, are HP-4 and HP-5 off the table?  
7 Okay.

8 MEMBER DEMEHIN: So, I know we are not  
9 discussing them here, but are they undergoing any  
10 further development or kind of where do you see  
11 it going?

12 DR. YONG: So, I will say what the  
13 committee will vote on is HP-1, 2, and 3.

14 CO-CHAIR WALTERS: Presumably, what  
15 the appropriate Steering Committee would hear  
16 along with the data presented, if that is the  
17 choice.

18 Okay, let's open it up for voting.

19 MS. QUINNONEZ: Voting is now open for  
20 IQR Program, communication about pain during the  
21 hospital stay. This is MUC16-263, the questions  
22 HP-1, HP-2, and HP-3.

1                   Option 1 is support; Option 2,  
2                   conditional support; Option 3, refine and  
3                   resubmit; and Option 4, do not support. You may  
4                   cast your vote.

5                   I will read those one more time.

6                   Option 1, support; Option 2,  
7                   conditional support; Option 3, refine and  
8                   resubmit; and Option 4, do not support.

9                   Okay, voting is now closed. We will  
10                  give the software a second.

11                  (Simultaneous speaking.)

12                  CO-CHAIR WALTERS: While I have an  
13                  opportunity, let me kind of give a layout of what  
14                  we are thinking here, at least some people.

15                  Since we just got done talking about  
16                  this measure, that is a preview of all previous  
17                  measures. We are going to have vote again,  
18                  aren't we? Oh, go ahead.

19                  MS. QUINNONEZ: Yes, we are going to  
20                  have to vote again. One second.

21                  CO-CHAIR WALTERS: Okay, let's do that  
22                  first.

1 MS. QUINNONEZ: Give me one second and  
2 I will queue.

3 CO-CHAIR WALTERS: Ready? One second.

4 MS. QUINNONEZ: Voting is now again  
5 open for MUC16-263, questions 1, 2, and 3.

6 Option 1, support; Option 2,  
7 conditional support; Option 3, refine and  
8 resubmit; and Option 4, do not support.

9 Thank you. Voting is closed. It was  
10 successful. The voting results read 17 percent  
11 voted for support, zero percent voted for  
12 conditional support, 67 percent voted for refine  
13 and resubmit, and 17 percent voted for do not  
14 support.

15 So, this will move forward with refine  
16 and resubmit.

17 CO-CHAIR WALTERS: Okay, here is what  
18 we were just talking about. And opportunity  
19 opened up this morning because, against, we  
20 didn't have anything in the Consent Calendar for  
21 value-based purchasing but it cleared. And it is  
22 exactly the same measure that we just got done

1        talking about. So, we are going to go over  
2        briefly the rules of a value-based purchasing  
3        program. Probably there won't have to be a great  
4        deal of discussion about the details of the  
5        measures we just got done talking about. It will  
6        be mostly about whether it is appropriate for the  
7        value-based purchasing program.

8                    And then, for you hypoglycemic people,  
9        we are going to take a little bit more than just  
10       go get your food but a moderately brief break for  
11       lunch and then head into Consent Calendar 8 and  
12       9. So, that is kind of how things are laying out  
13       for one o'clock on.

14                   And we are going to go to the overview  
15       and then the opportunity for public comment and  
16       then talk about this measure.

17                   MS. MCQUESTON: Thank you. So the  
18       Value-Based Purchasing Program. Medicare bases a  
19       portion of hospital reimbursements on performance  
20       through this program. Medicare began withholding  
21       one percent of its regular hospital  
22       reimbursements from all hospitals paid under its

1 Inpatient Prospective Payment System to fund a  
2 pool of the value-based payment incentive  
3 payments.

4 The amount withheld from  
5 reimbursements increases over time. For 2016 it  
6 was 1.75 percent and for 2017 and for future  
7 fiscal years, it will be 2.0 percent.

8 Hospitals are scored based on their  
9 performance on each measure within the program,  
10 relative to other hospitals, as well as on how  
11 their performance on each measure has improved  
12 over time. The higher of these scores on each  
13 measure is used in determining incentive  
14 payments.

15 This is an overview of the current  
16 measures in the program and those proposed for  
17 rule. And we are currently considering one  
18 measure on the MUC List.

19 Current measure needs include adverse  
20 stroke events, cancer, behavioral health, care  
21 transitions, palliative and end of life care, as  
22 well as medication reconciliation.



1                   This is an overview of the first part  
2 of the current measures in the set. The program  
3 includes seven safety measures, four measures  
4 related to clinical care measures around  
5 readmissions, and then there is the one measure  
6 related to efficiency and cost reduction, as well  
7 as the HCAHPS measure within the domain of person  
8 and community engagement.

9                   Value-Based Purchasing also has five  
10 measures for mortality, soon to be six, as CABG  
11 was more recently or actually now six. And then  
12 two measures related to payment associated with  
13 episodes of care.

14                  And now we will move to public comment  
15 on this measure.

16                  CO-CHAIR WALTERS: Operator, can you  
17 open up the lines for any public comment?

18                  OPERATOR: Thank you. At this time,  
19 if you have a comment, please press star then the  
20 number 1 on your telephone keypad. We will pause  
21 for just a moment.

22                  And there are no public comments at

1 this time.

2 CO-CHAIR WALTERS: Are there any  
3 public comments in the room?

4 Okay, there weren't any lead  
5 discussants assigned to this because it didn't  
6 exist until this morning. Oh, okay, thank you.

7 I might also just add that as far as  
8 I remember, a measure had to be on IQR for a year  
9 before being placed into the Value-Based  
10 Purchasing Program.

11 So, Lee -- well, he didn't know. Oh,  
12 Kim. You probably just acquired this, then.

13 MEMBER GLASSMAN: No, we were prepared  
14 and then it went away and it came back. So,  
15 obviously, because this isn't leading the fit  
16 test for what would be included in Value-Based  
17 Purchasing, we would not recommend it for  
18 inclusion.

19 CO-CHAIR WALTERS: Jack? Oh, I'm  
20 looking at the wrong one. Sorry. Akin. I am  
21 looking at my agenda. Akin.

22 MEMBER DEMEHIN: So, I think I am a

1 little confused about sort of how to address this  
2 particular measure in the context of VBP. I  
3 think it is way too early, frankly, to talk about  
4 whether it is a fit for VBP. And even a  
5 recommendation of refine and resubmit feels like  
6 well, if we don't even know if it is working in  
7 the IQR yet, it is very hard for us to get a  
8 sense of whether it is ready for VBP or not. So,  
9 I think we would probably lean towards do not  
10 support for now.

11 CO-CHAIR WALTERS: Could I ask the  
12 measure steward what their thinking was of  
13 putting this on VBP at this point in time?

14 DR. YONG: It is just for the  
15 committee's consideration as for potential  
16 inclusion in HVBP, just like I mean in this  
17 circle, we have done that. We put measures that  
18 we have potentially put in for IQR and for HVBP,  
19 either substantive changes or new measures for  
20 the committee at the same time.

21 CO-CHAIR WALTERS: So, Akin, I think  
22 I interpret yours as do not support. And Kim, I

1 am moderately sure I interpret yours as do not  
2 support.

3 Is there any other discussion about  
4 this measure for the Value-based Purchasing  
5 Program? Ready for a vote.

6 MS. QUINNONEZ: Voting is now open for  
7 the Value-Based Purchasing Program.  
8 Communication about pain during the hospital  
9 stay. This is MUC16-263, questions 1, 2, and 3.

10 Option 1 is support; Option 2,  
11 conditional support; Option 3, refine and  
12 resubmit; and Option 4, do not support.

13 Option 1, support; Option 2,  
14 conditional support; Option 3, refine and  
15 resubmit; and Option 4, do not support.

16 Okay, voting is now closed. The  
17 results read 5 percent voted support, zero  
18 percent voted conditional support, 19 percent  
19 voted refine and resubmit, and 76 percent voted  
20 do not support. This is a do not support  
21 recommendation.

22 CO-CHAIR WALTERS: Thank you very much

1       for your time.

2                       Now, the race to the counter, right?

3       How long?

4                       CO-CHAIR TRAVIS:   How far behind are  
5       we?

6                       CO-CHAIR WALTERS:   We probably have a  
7       good hour and a half yet for Consent Calendar 8  
8       and 9.

9                       Fifteen minutes, 1:10-ish.   Thank you.

10                      (Whereupon, the above-entitled matter  
11       went off the record at 12:55 p.m. and resumed at  
12       1:15 p.m.)

13                      CO-CHAIR TRAVIS:   Okay, I think it is  
14       time for us to get started.   Just as a reminder,  
15       we are still in the Hospital Inpatient Quality  
16       Reporting Program but we are now on Consent  
17       Calendar 8.

18                      Okay, if we could ask the people in  
19       the back of the room to recognize that we are  
20       about ready to get started and need to hear each  
21       other, I would appreciate that.   Is that a polite  
22       way of asking you all to -- thank you.

1 All right, I really appreciate it.  
2 Now, we are in Consent Calendar 8 and you see the  
3 measures that we are going to address in this  
4 Consent Calendar. And several of them, in fact,  
5 all four of them in this Consent Calendar, deal  
6 with nutrition and malnutrition.

7 We do have an update that we want to  
8 share with you before we get into whether or not  
9 any of these get pulled. And so I am going to  
10 turn it over to Melissa.

11 MS. MARINELARENA: Thank you, Cristie.

12 So, these nutrition measures were or  
13 are in the health and well-being project that is  
14 undergoing now. They were three of them being  
15 the number one, the MUC16-372, MUC16-294, MUC16-  
16 296 were all consensus not reached during the in-  
17 person meeting. MUC16-344 was not recommended by  
18 the Standing Committee during the in-person  
19 meeting.

20 On Tuesday, during the post-comment  
21 call, the Standing Committee met again to vote on  
22 the consensus not reached, the -- I think it was

1 validity and evidence on some of them.

2 We are in the process of finalizing  
3 those results and we do not have them yet. It  
4 should be finalized probably next week or so.  
5 And that is an up or down. They will either pass  
6 -- if they do pass and they are recommended by  
7 the standing committee, then they will go forward  
8 to member vote. If they do not pass, then they  
9 will not be recommended and they will not go on  
10 to member vote.

11 So, the way they stand right now,  
12 three out of the four are still consensus not  
13 reached but one has not been recommended. And  
14 you see that in the preliminary analysis, based  
15 on what the recommendations are. So, the ones  
16 that are with conditions is that they would be  
17 NQF-endorsed.

