

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
HOSPITAL WORKGROUP

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WEDNESDAY
DECEMBER 10, 2014

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The Hospital Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:33 a.m., Frank Opelka, Chair, presiding.

MEMBERS:

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

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

INDIVIDUAL SUBJECT MATTER EXPERTS:

JACK FOWLER, Jr., PhD
MITCHELL LEVY, MD, FCCM, FCCP
DOLORES L. MITCHELL
R. SEAN MORRISON, MD
MICHAEL P. PHELAN, MD, FACEP

FEDERAL GOVERNMENT LIAISONS:

KATE GOODRICH, MD, Centers for Medicare and
Medicaid Services
PAMELA OWENS, PhD, Agency for Healthcare
Research and Quality
DANIEL POLLOCK, MD, Centers for Disease
Control and Prevention
PIERRE YONG, MD, MPH, Centers for Medicare
and Medicaid Services

NQF STAFF:

CHRISTINE K. CASSEL, MD, President and CEO
TAROON AMIN, Senior Director
POONAM BAL, Project Manager
LAURA IBRAGIMOVA, Project Analyst
ELISA MUNTHALI, Senior Managing Director
ERIN O'ROURKE, Senior Project Manager

ALSO PRESENT:

SUSANNAH BERNHEIM, MD, Yale CORE

EMILY CRAMER*

MEGAN HAYDEN

STACIE JONES

BARB JAGELS

ERICA MCNAMARA*

MAMATHA PANCHOLI

JENNIFER PAVELKA

AMITA RASTOGI

* present by teleconference

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

2 8:33 a.m.

3 CHAIR OPELKA: Thank you and good
4 morning. Welcome, everyone.

5 We have been graciously joined by
6 Sean. Thank you, Sean. We're glad you joined us
7 yesterday by phone, but it's even better in
8 person. And we actually officially have a
9 meeting now because Dolores is here.

10 (Laughter)

11 CHAIR OPELKA: But yesterday we had
12 the disclosure, so if you could, Dolores, inform
13 us who you represent and I believe Ann's not here
14 today to give you the guidance, but the guidance
15 we got from Ann yesterday was any significant
16 affiliations, and that was defined as investments
17 that were \$10,000 or more you needed to disclose.

18 MS. MITCHELL: I'm Dolores Mitchell.
19 I'm the Executive Director of something called
20 the Group Insurance Commission, a Commonwealth of
21 Massachusetts agency for health and other
22 benefits. And I wish I could plead guilty to

1 having those investments, but I don't. So other
2 than moral conflicts, I have none.

3 CHAIR OPELKA: Thank you. Sean?

4 DR. MORRISON: Nothing to disclose.

5 CHAIR OPELKA: Great. Thank you. And
6 also joining us today; I'm sure she'll be in and
7 out because of her busy schedule, is the
8 leadership of the National Quality Forum Chris
9 Cassel.

10 Chris, would you like to say hello to
11 the group this morning?

12 MR. AMIN: Frank, I'm sorry to
13 interrupt Chris.

14 Sean, do you just mind doing the
15 disclosure into the mic just so that it's on the
16 record? I'm sorry.

17 CHAIR OPELKA: He was yesterday.

18 DR. MORRISON: I was here yesterday,
19 but on the phone, but yes.

20 MR. AMIN: Oh, okay. Thank you.

21 DR. CASSEL: Okay. So thanks, Taroon,
22 for dotting the "I's and crossing the "T"s.

1 That's something that NQF is really famous for
2 and responsible for.

3 So first of all, apologies for not
4 being able to join you yesterday; and Frank and
5 Ron are right, I will be in and out again today.
6 But I do just want to mostly acknowledge the
7 importance of this work and thank all of you for
8 the time and effort that you put into this on
9 behalf of the multi-stakeholder process.

10 And I want to also recognize and thank
11 the staff and everyone here for the innovations
12 that I've just been hearing informally, which are
13 very much appreciated as we try to streamline
14 this process, make it more workable and more
15 effective, particularly as this measurement
16 environment becomes more consequential and more
17 visible in so many different parts of our health
18 care system.

19 So thanks very much and I'm not going
20 to slow you down anymore. Let us get going.

21 CHAIR OPELKA: All right. So our job
22 today, lining this up for you, is we've got

1 several programs to go through. The hospital
2 IQR, which will be our first. And if there's
3 anything left, then we'll go onto the Value-Based
4 Purchasing Program, the Cancer PPS-Exempt Cancer
5 Hospital Program, and finish with the Hospital
6 Readmission Program. And we're hoping to get out
7 on our agenda on time because I know everyone is
8 at that point of getting back home.

9 So, what we've got, for Dolores, you
10 did not have the opportunity going through the
11 experience yesterday of a new voting system, but
12 to be very brief, what we present are a series of
13 consent calendars which will be voted on up or
14 down, and those consent calendars require a 60
15 percent pass to be passed as a consent calendar.

16 What we put forward are a series of
17 consent calendars to start, and the consent
18 calendars have been populated by the staff using
19 the MUC list that we got from CMS. The staff has
20 applied the rules that we have developed over
21 time to the best of their ability in populating
22 the consent calendars.

1 We then look at them to see if there's anything
2 we want to move from one consent calendar to
3 another. And that's a simple majority vote to
4 move something from one calendar to another.

5 So that's been our process. It took
6 us a little time to get used to it, but once we
7 did, I think the group did really well all
8 yesterday when we got past our first trial.

9 MS. MITCHELL: Do I take it that by
10 "consent calendar being populated," you mean that
11 there is a recommendation which unless pulled is
12 assumed to have passed? Is that correct?

13 CHAIR OPELKA: It's not necessarily
14 assumed to have passed. It will be voted on as a
15 consent calendar and it may not pass.

16 MS. MITCHELL: Right, but --

17 CHAIR OPELKA: So we had a consent
18 calendar yesterday that did not pass.

19 MS. MITCHELL: But the population that
20 you refer to, the populating that you refer to is
21 a set of recommendations --

22 CHAIR OPELKA: Right. It is.

1 MS. MITCHELL: -- about what the staff
2 thinks ought to pass?

3 CHAIR OPELKA: Correct.

4 MS. MITCHELL: Okay. Got it.

5 CHAIR OPELKA: That's correct. But
6 all the rest of the consent calendars actually
7 did pass except for one that we'll bring to the
8 Coordinating Committee.

9 Okay. So we're beginning with IQR.
10 Poonam, are you going to walk us through?

11 MS. O'ROURKE: I actually just wanted
12 to make a few housekeeping announcements about
13 the voting process before Poonam gets started
14 with the IQR summary.

15 I just wanted to clarify the role of
16 our federal liaisons for everyone who might have
17 some confusion. Our federal liaisons, while
18 Workgroup members, are non-voting. So just
19 wanted to make sure that was clear for everyone.

20 And I also wanted to clarify that
21 while yesterday I was casting Sean's votes, today
22 I'll be casting Missy Danforth's, our substitute

1 from the St. Louis Business Group on Health,
2 who's joining us via phone.

3 MS. BAL: Okay. So the Inpatient
4 Quality Reporting Program, also known as IQR, is
5 a behavioral reporting and public reporting
6 program. A subset of the measures in the program
7 are publicly reported on the Hospital Compare Web
8 site. If hospitals do not report data on the
9 required measures, they will receive a 10 percent
10 reduction in their annual Medicare payment
11 update.

12 A main goal is to provide this
13 incentive for hospitals to publicly report
14 quality information about their services so
15 consumers can be informed about health quality
16 and make informed choices. The critical program
17 objectives that we determined in October were to
18 choose high-impact measures that will improve
19 both quality and efficiency of care and are
20 meaningful to consumers, move toward more outcome
21 measures rather than structure or process
22 measures, align reporting requirements with other

1 clinical programs where appropriate to reduce the
2 burden on providers and support efficient use of
3 measurement resources. Also to engage patients
4 and families as partners in their care.

5 And some of the goals were to expand
6 the program to include measures that allow rural
7 and other small hospitals to participate and also
8 rapid filling of the following fairly extensive
9 gap list, which is peds, maternal and child care,
10 cancer, behavioral health, affordability and
11 cost, care transitions, patient education,
12 palliative and end-of-life care, medication,
13 cultural safety, pressure ulcer prevention and
14 adverse drug events.

15 Last year it was also recommended that
16 HHS look at existing measures in the PPS-Exempt
17 Cancer Hospital Quality Reporting Program and the
18 Inpatient Psychiatric Facility Quality Program
19 and Hospice Quality Reporting Programs to fill
20 these gaps.

21 MS. O'ROURKE: So our first calendar
22 for the IQR Program is five measures that have a

1 preliminary analysis of support. Four of these
2 are updates to measures that are currently in the
3 program. One of them is a new measure.

4 The first two measures are measures
5 that you saw yesterday. The NHSN, CLABSI, and
6 CAUTI measures. These are updates to the measure
7 addressing expanding the setting beyond the
8 hospital ICU, as well as addressing adding
9 another risk adjustment model. So we'll have the
10 SIR and the new ARM models.

11 We received no comments on the CLABSI
12 measure. We did receive one comment on the CAUTI
13 measure. Again, the same comments we heard
14 yesterday strongly encouraging measure developers
15 and CMS to exclude patients with spinal cord
16 injury from this measure.

17 The next two measures address updates
18 to the 30-day pneumonia readmission and mortality
19 measures. For the 30-day readmission measure we
20 had a preliminary analysis that this is a high-
21 impact, fully-specified, tested and endorsed
22 measure. It's part of the MAP safety family of

1 measures. It's already in use in several public
2 and private programs including already in use in
3 IQR. MAP is being asked to consider a revised
4 version of this measure that would expand the
5 cohort of patients included to include patients
6 with a primary diagnosis of aspiration pneumonia.
7 CMS believes that this revised measure would
8 decrease biases in coding.

9 We did receive public comments on this
10 measure. One commenter noted that all
11 readmission measures should report both the
12 numerator and denominator since there is a
13 possibility that a very low or shrinking
14 denominator might make it difficult to detect --
15 apologies. I lost my place and I don't want to
16 butcher this commenter's word -- might detect the
17 pattern of practice is actually quite good. All
18 readmission metrics should carry a caveat about
19 the potential for social supports and community
20 resources to affect the determination and the
21 readmissions per 1,000 and admissions per 1,000
22 metrics that have been presented to NQF should be

1 listed in the list of potentially useful metrics
2 to CMS. And this commenter will refer to these
3 three conditions in future measures.

4 MR. AMIN: Sorry, Erin. Could I just
5 point out that that was a similar comment that
6 was provided across all of the readmission
7 measures? So we won't necessarily repeat those
8 same notions around readmissions per 1,000,
9 admissions per 1,000 and the importance of social
10 supports and community supports as we're looking
11 at readmissions. But I just wanted to point out
12 that those comments were received across all the
13 readmission measures.

14 MS. O'ROURKE: So again we have the
15 pneumonia mortality measure. This had a similar
16 update to expand the cohort of included patients
17 to include patients with a diagnosis of
18 aspiration pneumonia.

19 We received one comment on this
20 measure. The commenter supported this measure
21 and the three conditions noted in prior measures
22 should be considered here as well, just to carry

1 over what Taroon was saying.

2 Finally, we have a new measure under
3 consideration for this program: Cardiac
4 rehabilitation patient referral from an inpatient
5 setting. This measure would address a known gap
6 in care transitions and referrals to the next
7 site of care. Cardiac rehabilitation has been
8 found to be under-utilized despite being included
9 in the American Heart Association Get With the
10 Guidelines Program.

11 We received a comment on this measure.
12 The commenter noted a key window of opportunity,
13 a Class 1 indication and strong evidence of
14 benefits supported this measure.

15 MR. AMIN: Given that we have seven
16 calendars, Frank, would it be okay to at least
17 initiate some conversation around this particular
18 calendar to see if there are any that need to be
19 pulled before we move on, or would you prefer to
20 keep moving?

21 CHAIR OPELKA: I think we need to walk
22 through them all because you don't -- the

1 conversation is going to be framed by the other
2 calendars.

3 MR. AMIN: Okay. That's fair. Let's
4 move on then.

5 MS. O'ROURKE: Our next calendar
6 addresses measures that have a preliminary
7 analysis of conditional support pending NQF
8 review of the testing data in a Medicare
9 population and resolution of parsimony concerns
10 with measures currently in the IQR program.

11 The first measure is proportion of
12 patients hospitalized with AMI that have a
13 potentially avoidable complication during the
14 index day or in the 30-day post discharge period.
15 This measure addresses a number of adverse
16 outcomes that are meaningful to patients and can
17 increase costs across the system. The
18 preliminary analysis resulted in a conditional
19 support pending NQF review of the testing data in
20 a Medicare population and resolution that this
21 measure might be duplicative of measures
22 currently in the program.

1 We received one comment. This
2 commenter was generally supportive of this
3 measure.

4 The second measure in this calendar is
5 a similar measure addressing the proportion of
6 patients hospitalized with pneumonia that have a
7 potentially avoidable complication during the
8 index day or in the 30-day post-discharge period.
9 Again, the same preliminary analysis and comments
10 were received.

11 And then finally we have a third
12 measure addressing proportion of patients
13 hospitalized with a stroke that have a
14 potentially avoidable complication during the
15 index day or 30-day post-discharge period.
16 Again, we had the same preliminary analysis and
17 received the same generally supportive comments.

18 Calendar 3 is another conditional
19 support calendar with a condition that this
20 measure should be quickly replaced with a measure
21 assessing results of a survey of a culture of
22 patient safety. We received one comment. The

1 commenter was generally supportive of this
2 measure.

3 Calendar 4, another conditional
4 support calendar. This was conditional support
5 pending demonstration of applicability at the
6 facility level and resolution of the duplicative
7 nature of this measure with the falls and trauma
8 component of PSI-90. So on this calendar we had
9 two measures, one addressing a patient fall rate.
10 The rationale for our preliminary analysis was
11 that falls are a common adverse event in
12 hospitals with estimates between 2 to 5 falls per
13 1,000 patient days. About 30 percent of falls
14 result in injury, disability or death.

15 While falls and trauma are currently
16 addressed in the IQR program and the PSI-90
17 composite measure, MAP has previously noted that
18 these measures NQF-141 and 202 are based off of
19 clinical data and may provide better data than
20 claims-based measures. We did not receive any
21 comments on the patient fall rate measure.

22 The next measure is falls with injury.

1 Again, we had a similar preliminary analysis
2 noting that these are a pair of measures and work
3 together and could provide better data than we
4 are currently getting through the claims-based
5 measure in the program.

6 We did receive one comment. The
7 commenter was not supportive of this measure
8 noting the definition of injury levels would have
9 to be very specific for standardized reporting
10 across all hospitals.

11 MR. AMIN: Thanks, Erin. So there are
12 a few more. I just wanted to point out that we
13 received some indication from CMS that four of
14 the measures under development that NQF had
15 considered under our measures under development
16 pathway have completed testing. So we've updated
17 this Discussion Guide and shifted four measures
18 from what we've discussed as IQR Calendar 7: the
19 kidney, urinary tract infection clinical episode
20 payment measure, the spine fusion/refusion
21 clinical episode-based payment measure, the
22 cellulitis cost-of-care measure and the

1 gastrointestinal hemorrhage measure into our
2 Calendar 5.

3 So Calendar 5, I'll just point out
4 here, following along with this updated
5 Discussion Guide that Poonam sent out last night.
6 We'll start with the first, which is hospital 30-
7 day all-cause unplanned risk standardized days in
8 acute care following AMI hospitalization. There
9 are three measures that follow very similar
10 constructs, so I'll just read them aloud and then
11 give the preliminary analysis and the comments
12 since they were very similar.

13 The second is the hospital 30-day all-
14 cause unplanned risk standardized days in acute
15 care following heart failure. And the third is
16 risk standardized days in acute care following
17 pneumonia.

18 The preliminary analysis was
19 conditional support pending NQF review and
20 endorsement. These measures helped to address
21 the concern noted by the NQF Admissions and
22 Readmissions Endorsement Standing Committee that

1 observation days and ED visits may be resulting
2 as an increased focus on readmissions.

3 We had one commenter across all three
4 of these measures that were supportive of the
5 measure pending NQF endorsement noting the
6 potential of these measures to identify an early
7 warning. Additionally, commenters noted the
8 intensity and cost of ED types -- actually, we
9 had one supportive commenter. And then we also
10 had another commenter that was less supportive
11 noting that the intensity and cost of ED visits
12 in Type 1 observation is much less than for
13 admissions. The commenter also noted that there
14 has not been chart review validation of these
15 metrics which would indicate whether these
16 returns to care were not urgent or emergent.

17 So moving on, we have the hospital-
18 level risk standardized payments associated with
19 an episode of care for primary elective total hip
20 or total knee. Again, joint replacement
21 surgeries are increasingly common with a
22 significant number in the Medicare population

1 representing a significant cost to the Medicare
2 Program.