18 CO-CHAIR TRAVIS: Okay, so we have one  
19 update but still more news to come on these  
20 measures because the results of the standing  
21 committee and then the CSAC review, we don't know  
22 that as of today. So, we won't have that much

1 added information but it is helpful to know that  
2 they are moving through the process.

3 So, we have already had public comment  
4 on our IQR program. So, we won't be doing that  
5 at the moment. So, we can move right into these  
6 particular measures. And I will read for you  
7 what the recommendation is for each measure and  
8 then see if anybody wants to pull it off the  
9 Consent Calendar or leave it on the Consent  
10 Calendar.

11 The first one is nutrition care plan  
12 for patients identified as malnourished after a  
13 completed nutritional assessment, which is MUC16-  
14 372. It is currently sitting with a  
15 recommendation for condition support or  
16 rulemaking, which is based on it continuing to go  
17 through the NQF process and to pass and be  
18 endorsed.

19 So, is there anyone that wants to pull  
20 this measure for discussion and vote?

21 Okay, Karen.

22 The second measure is completion of a



1 malnutrition screening within 24 hours of  
2 admission. It currently sits on the Consent  
3 Calendar as conditional support for rulemaking  
4 or, essentially, the same condition, which is  
5 that it goes through the NQF process all the way  
6 through and receives endorsement.

7 Would anyone like to pull this measure  
8 for discussion? Okay, Karen and Lee.

9 The third measure is completion of a  
10 nutrition assessment for patients identified as  
11 at-risk for malnutrition within 24 hours of a  
12 malnutrition screening. This is conditional  
13 support for rulemaking for the same reasons to  
14 complete the NQF process and be endorsed.

15 Pulling that one? Okay.

16 I feel like I am almost at an auction.  
17 People are raising their hands back and forth.

18 And then the fourth one is appropriate  
19 documentation of a malnutrition diagnosis. This  
20 currently sits as a do not support. The  
21 rationale was that it did not meet the evidence  
22 requirement for the NQF standing committee. Does

1 anyone wish to pull this measure for discussion?

2 Okay. So, we have a Consent Calendar  
3 that includes in item. It is MUC16-344  
4 appropriate documentation of a malnutrition  
5 diagnosis. The recommendation moving forward  
6 would be to do not support. Are there any  
7 comments that we would like to hear about this  
8 measure? Lee.

9 MEMBER FLEISHER: More of a comment to  
10 Pierre. I have been thinking a lot about this  
11 measure because it may get to frailty and this  
12 may be the missing measure that we need to help  
13 risk-adjust, rather than SES. So, I don't know  
14 where in the future you want to think about this.  
15 This is actually the reason I pulled the other  
16 measure but Yale Corp. keeps saying if we want to  
17 do it clinically, I think this is -- could be the  
18 missing clinical factor.

19 CO-CHAIR TRAVIS: Thank you for that  
20 input, Lee. Anyone else?

21 Okay, are there any objections to the  
22 Consent Calendar which just has this one measure

1 on it? Okay, seeing none, the Consent Calendar  
2 moves forward.

3 Okay, let's go to MUC16-372, nutrition  
4 care plan for patients identified as  
5 malnourished, after a completed nutrition  
6 assessment.

7 Karen, you pulled the measure. If you  
8 would to tell us your rationale for pulling it  
9 and then we will have a broader discussion.

10 MEMBER SHEHADE: Thanks. So,  
11 initially, on 372 I wanted to get some  
12 clarification around what had come from that  
13 meeting.

14 So, initially, it was to really get a  
15 sense of what had happened in the meeting on  
16 December 6th, to get a sense of where the  
17 Committee was headed, you know what kinds of -- I  
18 think they were looking for evidence for that  
19 one. So, what additional evidence were they  
20 looking for?

21 CO-CHAIR TRAVIS: It's validity. This  
22 one is validity.

1 MEMBER SHEHADE: Okay.

2 CO-CHAIR TRAVIS: So, there were some  
3 testing questions.

4 MEMBER SHEHADE: And in looking at  
5 some of these nutrition measures, and it is hard  
6 to think about them all as single measures  
7 because it is really about the patient, when they  
8 come in, for doing an appropriate screening for  
9 that patient, doing an appropriate assessment for  
10 the patient and then doing something about it.

11 And as a clinician who, as I mentioned  
12 yesterday, and who has cared for lots of Medicare  
13 beneficiaries over the years, when they come in  
14 to an inpatient setting, this was something that  
15 was key to the initial admitting process, an  
16 assessment for that patient.

17 And when I read that only 30-something  
18 percent had actually been completed, there is  
19 clearly a gap in the work that needs to take  
20 place to help identify patients for the  
21 appropriate care and especially in a frail  
22 elderly population where wound care is critical,

1 infections, good nutrition is just paramount.

2 And it became, from a clinical  
3 standpoint as a PA, I was the house officer that  
4 never left for 11 years and admitted over 500  
5 patients, this was something that we did  
6 automatically. And calling nutrition in, you  
7 know the dieticians in to come and help us come  
8 up with an appropriate plan was really just good,  
9 clinical care and it shouldn't be variable across  
10 the country. It is something that should take  
11 place and be really a standard. It should be an  
12 expectation of any Medicare beneficiary that good  
13 nutrition is just fundamental to what we are  
14 doing.

15 So, I am hopeful that whatever it is  
16 that is needed from the committee to look at this  
17 -- and clearly, we want to go through the  
18 appropriate process and make sure that everything  
19 has good evidence behind it, but clearly, to make  
20 sure that all those patients receive that same  
21 level of good screening assessments and a care  
22 plan identified for them.

1 CO-CHAIR TRAVIS: Thank you, Karen.

2 We have some other lead discussants.

3 We have Brock, Andrea, and Wei. And feel free,  
4 somewhat like Karen did, if you want to discuss  
5 these measures, all of these measures at the same  
6 time, I think that is fine. We will vote on them  
7 separately but feel free, if your comments are  
8 much like hers.

9 So, any comments from Brock? Anything  
10 to add?

11 MEMBER SLABACH: And I'm not sure.  
12 Were some pulled for further discussion?

13 CO-CHAIR TRAVIS: Yes, we have got the  
14 completion of the screening, completion of the  
15 assessment, and the care plan all pulled for  
16 discussion.

17 MEMBER SLABACH: Okay. It is our  
18 position that we are in agreement with the  
19 recommendations from NQF on staff and the Consent  
20 Calendar was appropriate.

21 CO-CHAIR TRAVIS: Thank you. Wei or  
22 Andrea?

1                   MEMBER YING: I just have -- so, it  
2 would be great if physicians working in hospital  
3 can comment so that completion of -- sorry.

4                   I was just going to say it would be  
5 great if the physicians working in hospital can  
6 comment on it so completion of a screening within  
7 24 hours of admission, I kind of feel like it is  
8 a given, right, as part of, as Karen mentioned,  
9 as part of the admission process. I don't mean  
10 screening. I mean this is a more formal way of  
11 documenting it but as part of the intake process,  
12 the height and the weight and the routine blood  
13 work that usually has been done in a timely  
14 fashion, from that a pretty good sense of where a  
15 patient is at in terms of nutrition status  
16 already presents. So, this is more a formal way  
17 of documenting it.

18                   My question is adopting this measure  
19 will change the clinical practice but does it add  
20 any value to the existing process? So, that is a  
21 comment on that.

22                   And then on nutrition plan for patient

1 identified as malnutrition, I looked at specs and  
2 it actually has five or six pretty long lists of  
3 the elements that has to be hit in order to be  
4 considered completed.

5 We talked about the burden for the  
6 hospitals. Is this an eMeasure so it can be  
7 pulled automatically from the system?

8 MS. MARINELARENA: Yes, it is an  
9 eMeasure and it is being proposed for IQR and the  
10 --

11 MEMBER YING: Okay, so this eMeasure.  
12 So, my question is more about the screening.  
13 Does it add value?

14 CO-CHAIR TRAVIS: Thank you, Wei.  
15 Andrea?

16 MEMBER BENIN: You know I think that  
17 obviously this is a critically important topic  
18 and a really important topic to address. These  
19 metrics make sense. I think the one concern that  
20 I had was really around the idea of having three  
21 or four malnutrition metrics in sort of the  
22 balance of the portfolio. And so if one were to



1 pair them down for this purpose, which one would  
2 be to choose -- you know it just seemed like a  
3 disproportionate number of metrics on  
4 malnutrition in the portfolio. And maybe it is  
5 that important. You know I don't have a good  
6 sense of that. And certainly in pediatrics, it  
7 is important to deal with this for everybody's  
8 nutrition but it is different when you get into  
9 geriatrics. So, I recognize that.

10 The idea that the screenings seem to  
11 me actually to be the most critical because I  
12 think that starts to trigger things. And I think  
13 that we do find that when these screenings, you  
14 know, you deliberate and you do whatever it is,  
15 you start doing these screenings, it does start  
16 the process going. So, that one seemed to me to  
17 be the most critical but I think perhaps those  
18 would be questions if this committee is going to  
19 meet again, the committee that is reviewing it is  
20 going to meet again.

21 Maybe there would be a way for that  
22 committee to also sort of prioritize how to think

1 about these things and that may help some of us  
2 decide. Because if we vote these all forward as  
3 conditional and then the committee approved,  
4 there may be an option to have a little bit of  
5 additional help with how to prioritize the  
6 metrics. So, I think having the experts weigh in  
7 on what that looks like would be valuable because  
8 this does seem to be critically important. And  
9 the one, to me, that seemed probably starter  
10 important was the screening. The other two  
11 seemed to me not to stand alone however. So, I  
12 think it did not seem to me that if you have 372  
13 or 296 without 294, that that didn't actually  
14 seem to make sense. So, if you were going to go  
15 with one, it seemed like 294 was the one that had  
16 it.

17 So, it just seemed like there could be  
18 a little bit -- there needed a little more  
19 thought in that. So, if we say conditional  
20 support, I might add the condition of with other,  
21 I don't know exactly how to frame it, but with a  
22 little bit more recommendation from the committee

1       that is working on this about how to think about  
2       it. But it was a little bit concerning that the  
3       committee, themselves, initially didn't even  
4       approve it. And that gave me a little pause,  
5       without understanding the nuances there.