3 The preliminary recommendation here is
4 that MAP would encourage a timely review of these
5 measures by the NQF Cost and Resource Use
6 Standing Committee to resolve potential
7 harmonization issues and encourage the most
8 parsimonious approach to measuring costs for hip
9 and knee replacements to minimize burden and
10 confusion among competing methodologies.

11 One commenter was not supportive of
12 this measure noting that CMS has not yet had the
13 opportunity to consider the comments that were
14 recently received on the measure.

15 So these are the additions to this
16 calendar. We have the kidney, urinary tract
17 infection, clinical episode of care payment
18 measure. This measure addresses the cost of care
19 for a common condition. UTIs are mainly treated
20 on an outpatient basis, but the cost of care can
21 be high if hospitalization and follow-up care is
22 needed. We did not receive any comments on this

1 measure.

2 Cellulitis. Oh, we have spinal
3 fusion. Give me one second here. Okay. Well,
4 the comments around cellulitis -- all right. So
5 I'll come back to spinal fusion in a moment.

6 Cellulitis. This measure addresses cost of care
7 for a common but potentially serious skin
8 infection. The cost of cellulitis can be
9 significant if hospitalization is required.

10 There's been no comments on this measure from the
11 public.

12 And the GI hemorrhage clinical episode
13 of care-based measure, GI bleeding is a common
14 and costly condition and is responsible for more
15 hospitalizations than CHF or deep-vein
16 thrombosis. An episode-based approach could help
17 drive improvement for both cost and quality. We
18 didn't receive any comments on this measure.

19 And there were no comments on spinal
20 fusion. So again, just pointing out that spinal
21 fusion, the preliminary analysis noted that it's
22 an important area and the cost indicated spans a

1 period -- I'll come back to spinal fusion. I
2 can't seem to find my notes on that. I'll come
3 back to it. But it follows a similar
4 construction as the other episode of care
5 measures. Given that we've moved it around, I
6 seem to have lost my notes on this one.

7 So I believe that that captures IQR
8 Calendar 5. So just in summary, Calendar 5 has a
9 lot in it. It's mostly the risk standardized
10 days after acute care and then mostly episode of
11 care cost measures.

12 So moving on to Calendar 6, these are
13 the do not support measures. We have two in this
14 category. The first is the skill mix measure, so
15 the preliminary analysis of this measure notes
16 that the IQR Program currently includes measures
17 that assess outcomes addressed by nurse staffing
18 levels. The MAP previously noted its desire to
19 move toward the most parsimonious measure set as
20 possible. And the outcomes can be used in place
21 of these structural measures when possible. So
22 noting that the outcomes are available and this

1 is a structural measure that the MAP has
2 discussed in the past.

3 Second is the nursing hours per
4 patient day. The IQR Program currently includes
5 measures that assess outcomes addressed by
6 nursing hours. The MAP previously noted its
7 desire to move toward a parsimonious measure set
8 and that outcome measures should be used in place
9 of structural measures as possible. In both of
10 these there was one comment received in favor of
11 this measure.

12 So maybe we can stop there since those
13 are the fully developed measures, and then I'll
14 turn it over to Frank for discussion.

15 CHAIR OPELKA: Okay. All right.
16 Well, thank you very much. I know this is a
17 hefty group. I think the best approach will be
18 to go back to the first calendar. And now that
19 you see the various calendars that we have and
20 the measures that are in them, we can walk
21 through each calendar and ask if we've got any
22 desire to move anything that's on one calendar to

1 another.

2 So we'll start with the first
3 calendar. Mitchell?

4 DR. LEVY: So just a point of order.
5 I want to ask a question about one of the
6 measures, but not necessarily ask that it be
7 moved off. So I'm just looking for when we would
8 have a discussion about a measure.

9 CHAIR OPELKA: When that calendar
10 comes up.

11 DR. LEVY: Okay.

12 CHAIR OPELKA: So let's take these
13 that are on this calendar. So we've got CLABSI,
14 CAUTI, the hospital 30-day all-cause, risk
15 standardized pneumonia and readmission and then
16 the 30-day risk standardized mortality from
17 pneumonia, and then the cardiac rehab on the
18 support.

19 Nancy?

20 MS. FOSTER: So I'd like to pull the
21 30-day all-cause risk standardized readmission
22 rate for pneumonia and the cardiac rehab for

1 patient referral. The first I'd like to put in a
2 probably a new one conditional but conditional
3 upon adjustment for SES. The second one I'd like
4 to put in conditional -- gosh, I've lost track of
5 all those different conditional ones, but
6 conditional on some -- the data issues being
7 resolved, which was a category we had yesterday.

8 CHAIR OPELKA: The NHSN?

9 MS. FOSTER: I'm sorry. I'm not
10 pulling the NHSN one.

11 CHAIR OPELKA: That was the --
12 yesterday's data question was --

13 MS. FOSTER: Right.

14 CHAIR OPELKA: -- on the NHSN
15 data --

16 MS. FOSTER: Right. I'm just saying
17 the cardiac rehab also has some data issues that
18 need to be resolved.

19 CHAIR OPELKA: Okay. Richard?

20 DR. BANKOWITZ: Could I ask a
21 clarifying question on the pneumonia mortality?
22 Has NQF looked at that now that it's been

1 redefined to include aspiration pneumonia and is
2 that measure endorsed by NQF?

3 CHAIR OPELKA: Everyone's nodding
4 their heads saying that it's coming back, but no.
5 Maybe we can get clarification on that.

6 Please tell everyone who you are.

7 DR. BERNHEIM: Hi, I'm Susannah
8 Bernheim from Yale CORE. We're the developers of
9 this measure and now the re-evaluators. So the
10 changes to the pneumonia measures will go back to
11 NQF this year. So they haven't gone back yet.

12 And just a clarification. It's not
13 just the addition of aspiration pneumonia. It is
14 also adding patients who have pneumonia POA as a
15 secondary diagnosis with either sepsis or
16 respiratory failure as a primary diagnosis.

17 CHAIR OPELKA: Okay. Richard, did we
18 answer your question?

19 DR. BANKOWITZ: I would like to pull
20 that measure if this is the appropriate time. I
21 don't know if Nancy made a motion or not, but I
22 would move --

1 CHAIR OPELKA: So there are two
2 pneumonia measures. There's at the --

3 DR. BANKOWITZ: I would pull both of
4 them.

5 CHAIR OPELKA: All right. Mitchell,
6 is yours still up?

7 DR. LEVY: Actually I have a question
8 about the CLABSI measure that I meant to ask
9 yesterday. Would this be a time to ask that?

10 CHAIR OPELKA: Yes.

11 DR. LEVY: I'm not asking for it to be
12 pulled, but I think this question is either for
13 CMS or CDC. So the two revisions were, one,
14 extending the population, and the other was the
15 addition of a new risk model. And we haven't
16 said anything about it and it's now going to a
17 larger population. So I'm just wondering about
18 this new -- its adjusted ranking metric and has
19 it been validated and in what population? And I
20 don't know who I'm asking.

21 DR. POLLOCK: Well, this is Dan
22 Pollock at CDC, so I'll start off, Mitchell.

1 Thanks for your question.

2 The addition of the adjusted ranking
3 metric to the measure spec does not eliminate the
4 unadjusted standardized infection ratio. There
5 are, however, specific use cases or purposes that
6 the adjusted ranking metric serves. It is, in
7 our understanding, a better approach to rank
8 hospitals when you use the adjusted approach that
9 the adjusted ranking metric has built into it.

10 It is a full Bayesian method of taking
11 into account exposure volume and other risk
12 factors that are not taken into account in the
13 SIR, which itself has some aspects of risk
14 adjustment. But the primary advantage of the
15 adjusted ranking metric is that it deals with
16 differences in exposure volume and in a Bayesian
17 approach it takes into account all of the data
18 that are available for a particular time period.

19 So to give you a simple explanation,
20 the difference between a baseball player who's
21 hitting .400 in April and one who's hitting .400
22 in September after a six-month season is

1 substantial, and most would recognize that the
2 two should not be equated in terms of their
3 achievement because one has had limited exposure
4 volume. A batter who hits who successfully at
5 .400 clip, which is an excellent clip
6 performance, in April, in all likelihood will
7 regress to the mean by the end of the season.

8 So the adjusted ranking metric
9 performs a statistical adjustment that takes into
10 account the performance of all of the players and
11 factors that in, using a full Bayesian approach.
12 And so there is regression to the mean in terms
13 of the adjustment. That means that in some
14 instances hospitals will see a different end
15 result, but the implications for ranking are very
16 important because we think it's a more equitable
17 approach than treating the April .400 hitter as
18 though that hitter is equivalent to the September
19 .400 hitter.

20 DR. LEVY: It makes sense. Has it
21 been validated in a population in terms of
22 outcomes?

1 DR. POLLOCK: Well, when you say
2 "validated," what do you mean?

3 DR. LEVY: So looking in the same way
4 that if you did this logic in the first baseball
5 season ever you wouldn't really be able to be
6 sure that hitting .400 in April isn't the same
7 thing as hitting .400 in September, so --

8 DR. POLLOCK: Oh, we know that.

9 DR. LEVY: Okay.

10 DR. POLLOCK: Yes, we've looked at
11 that for sure.

12 DR. LEVY: Okay.

13 CHAIR OPELKA: Thank you. Pierre,
14 Kate, did you have anything to add?

15 DR. YONG: The only thing I'd just
16 want to -- but I believe they also both just
17 received NQF -- were approved for re-endorsement.

18 DR. POLLOCK: And let me just add just
19 to underscore the point that the NQF measure that
20 has been endorsed -- just as Pierre indicated,
21 that has just been endorsed includes both the
22 unadjusted SIR, which we think is a better metric

1 for quarterly reporting and in some instances a
2 better metric for annual reporting, as well as
3 the use of the ARM, the adjusted ranking metric,
4 which we formerly referred to as the adjusted
5 SIR, but to avoid confusion we gave it a new name
6 altogether. So the adjusted ranking metric in
7 our opinion, in our view is a much better fit
8 with hospital ranking, whereas the unadjusted
9 metric is a better metric to use to gauge
10 performance improvement over time.

11 CHAIR OPELKA: All right. Thank you
12 very much. Andrea?

13 DR. BENIN: How does this methodology
14 then address some of the concerns about
15 stratification that were brought up by the
16 commenter around some of the populations that
17 might be a particular high risk or have some
18 nuances to them? I think one equivalent in
19 pediatrics is kids with short gut. So we'll have
20 a unit at any time of kids who are TPM-dependent,
21 so your line days are extensive. So that unit,
22 when you start expanding it out of the ICU, those

1 kinds of units. So I think that's the equivalent
2 of your spine injuries with the urine, those
3 types of things. Will this methodology help
4 address this problem? Is this still an
5 appropriate way to go then based on those
6 comments?

7 DR. POLLOCK: So this methodology does
8 not address that problem or those sets of
9 problems that you're describing. Pretty much
10 have to take each of those individually. I don't
11 know how much of a deep dive we want to do on
12 that.

13 But let me address the spinal cord-
14 injured patient population for a moment, because
15 I didn't have a chance to yesterday. As Matthew
16 Davis indicated, we've had extensive discussions
17 with him and colleagues in the spinal cord injury
18 community of clinical practice and we recognize
19 from their reports the possibility of an
20 unintended consequence of the CAUTI measure
21 leading to selected non-use of in-dwelling
22 urinary catheters in spinal cord-injured patients

1 particularly when they're treated in non-
2 specialty centers. That's understood.

3 We think that is a clinical practice
4 problem that needs to be better addressed with
5 education and ongoing support for the correct way
6 to manage urinary tract function in the spinal
7 cord-injured patient population. The implication
8 of removing patient populations selectively such
9 as spinal cord-injured patients from the data
10 collection process for CAUTI is more complicated
11 than simply finding appropriate codes and using
12 them because the measure requires ongoing
13 determination of catheter use prior to patients'
14 diagnoses being coded. And so it becomes a very
15 labor-intensive effort to identify the spinal
16 cord-injured patient population and remove them
17 from the catheter use counts.

18 As a result we had a trade-off that
19 we're facing of do we invoke an exclusion for
20 spinal cord-injured patients opening up the
21 possibility that the next would be exclusions for
22 sedated patients, for stroke patients? And soon

1 we're eliminating groups of patients, all of whom
2 remain at risk for catheter-associated urinary
3 tract infections. Or do we look at the
4 fundamental question of how best to manage those
5 patients in clinical practice and support optimal
6 care of them?

7 So we made a decision not to remove
8 the spinal cord-injured patient population. We
9 have a standing offer to the spinal cord-injured
10 patient community of clinical practice to help
11 get the message out about appropriate catheter
12 use. So that's where we stand in our
13 interactions with Matthew and his colleagues.

14 We do have -- with a possibility of
15 capturing data about the extent of spinal cord-
16 injured patient census in a given hospital as
17 part of this annual survey that we do -- have an
18 opportunity to control in a risk adjustment
19 process for the presence of spinal cord-injured
20 patients in a facility's patient care locations
21 that are part of the CAUTI reporting. That's a
22 possibility. That type of risk adjustment would

1 be separate from the adjusted ranking metrics
2 risk adjustment process.

3 So that's a fairly long explanation,
4 and I apologize for that. There is complexity in
5 all of this. It's not something that can be
6 addressed in shorthand terms very easily.

7 DR. BENIN: That's very helpful to me.
8 With the bloodstream infections then as they
9 extend outside of the ICU, will there be the
10 stratification that's similar to how -- so
11 currently the expecteds, for example -- I'll use
12 the NICU example, the expecteds are calculated by
13 your birth weight, right? So there are certain
14 -- the expecteds are calculated by whether you're
15 in a PICU or a med-surg ICU or a surgical ICU,
16 etcetera, etcetera. Are there then other types
17 of stratifications that are going to
18 appropriately define these other areas outside
19 the ICU?

20 DR. POLLOCK: Well, we tend to
21 stratify, as your question rightly recognizes, by
22 patient care location type, and admittedly, that

1 is a proxy for the type of underlying medical
2 condition that patients have, medical or surgical
3 condition. Ideally we would have patient-
4 specific, patient-level data. But again, here is
5 a trade-off. The more we place a burden on
6 facilities to report patient-level risk factor
7 data that we can take into account in our risk
8 adjustment model, the more we're burdening the
9 collection of data, predominantly still in a
10 manual form.

11 Hopefully later today when we have our
12 open discussion about how we all want to go
13 forward, we'll reckon with the need to take
14 greater advantage of the enormous investments in
15 health electronic record systems and look at what
16 we can do collectively to foster greater
17 standardization of key clinical variables that
18 could be used electronically in risk adjustment
19 processes.

20 Right now the reality is despite
21 billions of dollars of investment we just don't
22 have the granular-level data for risk adjustment

1 in electronic form in anywhere near the type of
2 coverage that would make it sensible for us to
3 tip that balance towards collecting patient-level
4 denominator data that would enable the risk
5 adjustment.

6 So we are in a position to continue to
7 use patient care location. Burn ICU versus neuro
8 ICU versus medical ICU versus pediatric ward as a
9 proxy for the patient population that is being
10 treated in those locations, their underlying
11 disease conditions.

12 DR. BENIN: I mean, I'm very
13 supportive of all this, but I would -- and I
14 imagine that there will be some incentives to
15 sort of -- like where am I going to put all the
16 shortcut patients when I report this data? I may
17 want to think about that. And so I just think
18 that as you work through this it requires a
19 little bit of thought about some these high-risk
20 populations.

21 DR. POLLOCK: Right, and --

22 DR. BENIN: I don't want to dwell on

1 it, but I --

2 DR. POLLOCK: Yes. No, it's a good
3 point, and we are very sensitive and I think
4 responsive to concerns expressed by our clinical
5 communities of practice and individual
6 practitioners who weigh in. And that leads to in
7 some instances changes in our criteria for what
8 constitutes an infection such as changes that
9 we're introducing this coming calendar year for
10 what comprises a catheter-associated urinary
11 tract infection.

12 We are, for example, removing fungal
13 pathogens as a cause of urinary tract infections
14 for purposes of CAUTI reporting. That's a
15 significant change. And we're doing that in
16 large measure in response to input that we get
17 from the clinical world. That's very important
18 to us.

19 It's fundamentally imperative that we
20 maintain to the fullest extent that we can
21 credibility with clinical communities of practice
22 because the ultimate goal is of course to

1 prevent. And unless the clinicians are engaged,
2 we're not going to be preventing. So that's
3 something we take very, very seriously. But
4 every time we make a change, there's disruption
5 in our capacity to look at what's happening over
6 time. And there are educational challenges and
7 training challenges and all sorts of
8 implications. We update in NQF. That's a
9 process.