6                   CO-CHAIR TRAVIS: Thank you. Is there  
7       any additional kind of information that you can  
8       give us maybe from the meetings that have already  
9       occurred? Because then you are still out kind of  
10      finalizing the committee recommendations.

11                   MS. MUNTHALI: So, with regards to the  
12      screening, the committee had a lot of concern  
13      because the screening wasn't linked to evidence  
14      and it was so hard to see the proximity was quite  
15      distal.

16                   And then the other issue with  
17      screening was that all patients 18 and over were  
18      to be screened. So, patients at-risk was not  
19      stratified or there was no risk adjustment. So,  
20      the committee was really concerned about burden  
21      for inpatients and hospitals.

22                   Essentially, those are the largest

1 issues with the measure.

2 CO-CHAIR TRAVIS: That's helpful. And  
3 is there anything to add about any of the other  
4 two measures, too, at least from the MUC meeting?

5 MS. MUNTHALI: I have to pull it up.  
6 With the care assessment, I think we -- the care  
7 plan, the issue was around exclusions. They were  
8 not specified and that was the validity issue.

9 And then if I can refresh my memory,  
10 there is a third one.

11 CO-CHAIR TRAVIS: Issue of a nutrition  
12 assessment for those at risk after screening.

13 MS. MUNTHALI: And that was also  
14 evidence. And Angel, who is part of the  
15 developer team is there as well. And correct me,  
16 if I am wrong, but it was also around evidence  
17 and just linking process to help him.

18 CO-CHAIR TRAVIS: Thank you. I think  
19 that will help our thinking as we move forward.

20 Okay, I will start with Lindsey.

21 MEMBER WISHAM: Quick question in  
22 regards to the 1:34:38 or eCQMs. It does seem

1       that the specifications, one leads into the  
2       other. So, I didn't know if they were tested.  
3       When they were field tested, were they tested as  
4       a package? So, in essence, one of the measures  
5       will produce a data element that then feeds into  
6       the denominator of the next measure.

7               So, I think the best thing to consider  
8       is that do they get approved as a package or not  
9       at all? So, if you move one from the continuum  
10      do you then not use the prior data elements?

11             MR. VALLADARES: Yes, so the four  
12      measures were tested together. I'm sorry, Angel  
13      Valladares. I am with Avalere Health, who worked  
14      with the Academy of Nutrition and Dietetics who  
15      developed the four malnutrition eQMs.

16             So, the four eQMs were all tested in  
17      a cohort together with the same hospitals.  
18      However, as you indicated, yes, sort of if you  
19      look at them in order, so they are technically  
20      supposed to go along the nutrition care process,  
21      which is screening, assessment, care plan,  
22      recommended and documented, and then a diagnosis

1 by the provider. The data elements are generated  
2 from the predecessor measure.

3 So, for instance, if you really want  
4 to accurately identify the denominator of  
5 patients who should be assessed based on the risk  
6 level from the screening that was identified.  
7 You need to really identify that patient  
8 population in the first cohort, which is the  
9 patients that were screened for malnutrition  
10 risk.

11 So, if you don't have that cohort  
12 accurately identified, then what occurs is you  
13 may have a misleading denominator population in  
14 the assessment because the appropriate rates of  
15 documentation are not happening, which is what we  
16 are finding in terms of the gap for this, which  
17 is their measure set.

18 CO-CHAIR TRAVIS: Very good question.  
19 I was wondering about that, myself.

20 Akin.

21 MEMBER DEMEHIN: So, this set of  
22 measures definitely gives us a little bit of

1 pause, especially since there are two of the  
2 three are ones where the evidence doesn't appear  
3 to be particularly strong and it sounds like that  
4 is why it is landing in the consensus not reached  
5 at this point.

6 And if there are questions about  
7 validity in terms of whether it is actually  
8 measuring what we think it is measuring, I don't  
9 know. And I also have to say that the fact that  
10 it is an eMeasure, I do think that something like  
11 this makes sense as an eMeasure but I don't  
12 necessarily think that this being an eMeasure in  
13 and of itself obviates the potential burden that  
14 this could entail. And in particular, I am  
15 curious about whether this measure is supported  
16 by all of the -- or would be supported by all of  
17 the EHR vendors.

18 I think it would be hard to lend this  
19 too much support without an understanding of kind  
20 of where they are in that process. And some of  
21 the evidence and validity issues, that gives us  
22 some pause, too.

1 CO-CHAIR TRAVIS: Is your card still  
2 up, Lindsey?

3 Andrea.

4 MEMBER BENIN: I would just say that  
5 having heard some of this other discussion a  
6 little bit more about what the committee was  
7 thinking, perhaps this needs to go into a refine  
8 and resubmit category. Maybe it needs a little  
9 bit more work than I understood it to need for  
10 all three of them.

11 I mean if I had to choose one, I would  
12 probably choose the screening one but maybe there  
13 is a little bit more work to go into those.

14 CO-CHAIR TRAVIS: Thank you, Andrea.

15 I guess my question is how did the  
16 committee really look at these? Did they look at  
17 them as related? Did they look at them as -- I  
18 mean they are not a composite. So, how did the  
19 committee kind of look at the cascading effect,  
20 if you will, of this set of measures?

21 MS. MUNTHALI: It was a topic of  
22 discussion and I think there were some



1 recommendations for the developer prior to  
2 submitting to think about them as a composite  
3 because they did recognize that they were related  
4 and that, as it was mentioned before, this  
5 screening proceeds, particularly for the first  
6 two measures. I think the other measure on the  
7 evaluation plan, the assessment plan, is not a  
8 screening measure. And that is something the  
9 developer wanted to point out. But for the  
10 others, you have to set your base population and  
11 then build on that.

12 So, that was a recommendation by  
13 staff, prior to submission and then the  
14 Committee, when they first looked at the  
15 measures.

16 CO-CHAIR TRAVIS: Okay, Sean.

17 MEMBER MORRISON: Yes, quickly  
18 Cristie. So, if that is the case, that there was  
19 a recommendation on a composite measure, what I  
20 would -- and it has not gone through endorsement  
21 process, what I would like to recommend or  
22 suggest is it goes back as a revise and resubmit

1 with that comment.

2 Because if it goes through and is  
3 endorsed by NQF -- I'm sorry -- and we put that  
4 as a conditional support, then it goes through  
5 four specific measures and we never see it again.  
6 What I would like to see is it go through the  
7 evidence process and then for us to evaluate as  
8 whether those four items are appropriate for this  
9 program.

10 CO-CHAIR TRAVIS: And so that is  
11 refine and resubmit from your perspective. Okay.

12 Are there any other comments? Would  
13 you like to make one? Sure.

14 MR. VALLADARES: So, I have a few  
15 comments that I can make on some of the concerns  
16 that were addressed by the committee members. I  
17 think one of the important things I can start  
18 with sort of high or low. We will talk about  
19 sort of the feasibility of the measures and  
20 validity to adjust Akin's question that was  
21 around the EHR vendors.

22 So, we did conduct feasibility

1 assessments with three of the largest EHR vendors  
2 in the country, Epic, Cerner, and Allscripts. We  
3 received very high scores on our feasibility  
4 assessments for all of the data elements on all  
5 four of the eCQMs. They indicated to us, in  
6 general, that at this time most of their recent  
7 platforms have the capabilities to capture these  
8 data elements. However, it is up to the  
9 discretion of the hospital implementing that  
10 particular platform to, obviously, decide if they  
11 want to incorporate that data element in the  
12 structured manner that is required for the  
13 collection of an electronic measure. So, I just  
14 wanted to share that.

15 Then with validity to be clear as  
16 well, we did test the measure. So, this is the  
17 nutrition care plan measure. So, we did test  
18 that measure with -- well, we tested all four  
19 measures because they were tested together as a  
20 package for specific exclusions. When we worked  
21 with our technical expert panel, we were not able  
22 to show with our data we were able to collect

1       that there was a valid reason to include the  
2       exclusions that we tested on, with the exception  
3       of the length of stay under 24 hours because  
4       don't want to, obviously, penalize a hospital for  
5       a process if there wasn't even enough time to  
6       complete that process or location.

7               However, there were three what we were  
8       calling experimental exclusions which were  
9       discharged to Hospice, discharged palliative care  
10      as well and then also, left against medical  
11      advice, which those were the three major  
12      exclusions. So, that is something that we are  
13      continuing to test as we move forward with these  
14      measures. We are testing these in other  
15      hospitals.

16             So, the other comment around the  
17      evidence, that is something that I do want to  
18      bring to the committee's attention because I  
19      think this is helpful with the discussion and  
20      will also help with your recommendations to us as  
21      to how we can move forward with these measures.

22             So, the evidence really sits more on,

1 of course, as we know whatever process is most  
2 linked directly to patient outcomes and  
3 improvement in patient outcomes. And that is  
4 really when the intervention, the nutrition  
5 invention gets implemented. We know that when a  
6 specific nutrition intervention, there are  
7 several. ONS is one. There is different  
8 parenteral enteral nutritions, supports as  
9 dietary, supports and modifications to the diet.  
10 Those, there is strong evidence to link that  
11 patient impact. And that is why the third  
12 measure of the nutrition and care plan did pass  
13 evidence.

14           However, the first two measures, which  
15 are further back in the process, as we know, they  
16 are a little more distal to the process but the  
17 guidelines internationally, there is  
18 international consensus from the United States,  
19 Europe, other countries, that before you can  
20 reach intervention, you need to properly identify  
21 and assess the patient for physical indicators  
22 for malnutrition. So, a lot of these studies

1       that we cited in our evidence submission showcase  
2       the use of the proper screening and assessment  
3       tools for studies that looked at really what type  
4       of interventions were implemented for patients.

5               So, I think that is where a lot of our  
6       -- the challenge for us has been is really being  
7       able to hone in on the direct causal linkage of a  
8       screening to the outcome of the patient. We have  
9       a lot of evidence to showcase that. If you  
10      identify the patient and intervene on them early,  
11      you can improve outcomes. And we also have a lot  
12      of evidence to showcase that assessments are a  
13      great tool to identify risk factors for patients  
14      and there is independent associations with  
15      increased length of stay, increased readmission,  
16      mortality, several other clinical indicators that  
17      are very important, obviously, for Medicare  
18      patients.

19              So, those are a few of the items that  
20      I wanted to mention.

21              And the last thing -- and I do  
22      apologize for going I am sure overtime, is the

1 composite. So, that is another discussion that  
2 we did have, as Elisa mentioned, at NQF.

3 So, one of the challenges that, of  
4 course, there is with the development of a  
5 composite measure is that you need to test all of  
6 the individual components in the field and  
7 generate performance evidence for each of the  
8 individual composite components.

9 PARTICIPANT: No, that is not NQF.

10 MR. VALLADARES: Okay, well,  
11 originally, that was our perspective, was we  
12 wanted to first implement each of the measures  
13 and sort of allow the performance used to be  
14 generated and then create the composite but it is  
15 not anything that we were held to but that was  
16 sort of the approach that we took. Before  
17 actually submitting a composite measure, we  
18 wanted the four measures to be considered as  
19 such.

20 So, those are the comments. Thank  
21 you.

22 CO-CHAIR TRAVIS: Thank you very much.

1 Mimi.

2 MEMBER HUIZINGA: I will be very  
3 quick. So, in general, we support these  
4 measures. We think that malnutrition has been  
5 linked to many conditions and that it is  
6 something that hospitals can have direct impact  
7 on and make a difference here. And it aligns  
8 with maybe the other initiatives that our  
9 hospitals are working on to try to prevent  
10 complications and reduce readmissions.

11 So, we are supportive of the three in  
12 the conditional support that were recommended by  
13 NQF. However, if we had to choose one, I would  
14 likely recommend actually a little bit different  
15 than what was mentioned before.

16 I would probably go with the full  
17 assessment, instead of just a screening. Care  
18 planning often happens with assessments but we  
19 find that the breakdown often happens from the  
20 screening to full assessment. So, we would, if  
21 you are only going to go with one, that is the  
22 one that we would like. And if there is going to



1 further information available from this, we would  
2 like to see and provide more information about  
3 what validated tools we should use for specific  
4 conditions. For example, what should be used in  
5 a patient with concerns much like that.

6 But in general, we think these  
7 measures are a very good idea and we are very  
8 appreciative if they are e-specified.

9 CO-CHAIR TRAVIS: Jennifer.

10 MEMBER EAMES HUFF: I guess I have the  
11 question, and I am thinking again of the diagram,  
12 Helen, that you showed yesterday about the  
13 outcomes and the drivers. I forget the bottom  
14 one.

15 I am not clear what role malnutrition  
16 plays against the other drivers we have been  
17 talking about in terms of priority. I got this  
18 great evidence management, the role it plays in  
19 terms of better outcomes, and the patient safety,  
20 and better costs but I just want to connect to  
21 the conversation that we are trying to -- or not  
22 have it so separately in terms of thinking

1 holistically of how you prioritize about what  
2 gets in this program.

3 So, I guess that is a question for me  
4 because where does it stand in the priorities of  
5 drivers in terms of whether or not just being  
6 sure it be in the program.

7 And then looking at the specific  
8 measures, themselves, it sounds like the if you  
9 had to choose one, you would choose. So, I will  
10 throw mine in of I would choose the 372, which is  
11 the nutrition care plan for malnourished.

12 And as a part of that, as a part of  
13 the dominant, it includes and assessment and it  
14 feels a little bit more complete and actionable.  
15 It means you know what actions are going to be  
16 taking place based on that, their status of  
17 malnutrition.

18 CO-CHAIR TRAVIS: Thank you, Jennifer.  
19 Akin.

20 MEMBER DEMEHIN: All very helpful  
21 points to hear. I mean I am a little caught up  
22 in sort of this not necessarily a dichotomy but

1       when we are talking about malnutrition screening,  
2       we are talking about what a patient comes into  
3       the hospital with. And then the plan portion of  
4       it, the 372 is what you do once you know someone  
5       is malnourished.

6               From what I am hearing, there may be  
7       some pretty good evidence around there being  
8       downstream impacts on outcomes as the result of  
9       having that care plan in place but less certain  
10      that there is good evidence around just the act  
11      of screening and the act of documentation.

12             So, it still feels to me that there  
13      are enough questions about these measures and how  
14      they hang together and how they are packaged that  
15      a refine and resubmit sounds a little better to  
16      me.

17             I do think Jennifer raises a really  
18      interesting question, too, about so where does  
19      this fit in the overall constellation of issues  
20      that you would look at. Is this one of the most  
21      important things we can do to affect outcomes?  
22      And based on that we see here, it is not quite as

1 clear-cut as one might hope.

2 CO-CHAIR TRAVIS: Sean.

3 MEMBER MORRISON: Sorry.

4 CO-CHAIR TRAVIS: Dan is that you? I  
5 can't tell whose card is up. Oh, Lindsey.

6 MEMBER WISHAM: And just in regards to  
7 the comment about if I had to pick one, just  
8 based off of Angel's comment, I would strongly  
9 suggest not just picking just one, simply because  
10 if we pick one or we recommend one, there is  
11 going to be a whole host of implementation  
12 problems when it comes to actually identifying  
13 what data elements or codified data elements,  
14 rather, are we able to pull in.

15 I think there is somewhat of a cat and  
16 mouse game already with eCQMs, which is we  
17 specify the measure and then vendors and  
18 clinicians then figure out how to put it in some  
19 sort of a discrete field. So, it looks like --  
20 again, I have not reviewed the exact data  
21 elements in this group of measures but it sounds  
22 like from the description because they feed into

1 each other you are, in essence creating your  
2 denominators for the next round of measures.

3 CO-CHAIR TRAVIS: Well, I think we  
4 have run the gamut. I think there is general  
5 consensus that nutrition and malnutrition is an  
6 important topic. However if it is within the  
7 whole measure set, I think is something else that  
8 would be important for us to kind of feel and be  
9 sure that it is one of the drivers.

10 And then it does appear to me that  
11 there are a number of questions about the  
12 measures, themselves, and how they hang together.  
13 And I'm still trying to get a better feel for  
14 what the Standing Committee's recommendations  
15 are.

16 It would seem to me we are going to  
17 vote but I have heard a lot about refine and  
18 resubmit, some of which is defined by what  
19 happens in the endorsement process but not all of  
20 which is having to do with the endorsement  
21 process. And that is what makes refine and  
22 resubmit different than conditional support.

1       Because if it went through and was endorsed, it  
2       would automatically be eligible for the program.

3               So, as you are thinking about the way  
4       you want to vote, just keep that in mind in terms  
5       of the difference between conditional support and  
6       refine and resubmit. Conditional support is if  
7       it goes to the endorsement process. If each of  
8       these goes through and they are endorsed, then  
9       they would be eligible with our recommendation.  
10      Our recommendation would be they are eligible for  
11      the program.

12             If we would like to see how they hang  
13      together and see what the ultimate results were,  
14      then refine and resubmit what would be what we  
15      would need to do.

16             So, we will go on with the vote.

17             Oh, I'm sorry. There is a question.

18      David.

19             And then I realized I was talking  
20      about all three measures. We are going to vote  
21      on each of these measures separately, right?

22      Okay.

1                   MEMBER ENGLER:   So, I just had one  
2                   comment and it goes to the question of food  
3                   insecurity. And how close of these metrics point  
4                   to issue of food insecurity with patients that  
5                   are being treated?

6                   There is a hunger crisis in America  
7                   that has wound up on the doorsteps of a number of  
8                   the hospitals, in particularly in California, who  
9                   are facing large amounts of food insecurity,  
10                  especially when their supplies run out at the end  
11                  of the month. And we know that because we see  
12                  major spikes, hypoglycemic spikes and ED returns  
13                  and high amounts of ED utilization at the end of  
14                  very predictable times.

15                  So, I am wondering, because I don't  
16                  know the literature on malnutrition in these  
17                  particular measures, whether or not they are  
18                  picking up or there are other metrics that they  
19                  can look at relative to issues of food  
20                  insecurity, which to your point, are real drivers  
21                  of negative outcomes, especially in the high  
22                  rates of ED utilization.

1 CO-CHAIR TRAVIS: Thank you, a very  
2 important thing for us to keep in mind.

3 We are going to vote on each measure  
4 separately. So, the first one we are going to  
5 look at it is nutrition care plan for patients  
6 identified as malnourished after completed  
7 nutrition assessment, which is MUC16-372.

8 MS. QUINNONEZ: Voting is now open for  
9 IQR Program measure MUC16-372. Option 1,  
10 support; Option 2, conditional support; Option 3,  
11 refine and resubmit; Option 4, do not support.

12 Option 1, support; Option 2,  
13 conditional support; Option 3, refine and  
14 resubmit; and Option 4, do not support.

15 If we have anyone on the phone, if you  
16 could submit our votes, please.

17 Okay, voting is now closed. For MUC  
18 measure 16-372, 9 percent voted for support; 43  
19 percent voted for conditional support; 39 percent  
20 voted refine and submit; and 9 percent voted do  
21 not support.

22 MS. MARINELARENA: So if it is refine



1 and resubmit, we need a rationale of the  
2 suggested modifications. This is a measure that  
3 is fully developed and tested and going through  
4 the NQF process.

5 DR. BURSTIN: One of the opportunities  
6 here says opportunities for improvement. And I  
7 suspect from the discussion, something along  
8 those lines.

9 CO-CHAIR TRAVIS: Yes, I mean I think  
10 that was the main thing was that the  
11 opportunities to kind of think about how they  
12 hang together and some of those issues that I am  
13 sure you recorded well conversation.

14 Ready?

15 MS. QUINNONEZ: Voting is now open for  
16 IQR measure completion of a malnutrition  
17 screening within 24 hours of admission. And this  
18 is MUC16-294. Option 1, support; Option 2,  
19 conditional support; Option 3, refine and  
20 resubmit; and Option 4, do not support.

21 Option 1, support; Option 2,  
22 conditional support; Option 3, refine and

1 resubmit; and Option 4, do not support.

2 Okay, all votes are in and voting is  
3 now closed. For the recommendation of MUC16-294,  
4 13 percent voted for support, 46 percent voted  
5 conditional support, 39 percent voted refine and  
6 resubmit, and 4 percent voted do not support.

7 So, this yields a refine and resubmit.

8 Voting is now open for IQR program  
9 completion of a nutrition assessment for patients  
10 identified as at-risk for malnutrition within 24  
11 hours of a malnutrition screening. This is  
12 MUC16-296. Option 1, support; Option 2,  
13 conditional support; Option 3, refine and  
14 resubmit; Option 4, do not support.

15 Option 1, support; Option 2,  
16 conditional support; Option 3, refine and  
17 resubmit; and Option 4, do not support.