10 So on the one hand; and we're not
11 going to deviate from this, we're going to
12 continue to make sure to the fullest extent that
13 we can with the information practices as they
14 exist in 2014 and 2015 capturing the data and
15 defining infections and criteria in accordance
16 with what's available.

17 But on the other hand, we fully
18 recognize there are imperfections and
19 shortcomings in what we're able to do right now.
20 We want that to change. We want to continue to
21 work in a concerted way to bring those changes
22 about.

1 CHAIR OPELKA: All right. And I want
2 to thank you, Dan, for that. Those were very
3 insightful remarks that I think we needed to
4 hear, and it's very helpful.

5 At this point we have the CLABSI and
6 CAUTI on the support list and we have a
7 recommendation to pull the risk standardized
8 readmission. And that was to go to NQF
9 endorsement, I believe. I'm trying to walk
10 through our conditions.

11 MS. FOSTER: That will be fine. That
12 was not what I originally said, but that's what
13 Richard said and that's what I --

14 (Simultaneous speaking)

15 DR. BANKOWITZ: Originally I wouldn't
16 recommend that. I would recommend not support
17 that measure. And I have a rationale for it at
18 the appropriate time.

19 CHAIR OPELKA: So we have two motions
20 on that one. So we have a conditional condition
21 to be defined.

22 MS. FOSTER: No, condition would be

1 NQF endorsement.

2 CHAIR OPELKA: NQF endorsement. And
3 then a recommendation do not support. Then on
4 the hospital -- on the mortality pneumonia
5 measure, Richard, where did you want to suggest
6 that one?

7 DR. BANKOWITZ: I suggest we do not
8 support.

9 CHAIR OPELKA: Okay.

10 DR. BANKOWITZ: Do you want a
11 rationale or do you want to --

12 CHAIR OPELKA: In just a moment. If
13 you'll just hang onto that, because we'll go back
14 to it. I just want to make sure we've got the
15 list right. Cardiac rehab was conditional for
16 data. That's NQF endorsed. So we're going to
17 probably need to understand what data is missing
18 if you've already got endorsement.

19 Okay. Any other thoughts? Is
20 everyone pleased that we can walk then into the
21 detail? Emma?

22 MS. KOPLEFF: Just sort of a question

1 about the framing of these motions. Given that
2 we're reviewing in this case, and there will be
3 others, measures that are already in programs and
4 have been in programs, if we were to discuss a
5 measure that's been pulled to either a
6 conditional support calendar and a do not
7 support, are we discussing that those can --
8 let's say the conditional support route. Are we
9 discussing the pneumonia measure if the condition
10 is not met, does that mean that the currently
11 NQF- endorsed, currently in the program version
12 of the measure stands, or are we discussing the
13 inclusion of the measure, period, in the program?
14 I think that can be --

15 (Simultaneous speaking)

16 CHAIR OPELKA: Well, what we're
17 talking about is -- take IQR.

18 MS. KOPLEFF: Yes.

19 CHAIR OPELKA: If a measure is in
20 another program, it doesn't matter. We're only
21 looking at it in IQR. In IQR if the condition is
22 NQF endorsement and it does not achieve

1 endorsement, then the MAP is not supporting that
2 measure.

3 MS. KOPLEFF: We're not supporting
4 this version of the measure or we're not
5 supporting --

6 CHAIR OPELKA: We're not supporting
7 that measure that is on this list if it is
8 conditional upon NQF endorsement and it fails.

9 MS. KOPLEFF: Okay.

10 MS. KOPLEFF: So what I'm trying to
11 clarify if --

12 CHAIR OPELKA: So that means we're not
13 supporting it.

14 MS. KOPLEFF: Understood. But if I
15 may restate, I think we're not supporting this
16 version of the measure for the IQR Program, but
17 we aren't necessarily making a statement it is
18 not within our scope to discuss the finalized
19 version of the measure that is currently in use
20 in the IQR Program.

21 CHAIR OPELKA: That's correct. We're
22 looking at this measure as it stands here.

1 MS. KOPLEFF: Okay. Thank you.

2 CHAIR OPELKA: Any other questions?

3 (No audible response)

4 CHAIR OPELKA: Okay. So then we go to
5 the readmission rate, and the motion is to move
6 this to NQF endorsement, conditional support
7 pending NQF endorsement. All right. So any
8 discussion?

9 MS. FOSTER: That was my motion. Are
10 we only entertaining my motion and not Richard's?

11 CHAIR OPELKA: Yes, we can't have
12 multiple motions on the same measure.

13 MS. FOSTER: All right.

14 CHAIR OPELKA: So if your motion
15 passes, then Richard's motion -- he can make his
16 motion, but we'd have to --

17 MS. FOSTER: Understood. Okay.

18 CHAIR OPELKA: Or re-pulling a measure
19 for another motion. But yours is the only one.

20 MS. FOSTER: So just to be clear for
21 Emma, my motion was intentional of not supporting
22 this new iteration of the measure. And for me

1 there are two important issues here. One that we
2 understand fully and have NQF endorsement and
3 understand fully the implications of the major
4 changes in this measure and their scientific
5 integrity, and which to me come through NQF
6 endorsement, at least in part.

7 And secondly, I know you all have
8 heard me on this subject, so I'll just be very
9 brief. Any change to this measure that does not
10 include adjustment for socioeconomic factor or
11 proof that there is no need for adjustment for
12 socioeconomic factor, which is doubtful as far as
13 I'm concerned given the growing body of evidence
14 about the need for socioeconomic adjustment, is
15 not supportable. We just have to get around to
16 making those adjustments and getting these
17 measures into that process.

18 CHAIR OPELKA: And I want to be clear,
19 because I think the socioeconomic adjustment
20 status is different from socioeconomic risk
21 adjustment. So if it's stratified versus risk-
22 adjusted, that's been the issue that is on the

1 table within the NQF. It's in a pilot program
2 now. The NQF came to a point of saying it's
3 split on whether we should have risk-adjusted or
4 risk-stratified socioeconomic -- and that pilot
5 is moving forward in testing that.

6 MS. FOSTER: Could we have an update
7 from NQF staff, because that's not how I
8 understood what the pilot was testing.

9 MR. AMIN: Okay. So, and I actually
10 had a follow-up question for you, Nancy, as well.

11 So for those of us that are maybe a
12 little less familiar with insider NQF baseball,
13 NQF is moving forward January 1 on implementing a
14 pilot to a trial period to look at the question
15 of SDS adjustment. Prior to January 1st, 2015
16 NQF had essentially restricted the use of SDS
17 variables for risk adjustment for the purposes of
18 outcome measures, or any measures in general, any
19 risk-adjusted measures. Starting January 1st,
20 2015 that restriction is being lifted and we are
21 allowing measures to be submitted to NQF that
22 include SDS adjustment.

1 In addition, the trial period is
2 asking specific questions around the conceptual
3 and empirical relationship between SDS factors
4 and the outcome being measured, in this case
5 pneumonia readmissions.

6 So that's the definition of the pilot.
7 We are asking for multiple specifications,
8 meaning specifications for including SDS
9 adjustment in the risk model and not including it
10 in the risk model, which would serve as the
11 foundation for allowing the measure for an SDS-
12 adjusted measure to be stratified for the
13 purposes of internal quality improvement and
14 understanding the differences in performance.

15 So with that being said, the question
16 I have for Nancy is the way that you framed the
17 motion to begin with was conditional on
18 adjustment for SDS. I would ask the question is
19 it really an adjustment for SDS or are you asking
20 the question that NQF consider whether SDS
21 adjustment is appropriate for these measures,
22 which would fit under the construct of what we're

1 doing starting January 1, which is we're not
2 requiring SDS adjustments for risk adjustment.
3 We are asking measure developers to work along
4 with NQF and CMS to work along with NQF to
5 evaluate whether SDS adjustment is appropriate
6 conceptually and empirically for each outcome and
7 measure that we're looking at.

8 MS. FOSTER: Thanks for the clarity,
9 Taroon. I meant the latter. I was trying to be
10 brief --

11 MR. AMIN: Okay.

12 MS. FOSTER: -- and in so doing
13 shorthanded it too much. I want SDS considered
14 for these measures, this measure in particular
15 that we're talking about now, and other
16 readmission measure that comes along.

17 CHAIR OPELKA: But it's in this
18 framework of it's the trial which is both risk
19 adjustment and risk stratification. Arguments
20 were both of sides of that.

21 MS. FOSTER: Correct.

22 CHAIR OPELKA: And they were very

1 strong on both sides.

2 So I really want to kind of frame this
3 condition once and not 100 times today, because
4 we had a pretty good healthy discussion on it
5 yesterday. So I would really like you to
6 consider on this particular measure, as a good
7 one for us to work on, how do we frame the
8 guiding principles that we can then apply when
9 you wish as a group conditionally so that we're
10 not going to do this -- have this conversation
11 over and over again all day long. It's an
12 important one to have. I would love a proposal.

13 MR. AMIN: Okay. What I'm hearing as
14 the condition; and maybe we can recycle this
15 condition going forward, is the condition is
16 support with the condition that the measure is
17 considered for SDS adjustment during NQF's
18 upcoming trial period.

19 MS. FOSTER: And my only addition to
20 that would be an that it becomes NQF endorsed.

21 CHAIR OPELKA: And I'm going to go
22 down the list here in a minute, so if you're just

1 hang on for a second, because I want to clarify
2 your action on this measure within this
3 condition. Okay? It's important for our
4 discussion so that all risk standardized
5 readmission for pneumonia would have two
6 conditions. One would be the NQF endorsement and
7 the other one would be within the framework that
8 Taroon just identified regarding socioeconomic
9 status adjustment within the pilot. Okay?

10 Okay. Everyone understand that? We
11 good?

12 (No audible response)

13 CHAIR OPELKA: All right. I'm going
14 to go down the list. Jack?

15 DR. FOWLER: Since you said you want
16 to talk through this now, I'd like to put in a
17 word for stratification as compared with risk
18 adjustment or in addition to. I mean, as most
19 folks have thought about this, I guess I
20 understand, the problem is that the argument is
21 partly; at least as I hear it, one that people
22 from disadvantaged backgrounds, I'll represent,

1 have more challenges when you send them home to
2 take care of whatever it is that they've got to
3 deal with when they get back there.

4 So on the one hand you say, well, if
5 you're a hospital that has a lot of those, then
6 you're at an unfair advantage because you've got
7 more challenges. The alternative argument is,
8 well, you're supposed to take care of the people
9 you've got to take care and we don't give you a
10 break because you've got a set of people that are
11 harder. If you have harder cases, you deal with
12 it. And so to have different standards doesn't
13 make sense.

14 And I think that's a complicated
15 argument for sure; we've talked about that, but I
16 am just a huge fan of stratifying as in reporting
17 the results for, if you can, the people who are
18 at higher risk and the people who are at lower
19 risk and see what your readmission rates are for
20 both of those.

21 Now, if you want to combine those in
22 some fashion, you can do that, but at least we

1 would then have the information both at a
2 hospital level by how well they were doing
3 overall and also how well they were doing with
4 their people who were more challenged. And that
5 from a patient perspective would give me the
6 information that I would me most interested in.

7 And so, I know that there have been a
8 lot of articles written and there won't be an
9 right answer, but I think stratification is a
10 really strong model for giving patients and users
11 the information they need to understand how well
12 hospitals are dealing with their challenging
13 cases.

14 CHAIR OPELKA: Richard?

15 DR. BANKOWITZ: Yes, I have a concern
16 of a question about the whole process of this
17 conditional recommendation on NQF approval. So I
18 would like the NQF staff to correct me if I'm
19 wrong or give me some guidance here, but when NQF
20 looks at a measure for endorsement, they're
21 looking at the scientific validity of the measure
22 and they are looking at utility of the measure.

1 Is it useful for some purpose? They don't
2 specify what the purpose is. We're asked to
3 decide is this suitable for public reporting?

4 And I find it very difficult to say,
5 yes, I support this without any data, without
6 looking at any data on sensitivity, sensitivity
7 specificity, how this behaves in the field. And
8 my only condition is NQF will find it
9 scientifically valid, which is important, and
10 suitable for some purpose. But that might not be
11 the purpose that I'm asked to decide here, so
12 this is why I have a bit of a dilemma.

13 Am I saying this right? I'd like you
14 to help my logic here.

15 CHAIR OPELKA: You want to comment?

16 MR. AMIN: Well, I mean, so the NQF
17 endorsement process evaluates whether measures
18 meet scientific properties and also evaluates
19 broadly whether the measures are appropriate for
20 quality improvement and accountability
21 applications. Whether the measure is uniquely
22 appropriate for the use for this program is up

1 for this group to decide.

2 Now whether you have enough
3 information to make that decision or not as
4 you're describing, that is your own -- I mean, I
5 can't speak to that element.

6 DR. BANKOWITZ: Well, I'd feel much
7 more comfortable if we'd say we would reconsider
8 after NQF endorsement, but that's not what we're
9 doing. We're saying we support after NQF
10 endorsement. So that's why I'm a little
11 uncomfortable. And my only other choice is to
12 say do not support. So each of those is not an
13 optimal choice, but are those are the two choices
14 I have, I have to say don't support because I'd
15 like to see more data.

16 CHAIR OPELKA: Michael?

17 DR. PHELAN: I think this is a
18 critical issue, and we all know what's been at
19 least out there published particularly -- and I
20 think Jack spoke very eloquently about the
21 stratification, putting hospitals in whatever
22 category that they belong in order for patients

1 and the end users to do comparative analysis.

2 And, Frank, I'm trying to understand
3 from you. From the perspective of this risk
4 adjustment/risk stratification, are they both
5 going on right at the same time and all the data
6 is going to be pushed out to show the adjustment
7 and the stratification? I'm just unsure what the
8 process is at NQF right now around the
9 sociodemographic factors.

10 CHAIR OPELKA: Yes, it's going to be
11 up to the measure developer for a specific
12 measure that they bring forward. And I think
13 most measure developers were pretty well engaged
14 in the white paper that came out from the NQF
15 regarding this and heard the discussion.

16 And there were two sides, and they
17 were eloquently stated in that discussion. And I
18 think Jack did a great job summarizing the
19 stratification side. And the risk adjustment
20 side were those who were really looking to look
21 at the population as a whole and have a
22 regression model that corrected for socioeconomic

1 status. And that's also a reliable reasonable
2 request to put forward, but they have different
3 outcomes.

4 As a safety net system I actually want
5 the risk stratification. I want to know where
6 the problem is so that I can go get funding. I'm
7 under-funded. I need help. And I can't do that
8 if I'm regressed to the mean and I look good. So
9 I need as much of the truth as I can get to get
10 budgeted to solve my problem.

11 That's different from someone else
12 who's not in that same bucket who's saying we
13 take care of this population in addition to
14 everything else. Please don't punish us for
15 taking care of that population. We want
16 regression and we want a different adjustment.
17 And those are both rational arguments and they're
18 just fit for purpose.

19 So that's the challenge to the
20 developers when they put something into a measure
21 now, and that's part of this thought process in
22 the pilot. Let's not kill the idea of

1 socioeconomic status adjustment. It's obviously
2 important, but let's see if we can define it.

3 It also gives the payer, whoever it
4 is; CMS being the one that we talk about most
5 here, the opportunity to use multiple levers.
6 They don't all have to be black and white levers.
7 They can identify a hospital as a hospital that
8 takes care of socioeconomic challenge and they
9 could look at that hospital using one set of
10 adjustment factors and incentives and rewards,
11 and they can look at another hospital from its
12 socioeconomic profile differently. But that's
13 not MAP function. That's payer use of different
14 levers in the incentive programs.

15 DR. PHELAN: And I guess that's where
16 the rub is, so to speak. If this gets on the IQR
17 for a year, it can be utilized in any of the
18 value payment programs or any of the payment or
19 punishment programs, however you want to view it.
20 And the concern is where that's going to fall.
21 And I know it's not the Committee's job to do
22 that, but I would hope our comments make some

1 kind of recommendation or suggestions that that's
2 what we're concerned about. And I think that's
3 what Nancy is probably concerned about from her
4 hospital side, too.

5 Is that an issue for you, Nancy, like
6 where this is going to go in the end?

7 MS. FOSTER: Yes, certainly, but quite
8 frankly, it's been issue that's been on the table
9 for a very long time with mounting set of
10 evidence and any adjustment would be better than
11 none. So move. Let's move and then let's figure
12 out how to do it right.

13 CHAIR OPELKA: So, all these thoughts,
14 Erin and Taroon get to figure out how to put it
15 into common sense, but it's what we want to
16 capture. It's the conversation we want to share
17 with the Government and liaisons. So it's a very
18 important conversation we're having and I want to
19 get it all out as much as we can.