18 Voting is now closed. For the  
19 recommendation of MUC16-296, 17 percent voted for  
20 support, 43 percent voted conditional support, 39  
21 percent voted refine and resubmit, and zero  
22 percent voted do not support.

1                   This yields a conditional support  
2 recommendation.

3                   CO-CHAIR TRAVIS: Okay, thank you all  
4 very much for going through all of that with us.

5                   All right, now we are going to go to  
6 Consent Calendar 9. Ron doesn't think I have  
7 done enough today so I'm doing two in a row.

8                   So, Consent Calendar 9 is the tobacco  
9 use and antipsychotic and an influenza, and a  
10 safe use of opioids. So, we will be walking  
11 through those and if you will give me just one  
12 moment, I'm trying to be sure that I give you all  
13 the right information here.

14                   Well, it was done but it was done for  
15 a different program. Here I go. We will. We  
16 will.

17                   So, here we are. Okay, so the first  
18 one is tobacco use screening, which is MUC16-050.  
19 It comes to the Consent Calendar with a refine  
20 and resubmit. It is currently undergoing field  
21 testings. The field testing should demonstrate  
22 reliability and validity in the acute care

1        setting. The eMeasure needs to be submitted to  
2        NQF for review and endorsement.

3                Is there anyone that would like to  
4        pull this measure for discussion and vote? Okay.

5                The second one is use of  
6        antipsychotics in older adults in inpatient  
7        hospital setting, which is 16-041. It currently  
8        sits with a refine and resubmit. This is a newly  
9        developed eMeasure. It is fully developed and  
10       specified but it is currently undergoing testing.  
11       It is one of the reasons it sits here.

12               The testing results should demonstrate  
13       reliability and validity and then the measure  
14       should be submitted for NQF endorsement.

15               Anyone want to pull MUC16-041? Okay,  
16       Akin.

17               The next one is influenza  
18       immunization, MUC16-053. Oh, here it is. This  
19       is coming with a recommendation of do not  
20       support. I'm just going to read what is here but  
21       the Health and Well-Being Standing Committee  
22       acknowledged the importance of this hospital-

1 based measure but did not believe narrowing  
2 performance gaps were clinically significant in  
3 the chart abstracted version of this measure,  
4 which is already NQF-endorsed at 16-059. There  
5 was no data or evidence provided demonstrating  
6 that this eMeasure addresses a performance gap,  
7 essentially, in IQR. And Lindsey would like to  
8 pull this measure.

9 And then we have the safe use of  
10 opioids -- concurrent prescribing, which we did  
11 look at yesterday for a different program. And  
12 that is MUC16-167.

13 I have so many things I am keeping  
14 notes on, it is hard for me to find it. But I  
15 believe that this was seen in a hospital  
16 outpatient quality reporting and I believe it was  
17 a do no support in that program. And it comes  
18 into this program with a refine and resubmit on  
19 the Consent Calendar.

20 Anybody want to pull it? Lee and  
21 Sean. Okay, great. Thank you.

22 All right. If you all could see my

1 books and how many different pieces of paper I am  
2 trying to -- you would understand why I lose  
3 track. Everything gets updated along the way,  
4 too.

5 All right, let's go to our tobacco use  
6 screening, which is MUC16-050. And who pulled  
7 that one? Nobody. Sorry. Although, is there a  
8 comment?

9 Now, I know where I am. Is there a  
10 comment on that particular -- before we go with  
11 the Consent Calendar, is there a comment? And I  
12 think there is.

13 MEMBER DEMEHIN: Yes, just didn't pull  
14 it but did want to make a comment that, as we  
15 look at this kind of screening measure, we know  
16 that this is designed as an eMeasure. It makes  
17 sense to design it as an eMeasure. We know that  
18 some of the requirements around modified Stage 2  
19 and Stage 3 include a requirement around  
20 documentation of smoking status. I think it is  
21 more kind of the overarching conceptual question  
22 of how much value we get from measuring this.

1 Even if we are capturing in the EHRs and the EHRs  
2 required to capture it, it is less clear exactly  
3 how much value this will add to the program  
4 measure set.

5 CO-CHAIR TRAVIS: Okay, thank you very  
6 much. Are there any objections to the Consent  
7 Calendar, which has that one item on it, which is  
8 the tobacco use screening?

9 Okay, hearing none, we will accept the  
10 consent calendar.

11 Now, we will move to those that have  
12 been pulled, use of antipsychotics in older  
13 adults in inpatient setting. And Akin, I think  
14 you pulled this one. Can you give us your  
15 rationale and then we will see if we have any  
16 comments from our lead discussants?

17 MEMBER DEMEHIN: Yes, I mean this is  
18 one where the staff recommendation around refine  
19 and resubmit may actually be the right one here.  
20 But as we looked at the denominator exclusions,  
21 it made us wonder whether the right groups were  
22 included. So, it basically is looking at giving

1 antipsychotics to anyone other than patients with  
2 schizophrenia, Tourette's, bipolar, Huntington's  
3 disease at the time of admission.

4 So, just maybe this is more a question  
5 for some of the clinicians in the room. Does  
6 that look like the right group? Are there any  
7 others that we should include.

8 And then some more practical questions  
9 around where the data come from. It is an EHR  
10 measure or it is a claims-based measure? It is  
11 an EHR measure. Okay.

12 So, I mean I guess our overarching  
13 question is are there any other diagnoses for  
14 which you might be prescribed an antipsychotic  
15 for a clinically appropriate reason.

16 Otherwise, I think refine and resubmit  
17 probably is the right category here.

18 CO-CHAIR TRAVIS: Yes?

19 MEMBER EISENBERG: PQA has developed  
20 an almost identical measure for outpatients. And  
21 we came up with exactly the same categories of  
22 exclusion that appear in this measure.



1                   When we brought that measure before  
2                   NQF, the only objections that we received was  
3                   that there are some people that have seizures  
4                   that could be excluded but it was felt by the  
5                   endorsement panel, at that point, that those  
6                   represented such a small number of patients that  
7                   that exclusion should not be included.

8                   CO-CHAIR TRAVIS: Thank you, Woody.  
9                   Frank.

10                  MEMBER GHINASSI: Just a brief thing.  
11                  The other one to consider is augmentation with  
12                  depression and doses. So but many people looked  
13                  at that.

14                  But I think it is a good measure. I  
15                  just wanted to make that comment. I think that  
16                  my biggest concern is that often subclinical  
17                  doses of antipsychotics in moderate and  
18                  sufficient dosage to address any of these  
19                  disorders are given for two things, agitation and  
20                  sleep. So, I think this is a good measure.

21                  CO-CHAIR TRAVIS: Thank you, Frank.  
22                  Woody.

1                   MEMBER EISENBERG: Yes, I would just  
2 add that I would support this measure  
3 conditionally with an NQF endorsement. I am not  
4 sure what needs to be refined.

5                   MEMBER ENGLER: Can you repeat that?

6                   MEMBER EISENBERG: Yes, I don't think  
7 this measure needs refinement. I just think it  
8 needs NQF endorsement. I would support it  
9 conditionally.

10                  MS. MARINELARENA: It's not tested.  
11 That's why it ended up in this category.

12                  CO-CHAIR TRAVIS: And it doesn't --  
13 let me be sure I am on the right measure. It has  
14 not been submitted for review yet, right?

15                  So, if you look at kind of the way  
16 these decision categories cascade, it hasn't even  
17 been submitted yet. So, that is why it is in --

18                  MEMBER EISENBERG: Good. I withdraw  
19 my comment.

20                  CO-CHAIR TRAVIS: Okay. But it is  
21 good for them to know that that is how you feel.  
22 Okay, thank you.

1 Jack?

2 MEMBER JORDAN: Yes, I think one thing  
3 in this, too, as I have been starting to play  
4 with these, oftentimes with this, how they define  
5 the drug list. That EQM measure is usually in  
6 the RxNorm Codes, which aren't entirely stable  
7 and they also cause work statements for the  
8 people who are trying to maintain these  
9 eMeasures. Then, if they can actually be defined  
10 by a kind of pharmacy class methodology instead,  
11 those are much more stable and easy to build.

12 So, I think that is just a generic  
13 thing in how you are building these medication  
14 lists, that they are harder to build and maintain  
15 when the lists are defined by RxNorm Codes.  
16 There might be five or six thousand codes that  
17 you have.

18 CO-CHAIR TRAVIS: Thank you, Jack.  
19 Lee.

20 MEMBER FLEISHER: More of a question  
21 because there is a lot of concern, questions  
22 about the right treatment with delirium

1 postoperatively. So the question is, there is  
2 actually more and more talk about how there will  
3 be an ideal agent, certainly not Benadryl, which  
4 is the opposite.

5 So, that is my only concern. When it  
6 goes to NQF endorsement, whether or not a  
7 diagnosis of delirium during the hospitalization  
8 should be considered potential exclusion. So, I  
9 still would say refine and resubmit.

10 CO-CHAIR TRAVIS: Okay, I don't see  
11 any more cards. So, I think we are ready to go  
12 to a vote on this.

13 MS. QUINNONEZ: Voting is now open for  
14 IQR program measures use of antipsychotic in  
15 older adults in inpatient hospital setting. And  
16 this is MUC16-041. Option 1, support; Option 2,  
17 conditional support; Option 3, refine and  
18 resubmit; and Option 4, do not support.

19 Option 1, support; Option 2,  
20 conditional support; Option 3, refine and  
21 resubmit; and Option 4, do not support.

22 Okay, voting is now closed. The

1 results for measure -- for MUC16-041, 13 percent  
2 voted for support, 9 percent voted for  
3 conditional support, 78 percent voted for refine  
4 and resubmit, zero percent for do not support.

5 So, this yields a refine and resubmit  
6 recommendation.

7 CO-CHAIR TRAVIS: Thank you. The next  
8 measure is MUC16-053, influenza immunization.  
9 And Lindsey pulled it.

10 MEMBER WISHAM: Yes, thank you. So,  
11 going back to one of the conversations we had  
12 yesterday in regards in an outpatient measure, we  
13 ran into the same scenario, where there was a  
14 chart-abstracted version of the measure and an  
15 eCQM version that was aimed for this. And I know  
16 we tried to keep ourselves in line by saying the  
17 measure is the measure. That is what we are  
18 looking at.

19 The rationale behind the do not  
20 support list is two-fold and I don't disagree  
21 with it, which is that the measure is nearing top  
22 value rate. It is an 84 percent and even so,

1 looking at if there was any data performance gap.  
2 However, I would like the committee to consider  
3 that if this could be a conditional support,  
4 based on the fact that if the chart abstracted  
5 measure does remain in the program, that the eCQM  
6 version of this measure would offer a potential  
7 reduction in reporting burden for people that  
8 were reporting the measure.

9 So, just looking at the measure for  
10 itself, aside that the performance rate is high  
11 right now, if this an option for providers or  
12 hospitals to report, it is an option. So, I am  
13 asking for folks to consider conditional support  
14 based off of that the chart abstracted measure  
15 also remains in the program.

16 CO-CHAIR TRAVIS: Thank you.

17 Any other thoughts or comments on this  
18 influenza measure? Yes.

19 MEMBER DEMEHIN: So, I guess from our  
20 perspective, one of the most important things to  
21 consider with these reporting programs is whether  
22 we are identifying the right topics for measures

1 and whether we are really focusing on the most  
2 important opportunities to improve.

3 I certainly appreciate the potential  
4 benefits of an eCQM version of this but it seems  
5 to me that in terms of looking at it in terms of  
6 whether we are going to advance all that much  
7 here, it is hard to see.

8 I think we want to send the message  
9 that we want to move quality forward and not just  
10 implement measures to demonstrate that EHRs are  
11 able to report on measures. I think it needs to  
12 be tied to something a little more than that.

13 So, I guess the thing that I am  
14 personally struggling with, so I'm taking the  
15 chair hat off, is if the chart abstracted version  
16 stays in, I mean this could replace the chart  
17 abstraction version, at some point, I am assuming  
18 but maybe I shouldn't assume that. Is that the  
19 intent that this would replace that, roughly?

20 Okay. So, we get back into that same  
21 dilemma we had yesterday with the measure. So,  
22 whether it is better to live with the chart-

1       abstracted version of it or replace it with the  
2       eMeasure, that is my major struggle with it.

3               Lindsey.

4               MEMBER WISHAM: Just that I think for  
5       consideration that as we look to give opportunity  
6       for successful eCQM reporting, this is an  
7       opportunity to have a measure that is  
8       straightforward and that has been well-tested and  
9       well-received, transition over, I guess from the  
10      chart-abstracted world into the eCQM.

11              Again, I don't discount that the  
12      performance rate is high. I am not disagreeing  
13      with that at all. It is just that I think this  
14      should be considered as an opportunity if this  
15      measure is meaningful to CMS and it is meaningful  
16      to patients as recognizing quality in a facility.  
17      I think it should be further considered to remain  
18      in the program and ask that it be replaced with  
19      the eCQM.

20              CO-CHAIR TRAVIS: So, I do have a  
21      question for the staff, perhaps. I mean this  
22      looks like -- and I am just looking at this one



1 sheet of paper I have, which summarizes it pretty  
2 briefly. It looks like it is done through the  
3 Health and Well-Being Standing Committee but they  
4 didn't believe that narrowing the performance gap  
5 was clinically significant.

6 So, I guess did they not endorse? I'm  
7 trying to figure out what they did with it.

8 MS. MUNTHALI: It was recommended for  
9 endorsement with reserved status because of the  
10 performance gap. The gap was narrowing. I think  
11 it was around 95 percent.

12 CO-CHAIR TRAVIS: So, I am sorry for  
13 this technical question. Was MUC16-053 that  
14 version, e-version, it was endorsed for reserved  
15 status out the gate?

16 MS. MUNTHALI: No, we haven't seen  
17 that one. We have seen the chart-abstracted one.

18 CO-CHAIR TRAVIS: Okay. All right,  
19 I'm sorry. The way this read, it was difficult  
20 for me to --

21 MS. MARINELARENA: So, here is a  
22 little nuance, just to confuse everybody. Okay?

1       So, the chart-abstracted version is one that has  
2       been recommended for reserve status because it is  
3       considered topped out by the Standing Committee.  
4       That has not been finalized. It still needs to  
5       go to member vote, CSAC, be ratified. So, it has  
6       to go through the entire process.

7               However, for the eMeasure, the eCQM  
8       that is before us right now, would not qualify to  
9       come before us because the chart-abstracted  
10      version that this is based on is topped out. So,  
11      it would not meet the NQF requirements of there  
12      is a quality issue. So, that would -- it would  
13      not. It would get voted down. It would not.

14              So, it would not be -- if you wanted  
15      to do a conditional support, it wouldn't be NQF  
16      endorsement. I'm not saying you couldn't do it,  
17      but that couldn't be a condition.

18              MEMBER WISHAM: I mean I guess what I  
19      was proposing was that the conditional support --  
20      this should be considered if the chart-abstracted  
21      measure is intended to remain in the program,  
22      which, by looking at our spreadsheets, it is.

1                   So, that was just a suggestion, again,  
2                   to reduce reporting burden, just looking how  
3                   applicable it is to the programs.

4                   CO-CHAIR TRAVIS:   Ron.

5                   CO-CHAIR WALTERS:   That leads to an  
6                   interesting paradox.   So, what I just heard,  
7                   which I am still trying to think through is that  
8                   there is no incentive for developing an eCQM  
9                   version of a measure that is already topped out,  
10                  regardless of how important it is.

11                  So, the chart-abstracted version would  
12                  sit there forever in reserve status and we would  
13                  never have even an eCQM version in reserve  
14                  status, which you know --

15                  DR. BURSTIN:   It's a fair paradox and  
16                  we have talked about this a lot.   We love  
17                  paradoxes at NQF.   It is our specialty.

18                  But in this particular instance, if we  
19                  know, for example, that a clinical area is topped  
20                  out, we don't have any presuppositions that if  
21                  you made it an eMeasure it would be any less  
22                  topped out, do you?   I guess that is one of the

1       basic principles.

2                   MEMBER WISHAM:   We would hope not.

3                   DR. BURSTIN:   You hope not but then it  
4       might -- but if you think, for now, we think  
5       truth for now is what you are abstracting, right?  
6       And the eMeasure shows a performance that is not  
7       topped out. Your first reaction is is because  
8       the eMeasure is not valid because, again, it is  
9       circuitous.

10                  MEMBER WISHAM:   It does lead to  
11       questions about parallel reporting of the  
12       measures in chart-abstracted versus eCQM. If  
13       there are discrepancies between the two reporting  
14       rates, is it that there is incorrect with the  
15       eCQM? Maybe not. Is it that there is something  
16       in a configured EHR that is not being reported  
17       correctly? Could be. So, it raises questions as  
18       to it might not have the issue with the eCQM, per  
19       se, because this one is you would say relatively  
20       ingrained within a clinical process already.

21                  CO-CHAIR TRAVIS:   And just because I  
22       have already admitted that I am challenged today

1 with all of the paper in front of me, is this  
2 measure in any other program? Okay. Okay, I  
3 didn't remember it being.

4 I guess the question from my  
5 perspective would be if it is in a quality  
6 reporting program, one of the things we would be  
7 looking for would be that it is still high enough  
8 up on the radar screen of the providers to want  
9 to look good and to do the right thing and to  
10 keep immunizations high.

11 The other piece is for consumer and  
12 purchasers for transparency for us to be able to  
13 use it. I guess that is the dilemma I come into,  
14 and this is my personal opinion, is that if  
15 everybody is at the same rates from a selection  
16 standpoint, it is not helping me.

17 I guess I could feel good that my  
18 hospital is at that rate and they are not worse  
19 than every other hospital but there is, even in  
20 that arena, being topped out I think does have  
21 implications for the value to the people who  
22 would be trying to use the data.

1                   So, if anybody has any thoughts about  
2                   that to help me with my dilemma, I would  
3                   appreciate that.

4                   You found some. Thank you. I knew  
5                   where they would come from, too.

6                   Brock.

7                   MEMBER SLABACH: Yes, really it is my  
8                   memory. No, I think that this is a real problem  
9                   because if CMS is going to continue this measure,  
10                  I would much rather have it an eQOM than in an  
11                  abstracted form. So, I guess that is why I  
12                  really would prefer this because that is where we  
13                  need to go. But then NQF is saying that they are  
14                  not going to consider that because it is topped  
15                  out.

16                  So, we are on a hamster wheel and it  
17                  is --

18                  DR. BURSTIN: You know one possibility  
19                  is, regardless of the vote, your comment could  
20                  still go forward. So, whatever you say, again,  
21                  CMS is here. They are actually listening. So  
22                  you could, regardless of what you ultimately vote

1 on include the comment that says if this measure  
2 remains in this program, please move forward and  
3 at least consider moving towards an eMeasure as  
4 an option.

5 CO-CHAIR TRAVIS: Marty? I did Marty  
6 before. I'm sorry. Oh, it was Greg. So sorry.

7 MEMBER ALEXANDER: I just have a  
8 process question, I guess, because I don't  
9 understand what happens if we keep this measure  
10 or if we let this measure go and we don't endorse  
11 it, then how do we know at some point that by not  
12 requiring the reporting that the vaccine's rates  
13 will drop? And maybe it is doing a good thing by  
14 being high. Maybe that is why we want it. I  
15 mean do we just stop measuring it because it is  
16 -- as output reaches 95 percent, are you dropping  
17 all your measures that reach that?

18 DR. BURSTIN: We do have a requirement  
19 that measures show a gap in care or show  
20 variation across providers if this is otherwise  
21 topped out without variation.

22 We don't drop it but what Elisa was

1 saying is it becomes an inactive endorsement with  
2 reserve status. And the idea would be these  
3 would not be the measures you would go to at  
4 first choice but you should do some sort of  
5 ongoing surveillance to make sure exactly your  
6 point that you are not seeing a decrement in  
7 performance.

8 Obviously, the eMeasure would make  
9 that a whole lot easier and that goes back to  
10 Lindsey's comment.

11 CO-CHAIR TRAVIS: Mimi.

12 MEMBER HUIZINGA: I would just add if  
13 we think about what CMS is trying to do on a  
14 broad perspective, if you look at the physician  
15 measures and the ACO measures in terms of  
16 immunization, trying to improve reporting to  
17 registries that would help improve the care, I  
18 would see having these as an eCQM in addition to  
19 reducing potentially the fraction burden as also  
20 being supportive of trying to have it submitted  
21 to those broader registers.

22 So, I think if you look across the



1 whole portfolio, it might make sense to have this  
2 measure as an option.