20 Sean?

21 DR. MORRISON: Frank, this is a
22 different topic. Do you want me to table it or

1 --

2 CHAIR OPELKA: Yes, let's stay on this
3 one --

4 DR. MORRISON: That's what I thought.
5 Okay.

6 CHAIR OPELKA: -- that we have.
7 Marty?

8 MR. HATLIE: I'm afraid that my
9 question might be very naïve, but I just need to
10 ask it because I'm a little bit unclear. When we
11 talk about socioeconomic factors and when we talk
12 about stratification, are we including
13 demographic factors that aren't necessarily
14 socioeconomic like race? It is? It's included.

15 And the discussion yesterday about
16 mental illness and substance abuse, those kinds
17 vulnerable population issues, would they be
18 included in what we're looking at now in terms of
19 stratifying data?

20 CHAIR OPELKA: You want to handle
21 that?

22 MR. AMIN: So, and this also goes back

1 to Michael's point, the question around which
2 variables and which outcomes is one of the
3 elements that's really in the trial period, which
4 is to say that we don't want to make any a priori
5 statements about which SDS factors are really the
6 ones that are appropriate to be using because
7 it's very difficult to say that. It really
8 depends on the outcome that we're trying to
9 measure and the data that's available to
10 developers as they're developing these measures.

11 The real question that NQF will be
12 thinking very strategically about as we start
13 this pilot starting January is encouraging
14 developers to start bringing forward what factors
15 were available to them and really asking the
16 question around the empirical and conceptual
17 relationship between those factors and the
18 various different outcomes that are under
19 evaluation. Readmissions is one of them. Cost
20 and resource use is another area. But they may
21 require different types of variables depending on
22 what we're looking at.

1 So, the answer to the question is sort
2 of it depends. I mean, sociodemographic factors
3 are broadly under consideration. What developers
4 can bring forward to us is still to be
5 determined, but there's obviously a strong
6 interest by those being measured to have this
7 conversation be much more robust and get it
8 started. I think that's what we're hearing from
9 Nancy as well. So that's what this trial
10 represents, but there are no blanket statements
11 that I think we can make about the specific
12 variables or the data, because we haven't even
13 really begun that process yet.

14 MR. HATLIE: What I'd like to just say
15 then is, just for the minutes, in the partnership
16 for patients really through the patient/family
17 engagements strand of work a lot of issues around
18 disparity surfaced. And groups that I don't know
19 that we were even thinking about having special
20 issues came forward, like transgender people who
21 are really afraid of violence in the hospital.
22 So that was in a way the voice of the American

1 people coming up to that campaign because we
2 didn't get patients and families in a really
3 robust way. And I'd just like to be included in
4 general in thinking about what's important when
5 we measure outcomes.

6 I am not a technical measurement
7 person, so that probably wasn't eloquently stated
8 enough, but I hope you get my drift. I think it
9 is a really important issue for us to think about
10 going forward. Thanks for the time, Frank.

11 CHAIR OPELKA: All right. Thank you.

12 Cristie?

13 MS. TRAVIS: So this is a
14 clarification as well. It's my understanding
15 that when the measures go through the trial
16 period that they will present specifications for
17 stratification as well as adjustment. And I
18 assume that there will be data relative to that
19 from a testing standpoint and some issues around
20 that. I mean, that somehow we'll get some
21 information on that.

22 But as, Taroon, you indicated, it will

1 be up to the developer, or maybe Frank, how they
2 use the measure moving forward. So is this our
3 time, I guess is my question, that if we want to
4 say to CMS we would like for you to actually
5 publicly report stratified data, if it comes out?
6 If you get approval, NQF endorsement for SDS
7 adjustment, that we also want you to publicly
8 report stratified data as well as any SDS-
9 adjusted data? I'm trying to see if this is the
10 time for us to say that?

11 CHAIR OPELKA: No, I think that
12 belongs to this entire pilot project until we
13 learn what's coming out of there. We're kind of
14 getting back into the development side of things
15 --

16 MS. TRAVIS: Okay.

17 CHAIR OPELKA: -- and the endorsement
18 side. And it's outside of our scope. It's --

19 MS. TRAVIS: Okay.

20 CHAIR OPELKA: -- definitely --

21 MS. TRAVIS: That's fair.

22 CHAIR OPELKA: -- an NQF scope issue,

1 and it's with that whole socioeconomic
2 discussion, the white paper and the pilot will
3 help bring to us --

4 MS. TRAVIS: Right.

5 CHAIR OPELKA: -- but you're getting
6 ahead of it.

7 MS. TRAVIS: Okay. Thank you. That's
8 why I wanted to ask.

9 CHAIR OPELKA: So what we have is
10 really how Taroon framed it saying that Nancy's
11 request on this is a conditional support, NQF
12 endorsement and all these caveats that are built
13 into the pilot. Okay?

14 MR. AMIN: I guess one of the
15 additional questions that I have for the group,
16 particularly Nancy, since it's your motion, is
17 that these measures on the calendar are updates.
18 I just want to be clear about how does a question
19 around SDS adjustment relate to the issue around
20 updates, or is this a bigger signal that we're
21 trying to send as it relates to the actual
22 endorsed measure that's in the program, which is

1 a little bit out of scope, but I'm just trying to
2 understand exactly how this relates to the
3 updates that are in front of you.

4 MS. FOSTER: I know this will come as
5 a surprise to many people around the table, but
6 we've been trying to send that signal on the
7 measure that's in the program. That
8 notwithstanding, it is my understanding, and
9 particularly after a conversation this morning
10 with Susannah, it was that this will indeed sweep
11 a bunch of patients into the measure that
12 previously have not been in the measure. And so,
13 a significant expansion of the patient population
14 without addressing the significant issue I think
15 is just wrong.

16 CHAIR OPELKA: Okay. So what we have
17 is Nancy's motion as stated. I need a second.

18 (Off microphone comment.)

19 CHAIR OPELKA: Thank you. So we can
20 vote on moving this measure at this time as a
21 conditional support as we've so identified. So
22 we've voting on do you agree with the motion to

1 move it?

2 MS. IBRAGIMOVA: So the question is
3 hospital 30-day all-cause risk standardized
4 readmission rate following pneumonia
5 hospitalization, do you agree with the motion to
6 move to conditional support? Vote one yes, two
7 no.

8 (Voting)

9 MR. AMIN: Just for the record, the two
10 conditions include the consideration for SDS
11 adjustment during NQF's upcoming trial period and
12 that these updates are reviewed by NQF and
13 endorsed.

14 DR. PHELAN: Should it be adjustment
15 and stratification, or just adjustment?

16 CHAIR OPELKA: We're saying
17 socioeconomic status adjustment, which allowed
18 for both risk adjustment or risk stratification.

19 MS. IBRAGIMOVA: Can you try voting
20 again. We're missing five.

21 So the results are 78 percent yes, and
22 22 percent no.

1 CHAIR OPELKA: All right. Thank you
2 very much.

3 So the next is the hospital 30-day
4 all-cause standardized mortality rate following
5 pneumonia, and this is moved to do not support.
6 Richard?

7 DR. BANKOWITZ: So my rationale on
8 this is we have expanded the population
9 significantly. I do think that looking at
10 inpatient mortality rates for community-acquired
11 pneumonia is very important. I think it can tell
12 you a lot. You can make a lot of inferences
13 about the hospital. But now we've included
14 aspiration pneumonia, which is basically seen in
15 patients who are debilitated, have had a stroke,
16 who are in a nursing home, maybe have had
17 alcoholic or drug-induced stupor and also septic
18 patients who are arriving at the door in a state
19 of sepsis, and I have no idea what that is going
20 to do to the usefulness of this measure.

21 I would like to see what it does to
22 this measure and how the status of hospitals

1 change when we make this pretty broad inclusion
2 before recommending it to be included in public
3 reporting. I think I personally need to see that
4 data.

5 Now, I know the trend has been we
6 defer; I'll use the word "defer," to NQF for the
7 scientific validity, which is what we should do,
8 but I also think we need to understand what those
9 changes have done for the suitability of public
10 reporting. I know that's a little bit swimming
11 upstream because it's not what we've been doing;
12 we've been kind of deferring to NQF, but I'll
13 still make the motion to do not support.

14 But the signal I want to send; and you
15 can maybe help me do this with the motion, is
16 it's important to do this. This is an important
17 measure, but we need to understand what the
18 changes have done before we include it in public
19 reporting. How is it best to do that? Is it
20 best to say, we'll condition it on NQF, or is it
21 best to say we don't support and in the hopes it
22 will come back here again?