3 CO-CHAIR TRAVIS: Akin.

4 MEMBER DEMEHIN: So, I mean I actually  
5 do think part of our role as the MAP is to say  
6 whether we think something has enough importance  
7 to merit its inclusion in a program, regardless  
8 of how that measure happens to be reported. And  
9 to me, keeping a measure, even if the eCQM  
10 version is easier, and I think, frankly, there is  
11 a pretty significant switching cost to go into an  
12 eCQM that would have to be factored into the  
13 conversation as well, but retaining a measure  
14 like this, to me, feels a little bit like going  
15 back to the future and not really advancing  
16 quality forward.

17 I think looking to include eCQMs in  
18 programs, I certainly agree that that is a good  
19 goal but really to focus the development efforts  
20 around something more fruitful, I think would be  
21 great. Like tetanus, for example, to me feels a  
22 lot more like a topic that would merit exploring

1 an eCQM and potentially implementing one in the  
2 future, rather than a measure that has been  
3 around for years and that has already been topped  
4 out.

5 CO-CHAIR TRAVIS: Okay, Andrea.

6 MEMBER BENIN: I will just, I guess,  
7 just make a couple comments. You know as far as  
8 metrics that are potentially even feasibly  
9 measured well electronically, this one has  
10 potential to be in that category more than many  
11 others. I think certainly more than, I'm sorry,  
12 the sepsis measures, which are frightening to  
13 think of in an electronic format.

14 So, if we were to want to place value  
15 on the typed in metrics that may be more readily  
16 measured electronically, this would fall, I  
17 think, into that category.

18 I will also say, and this is at least  
19 an opinion, I don't necessarily have fact, but I  
20 would assume that if this metric were to be  
21 withdrawn from the measure set, that the  
22 performance would drop because there is a

1       substantial -- and I don't know that -- there is  
2       a pretty substantial amount of activation energy  
3       that goes into getting this done but is not  
4       inconsequential. And even some of the hard stops  
5       that may have been written into various computer  
6       things are so painful that there is a lot of work  
7       that is going into getting this done. Maybe not  
8       just in pediatrics, I don't know. But it is  
9       pretty hard to achieve this and so people have  
10      hardwired it in various ways but there is a lot  
11      of resource going into that.

12                So, if we think that this is  
13      important, then I think we may need to make a  
14      decision that we should keep this metric if we  
15      think this is an important enough thing to do.  
16      Frankly, immunization is one of the few things we  
17      actually do in healthcare, I guess.

18                But if we don't think that this is  
19      important or that because you can easily screen  
20      out. Like this measure doesn't mean you get a  
21      flu shot. It just means you get screened for a  
22      flu shot. So, it is not even that powerful of a

1 tool. In some ways it is and in some ways it  
2 isn't, speaking, again, to the commentary about  
3 registries and the other things, which is really  
4 where we should be putting our energies in this  
5 country but that is a different conversation.

6 So, I guess I would just make those  
7 comments. That depending on how important people  
8 consider this, it probably is important to keep  
9 it in the measure set and that it is something  
10 that could be amenable to being electronic,  
11 whether it is the right place to put our  
12 resources. And maybe we could put our resources  
13 somewhere else because I don't think that the  
14 abstraction burden in this bowl full of  
15 abstraction burdens is the hardest one either.  
16 So, it is a little bit of six of one, half dozen  
17 of the other.

18 CO-CHAIR TRAVIS: Thank you. Greg,  
19 you still have yours up.

20 MEMBER ALEXANDER: I just wanted to  
21 say so I work in the long-term care world, like I  
22 said, so there is some redundancy. Because then

1       Nursing Homes Compare, which has over two million  
2       patients across the 16,000 nursing homes in the  
3       country, they have vaccination reporting there.  
4       And those immunization rates are up around 95, 96  
5       percent across the country.

6               So, that sort of validates these  
7       results, I think a little bit, too.

8               CO-CHAIR TRAVIS: That's helpful.  
9       Lindsey.

10              MEMBER WISHAM: Just one final  
11       comment, which is I think if we were to  
12       transition this to an eCQM and the performance  
13       were to remain as high as they are now, which we  
14       would hope would be the case, that because it is  
15       already going to be implemented as an eCQM would  
16       make it an ideal measure for surveillance. Even  
17       if it were just kind of put off to the side and  
18       not necessarily used in the program, hopefully by  
19       that point, by that time, the capabilities are  
20       already built into electronic health records to  
21       be reporting with the CDC.

22              CO-CHAIR TRAVIS: So, Lindsey, taking

1        what you just said and kind of the earlier  
2        conversation you had with us around conditional  
3        support, to you mind sharing with us what your  
4        thoughts are about your recommendation on where  
5        we come down on this measure?

6                MEMBER WISHAM:    So, it is a little bit  
7        different how we have been treating conditional  
8        support, which is take it to NQF because, as  
9        Helen points out, this is not one that would be  
10       eligible for that process.    I guess the condition  
11       I would place on this conditional support that if  
12       the chart-abstracted measure were to stay in the  
13       program, that, to me, tells me that CMS finds  
14       this an important measure and that the eCQM  
15       should be a reporting action with the idea that  
16       potentially then performance rates are stable,  
17       that the chart-abstracted measure could be  
18       removed.

19                So, conditional support and that the  
20       chart-abstracted measure is deemed to be  
21       important and ultimately in the program.

22                CO-CHAIR TRAVIS:    Okay, I think

1 everybody heard that clearly. Is there something  
2 we are huddling on over here?

3 MS. LEMONS: Hey, this is Tara Lemons.  
4 May I add a comment?

5 CO-CHAIR TRAVIS: Yes.

6 MS. LEMONS: Yes, I just wanted to  
7 clarify. I think there was a comment about the  
8 IMM-2 measure not requiring vaccination but it  
9 does require vaccination prior to discharge, if  
10 indicated by the screening. So, I just wanted to  
11 make that clarification.

12 CO-CHAIR TRAVIS: Thank you.

13 All right, well, let's move forward.  
14 If people feel comfortable with the way that  
15 Lindsey phrased the condition, let's consider  
16 that to be the rationale if you decide to vote  
17 for conditional support. So, we will vote for  
18 all of these measures.

19 Marisa, do you have a comment?

20 You want to read it?

21 MS. MCQUESTON: A brief comment from  
22 Marisa Valdes at Baylor Scott & White that they

1 would support the CMS moving to the eMeasure for  
2 several reasons, testing of the validity as a  
3 possible replacement of the chart-abstracted  
4 measure.

5 CO-CHAIR TRAVIS: All right, so now we  
6 have had an opportunity to hear from everybody.  
7 It is important not to forget our people on the  
8 phone. So, thank you, Marisa.

9 Okay, so, let's go to voting.

10 MS. QUINNONEZ: Voting is now open for  
11 IQR program measure influenza immunization, IMM-2  
12 and this is MUC16-053. Option 1, support; Option  
13 2, conditional support; Option 3, refine and  
14 resubmit; and Option 4, do not support.

15 Option 1, support; Option 2,  
16 conditional support; Option 3, refine and  
17 resubmit; and Option 4, do not support.

18 Thank you, Marisa. Thank you, Jeff.

19 Voting is now closed. The results of  
20 the influenza immunization, MCU16-053 16 percent  
21 voted for support, 68 percent voted conditional  
22 support, zero percent voted for refine and



1 submit, and 16 percent voted for do not support.

2 This yields a conditional support  
3 recommendation.

4 CO-CHAIR TRAVIS: Okay, thank you all  
5 very much.

6 So, our last item on this Consent  
7 Calendar is the safe use of opioids -- concurrent  
8 prescribing MUC16-167. And I believe that Lee  
9 and Sean pulled this.

10 Lee.

11 MEMBER FLEISHER: I do not support;  
12 ditto from yesterday.

13 CO-CHAIR TRAVIS: Sean.

14 MEMBER MORRISON: Ditto.

15 CO-CHAIR TRAVIS: All right, Woody.

16 MEMBER EISENBERG: I would just like  
17 to point out the importance, again, of trying to  
18 limit as best we can the combination of opioids  
19 and benzodiazepines for sure. Real killers.

20 And if this measure could be refined  
21 to just focus on that combination, I would vote  
22 for a refine and resubmit.

1 CO-CHAIR TRAVIS: Okay, thank you,  
2 Woody. Greg, do you still have a question?  
3 Okay.

4 That's okay. Jack.

5 MEMBER JORDAN: I would like to make  
6 one suggest or comment to CMS and that would be I  
7 think this is something that maybe very ripe to  
8 have some selection of in hospitals or QIOs  
9 really start to get a little bit of feel for how  
10 much of when this is happening it is really  
11 problematic and not thoughtful use of the  
12 medications and how often it is really  
13 thoughtful.

14 I think we would learn a lot from  
15 them. I think some people might pick up some  
16 things that might, without having pressure of a  
17 public website from CMS, you know ranking  
18 hospitals on that, may very well get the end  
19 results you are really looking for in kind of an  
20 alternative manner.

21 CO-CHAIR TRAVIS: Thank you, Jack.  
22 Any other comments before we vote, having

1 discussed this issue yesterday?

2 Okay, I think we are ready.

3 MS. QUINNONEZ: Voting is now open for  
4 IQR Program safe use of opioids -- concurrent  
5 prescribing. And this is MUC16-167. Option 1,  
6 support; Option 2, conditional support; Option 3,  
7 refine and resubmit; and Option 4, do not  
8 support.

9 Option 1, support; Option 2,  
10 conditional support; Option 3, refine and  
11 resubmit; and Option 4, do not support.

12 Okay, voting is now closed. The  
13 results for MUC16-167, 9 percent voted for  
14 support, 4 percent voted for conditional support,  
15 26 percent voted for refine and resubmit, and 61  
16 percent voted for do not support.

17 This yields a so not support  
18 recommendation.

19 CO-CHAIR TRAVIS: Okay, well, thank  
20 you all for that.

21 Now, we have done a little bit if  
22 shuffling about our schedule because we know we

1 are close to our time that we are going to end  
2 today and we know you have flights.

3 We are going to have a call where we  
4 are going to go over the other programs and get  
5 feedback. We can do that, we think, over a  
6 conference call. So, we will get that scheduled.

7 But before you pack up, we do have  
8 some comments that Pierre would like to make  
9 about the Cures Act and I think that would be  
10 very helpful to us. So, thank you.

11 DR. YONG: Great, thanks, Cristie.  
12 So, I just wanted to -- we referenced this  
13 yesterday. I just wanted to make sure that folks  
14 were aware of a provision in the 21st Century  
15 Cures Act relating to the hospital readmissions  
16 reduction program.

17 So, this is relating to Section 15002  
18 in the Cures Act, which pertains to adjustment  
19 for dual eligibles in the readmissions reduction  
20 program. We didn't have any measures for the  
21 reduction of readmissions program this year but  
22 it has been in prior years, last year, for

1 example. It has been a hot topic in terms of  
2 risk adjustment and what it is really about, SES.

3 So, I just wanted to make sure you  
4 were aware of the legislation that is currently  
5 and signed by the President, since he supports  
6 the bill.

7 It requires stratification of the  
8 hospitals in the readmission reduction program by  
9 status of full eligible dual -- full dual  
10 eligibles. So, if folks are familiar with the  
11 MedPAC report of I don't know there it was 2013  
12 or 2014 but where they did the analysis looking  
13 at what people call right to life hospitals. So,  
14 compensate hospitals that have similar  
15 proportions of SES patients, in this case, the  
16 Cures Act specifically calls out use of dual  
17 eligibles. So, that would be the stratification  
18 variable that would be used for a calculation of  
19 the human adjustments for HRRP.

20 That is sort of the main provision.  
21 The other provisions relating to that, although  
22 our program would remain budget neutral, there

1 are also some provisions in there relating to  
2 consideration of exclusions for certain  
3 conditions, consideration of use of certain V  
4 codes, as well as potential consideration for any  
5 recommendations that come forth on this  
6 particular topic.

7 CO-CHAIR TRAVIS: All right, thank  
8 you.

9 Operator, would you see if there are  
10 any public comments on the call?

11 OPERATOR: At this time, if you would  
12 like to make a public comment, please press star  
13 1.

14 And we have no public comments, at  
15 this time.

16 CO-CHAIR TRAVIS: Any public comment  
17 in the room?

18 Okay, well, I am going to turn it over  
19 to Kate to talk about what our wrap-up and next  
20 steps are.

21 Sounded like a drum roll for Kate.

22 MS. MCQUESTON: It must be time for us

1 to go.

2 So, we will be in touch regarding  
3 scheduling our call to discuss the current  
4 measure set shortly.

5 I just want to thank you again for all  
6 of your input into the discussion today and to  
7 thank our wonderful co-chairs. Thank you very  
8 much, Cristie and Ron.

9 And please feel free to be in touch  
10 with us with any questions in the meantime and we  
11 will be back in touch with everyone shortly.  
12 Thanks, again.

13 CO-CHAIR TRAVIS: And thank you to the  
14 wonderful staff. We couldn't have done this  
15 without you, clearly. So, thank you all very  
16 much and thanks to all of you.

17 (Whereupon, the above-entitled matter  
18 went off the record at 2:41 p.m.)  
19  
20  
21  
22

A			
<p><b>a.m</b> 1:19 6:2  <b>AAPM</b> 107:1  <b>AAPM&amp;R</b> 3:9  <b>abilities</b> 60:22  <b>ability</b> 16:17 18:4,11  19:5 20:13 35:7,13  37:8 38:2,3 45:5,14  58:17,20 63:11 64:4  64:10 118:6 121:15  177:5  <b>able</b> 6:11 13:15 14:17  23:12 25:4,12,12 27:1  30:22 32:17 52:1,20  55:6 86:2,2 87:14  108:12 109:3 141:21  145:6 150:13 155:19  184:17 185:5 215:5  259:21,22 262:7  268:14 287:11 293:12  <b>above-entitled</b> 237:10  311:17  <b>ABPP</b> 2:7  <b>absolute</b> 137:17 161:15  161:17  <b>absolutely</b> 10:14 15:16  33:21 52:4 208:7,17  223:14  <b>abstract</b> 215:2  <b>abstracted</b> 277:3 286:4  286:14 287:15 288:1  294:11  <b>abstracting</b> 126:13  292:5  <b>abstraction</b> 121:1  134:11 287:17 300:14  300:15  <b>abstractor</b> 120:8 134:9  <b>abstractors</b> 134:11,12  <b>abuse</b> 113:6,14 117:19  136:8 223:17  <b>academy</b> 3:15 104:20  106:1,17 253:14  <b>accelerate</b> 94:1  <b>accept</b> 111:13 154:5  279:9  <b>acceptability</b> 148:7,10  <b>accepted</b> 154:1  <b>accepting</b> 112:6  <b>access</b> 4:5 5:2 35:15  91:11 92:22 93:4,8,16  104:13 177:20 178:5  178:20,22 179:19  182:2,5,11 183:17  184:13 187:2,13  192:12 197:22  <b>accessible</b> 192:7  <b>accessing</b> 60:6</p>	<p><b>account</b> 7:7 177:19  178:13 183:18  <b>accountability</b> 43:15  48:13,14,22 50:8 58:3  155:16 156:18 162:22  163:7 170:22 172:20  180:18  <b>accountable</b> 48:18  172:22  <b>accreditation</b> 82:20  <b>accurate</b> 205:13  <b>accurately</b> 254:4,12  <b>achieve</b> 80:20 150:14  155:16 156:1 162:14  183:20,21 201:8  299:9  <b>achieved</b> 206:12  <b>achieves</b> 207:19  <b>acknowledge</b> 213:22  216:5 219:7  <b>acknowledged</b> 213:21  276:22  <b>ACO</b> 296:15  <b>ACOs</b> 182:13  <b>acquired</b> 234:12  <b>acronym</b> 11:17  <b>act</b> 36:21 37:21 198:6  267:10,11 308:9,15  308:18 309:16  <b>action</b> 65:9 182:8 183:8  302:15  <b>actionability</b> 73:22 75:4  169:7  <b>actionable</b> 114:13  164:5,11 166:18,19  168:5 171:8 266:14  <b>actions</b> 266:15  <b>activation</b> 299:2  <b>activity</b> 107:7 169:17  <b>actual</b> 33:3 40:14  103:11 138:21 211:3  211:13 214:7  <b>acute</b> 95:9 97:20 98:18  114:18 115:3 142:8,9  150:8 189:6,13 190:1  190:21 194:22 275:22  <b>adaptable</b> 39:20  <b>adapted</b> 17:19 42:9  <b>adaptive</b> 16:11,20 17:8  18:22 22:12 23:13  <b>add</b> 22:13 44:7 46:14  119:4 135:11 158:12  159:22 210:7,17  222:14 234:7 246:10  247:19 248:13 250:20  252:3 279:3 282:2  296:12 303:4  <b>added</b> 73:1 83:4 179:18</p>	<p>240:1  <b>addiction</b> 141:6  <b>adding</b> 86:21 130:17  208:12  <b>addition</b> 87:2 167:6,17  214:19 296:18  <b>additional</b> 40:13 72:12  73:2 79:14 89:16  137:1,3 138:2 144:3  174:16 180:2 204:7  243:19 250:5 251:7  <b>additionally</b> 190:16  <b>additions</b> 14:11  <b>additive</b> 128:12  <b>address</b> 91:7 108:21  109:21 118:18 125:13  169:15 202:12 203:6  208:15 219:19 235:1  238:3 248:18 281:18  <b>addressed</b> 36:22  129:10 212:4 219:9  258:16  <b>addresses</b> 40:4 277:6  <b>addressing</b> 107:11  151:2  <b>adequately</b> 121:3  <b>Adjourn</b> 5:22  <b>adjust</b> 154:22 198:1  226:3,10 258:20  <b>adjusting</b> 48:20  <b>adjustment</b> 183:16  251:19 308:18 309:2  <b>adjustments</b> 93:12,18  309:19  <b>administer</b> 12:1 14:16  15:4 22:3 43:20 44:10  44:21 45:4  <b>administered</b> 13:17  44:16 59:10  <b>administering</b> 11:20  14:15  <b>administration</b> 12:4  15:6 61:16  <b>administrator</b> 58:11  <b>administrators</b> 221:14  <b>admission</b> 5:7 59:11  128:17 241:2 247:7,9  273:17 280:3  <b>admit</b> 193:7  <b>admitted</b> 189:18 193:9  245:4 292:22  <b>admitting</b> 194:4 244:15  <b>adopt</b> 74:12 105:4  <b>adopter</b> 54:6  <b>adopters</b> 34:16,19  62:15  <b>adopting</b> 247:18  <b>adoption</b> 34:8 93:21</p>	<p>94:1  <b>adult</b> 156:7  <b>adults</b> 156:13 276:6  279:13 284:15  <b>advance</b> 140:15 162:16  180:20 287:6  <b>advancing</b> 297:15  <b>advantages</b> 12:1,3  <b>adverse</b> 232:19  <b>advice</b> 260:11  <b>advocates</b> 213:20  <b>affect</b> 57:4 169:22  267:21  <b>Africa</b> 147:16  <b>afternoon</b> 173:16  <b>age</b> 120:16  <b>agencies</b> 57:9 178:5  <b>agency</b> 10:20 39:13  44:22  <b>agenda</b> 8:22,22 9:1,4,5  171:4 175:9 200:8  234:21  <b>agent</b> 284:3  <b>aggregate</b> 68:11  <b>agitation</b> 281:19  <b>ago</b> 33:1 227:11,20  <b>agree</b> 54:10 66:11  78:22 106:22 114:9  116:15 121:5 126:8  170:1 177:1 184:13  206:22 209:14 297:18  <b>agreed</b> 66:12 138:14  <b>agreement</b> 180:1  246:18  <b>agreements</b> 72:22  <b>agrees</b> 207:9  <b>ah</b> 24:21 42:1  <b>AHA</b> 114:10,14  <b>ahead</b> 26:9 63:14 73:8  100:22 110:1 145:2  173:20 176:20 184:11  229:18  <b>AHRQ</b> 3:12  <b>aimed</b> 285:15  <b>Akin</b> 2:4 8:8 110:9  111:14 112:14 113:22  128:10 134:22 169:4  183:3 207:22 211:16  223:7 234:20,21  235:21 254:20 266:19  276:16 279:13 297:3  <b>Akin's</b> 258:20  <b>albeit</b> 140:3  <b>alcohol</b> 4:9,10,10,11,12  77:21,22 109:21  110:5,11,12,16,18  112:12 113:6,14  114:2 115:1,3,7,9,11</p>



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Hospital Workgroup In-Person Meeting

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