1 CHAIR OPELKA: Sean?

2 DR. MORRISON: And I just had a
3 comment for the last time. This was the comment
4 I wanted to make before, is I do have a little
5 bit of worry about some of the risk-adjusted
6 rates, particularly around mortality and
7 readmissions as more and more communities get
8 better equipped to take care of these people
9 outside of the hospitals. So what happens is the
10 hospitals may actually be penalized because
11 people never get the opportunity to be admitted.
12 So that as hospital-at-home develops and patients
13 with what would typically be hospital-treated
14 pneumonia are treated at home, they actually
15 never enter into the denominator.

16 And your comment, Richard, about
17 perhaps nursing home residents with end-stage
18 dementia who actually may be treated in the
19 nursing home and never actually be admitted into
20 the hospital will never enter into that
21 denominator. I don't think it's an issue right
22 now, but I do want to put it on the record as

1 something we need to think about moving forward
2 and to track to see if the denominator changes.

3 CHAIR OPELKA: Susannah?

4 DR. BERNHEIM: So again, this is
5 Susannah Bernheim for Yale CORE.

6 I have some of the information you're
7 asking about, and I'm happy to share it. You
8 just need to help guide me in terms of again when
9 we're sort of crossing a line into things that
10 you'd rather going to the scientific community.
11 But I can give a couple of sort of high-level
12 pieces of information that may just help the
13 Committee understand why this change came about
14 and how significant it is, if that would be
15 helpful.

16 CHAIR OPELKA: Please.

17 DR. BERNHEIM: So the first thing to
18 understand was this wasn't thought about by sort
19 of trying to expand the population per se. It
20 actually came about because a couple of important
21 studies were published that suggested that
22 there's been a lot of shifting in the way

1 pneumonia is coded for a whole variety of
2 reasons. Some of it may be about payment, but
3 it's also been about greater awareness of sepsis
4 and understanding what should be coded as sepsis
5 even if pneumonia was the original cause.

6 And what we saw in the literature and
7 then saw in our own analyses is a big increase in
8 the percentage of patients who are coming in with
9 pneumonia on admission, so they're POA, but their
10 principle discharge diagnosis because of how sick
11 they are when they come in is coded as either
12 sepsis or respiratory failure. But not only an
13 increase in that, but also a really clinically
14 unlikely difference in the percentage of
15 pneumonia patients at some hospitals that are
16 coded as sepsis and respiratory failure versus
17 other hospitals.

18 So the concern about the measure was
19 that we were no longer looking at similar
20 populations across the hospitals, that a hospital
21 that has tended to code most of their pneumonia
22 patients as principle discharge pneumonia will

1 have those sicker patients in their pneumonia
2 cohort, whereas a hospital that's moved towards
3 using respiratory failure and sepsis code as the
4 principle discharge diagnosis will -- their
5 sicker patients will be pulled out of the cohort.
6 And we were worried that it was -- and this been
7 happening over time, that they were starting to
8 distort and potentially bias the measure results.

9 So the effort behind this was to fix
10 a problem that's been happening with coding
11 shift. And again, this was coming out of our
12 response to some published literature. And what
13 we found indeed, just for you, Richard, is this
14 change is significant. It will increase the
15 population by almost 50 percent, which is why CMS
16 wanted to bring it to this group.

17 It's not a small change. It doesn't
18 change the overall distribution of hospital
19 results, but it will change who is seen as an
20 outlier. And not surprisingly, those hospitals
21 that have traditionally had few patients coded as
22 pneumonia and a much larger proportion coded as

1 respiratory failure and sepsis are going to be
2 bringing those patients into their cohort and it
3 will shift outlier status.

4 And I have some numbers. Again, I
5 don't want to get into too much detail, but I
6 just want the Committee to sort of understand
7 where this came from and why it occurred. We
8 think that it makes the measure fairer, but it's
9 not insubstantial.

10 CHAIR OPELKA: Karen?

11 DR. FIELDS: How do you risk address
12 for the patients? For example, bacterial
13 pneumonias versus fungal pneumonias, especially
14 in an immune-compromised patient population. So
15 patients undergoing chemotherapies, bone marrow
16 transplant, etcetera.

17 DR. BERNHEIM: So the risk adjustment
18 strategy for these measures has remained the
19 same, however, we are re-selecting risk variables
20 to understand whether or not we need to bring new
21 risk variables into the measure now that the
22 population has expanded. That work is happening

1 right now, basically.

2 DR. FIELDS: But that would change the
3 measure and the outcomes. Mortality rates would
4 be expected to be higher in patients with more
5 complex pneumonias like fungal, viral pneumonias.
6 So how do we understand how to approve a metric
7 like this without understanding why the risk
8 factors are?

9 DR. BERNHEIM: So just to be clear,
10 fungal and viral pneumonias have always been a
11 part of -- well, now you're going to ask me to
12 remember all of our ICD-9 codes. I believe
13 they've always been a part of -- somebody on my
14 team is hearing me and I'm trying to remember
15 exactly what we do about viral pneumonias.

16 But in general the broad range of
17 pneumonias have always been included. The
18 overall rate will change slightly because there
19 are more patients being brought in, but the
20 outcome remains the same. It's 30-day mortality.
21 And the risk standardization and sort of measure
22 methodology is the same, but the risk adjustment

1 factors will be updated to reflect this
2 population.

3 DR. FIELDS: And does that include
4 bone marrow transplant?

5 CHAIR OPELKA: We're getting off our
6 field now.

7 DR. FIELDS: The only reason I ask is
8 --

9 CHAIR OPELKA: I understand,
10 but --

11 DR. FIELDS: -- because the general
12 hospitals that --

13 CHAIR OPELKA: I understand. We have
14 --

15 DR. FIELDS: -- have large academic
16 cancer programs --

17 CHAIR OPELKA: We have --

18 DR. FIELDS: -- are --

19 CHAIR OPELKA: Karen, we have a
20 process, and the process is if we want better
21 risk adjustment, we go through the NQF
22 endorsement process. If we want to know the

1 measure specs, we go through the NQF endorsement
2 process. We cannot do the technical work, the
3 expert panel work or the endorsement work here.
4 We'll never through these measures. So that's
5 not our job. We've gotten afield here and we've
6 got to bring it back in.

7 If there are concerns about this
8 measure that need NQF endorsement and its
9 processes and its rigor, then our recommendation
10 is to conditionally support or do not support.
11 And that's how we have to voice it. We cannot
12 walk through the specifications of all these
13 measures. There's just not enough time.

14 (Off microphone comment.)

15 CHAIR OPELKA: It's really got to be
16 brief because we're off track.

17 DR. BERNHEIM: So people know, we look
18 back at all ICD-9 codes in the inpatient and
19 outpatient setting for each of these patients
20 over the prior year and see what comes into the
21 model. So everything is on the table for being
22 in the model. It's pretty robust for claims

1 data.

2 CHAIR OPELKA: Sean, is yours back up

3 or --

4 DR. MORRISON: Oh, I'm sorry.

5 CHAIR OPELKA: Okay. Emma?

6 MS. KOPLEFF: I understand Richard's
7 dilemma and I know NQF has worked really hard
8 over the last few years to make the endorsement
9 discussions and the MAP discussions flow
10 together. And I think we've come a long way.

11 If I could offer sort of a reframing,
12 maybe this will help. Again, sort of going back
13 to the question I asked earlier. If we don't
14 support this measure, we will see the continued
15 inclusion of the existing measure. And as we've
16 just heard, there's some new evidence that's been
17 published that speaks to issues with the current
18 measure. So I do think there's sort of a
19 moral/ethical/academic responsibility to respond
20 to new evidence, and I think that's what CMS is
21 doing.

22 That might not resonate with you, but

1 I'm offering that as this is the choice we're
2 faced with even if it is somewhat square-peg-
3 round-hole-kind of thing. I'm done.

4 CHAIR OPELKA: So just going back and
5 forth and trying to catch the spirit of both
6 these conversations, I think what Richard was
7 saying is that he does not support this measure
8 without fully understanding these changes and
9 what they mean and whether or not it would fit
10 within a public program. And he can't make that
11 judgment without that information, so he moved
12 not to support the measure. An alternative would
13 be a conditional support that meets these
14 requirements that Richard set forth. And he
15 mentioned that in his comments, but he elected to
16 go forward with a do not support recommendation.
17 So the motion that we have is do not support.

18 Michael?

19 DR. PHELAN: And I guess I would just
20 add to that that all of these measures are going
21 to be very iterative in nature. They're going to
22 be rolled out and then, oh, wow, look, there's

1 been a whole bunch of change in coding over the
2 last two years. Maybe we need to add some things
3 to it.

4 And I would be voting for conditional support in
5 this situation and not not support, because this
6 is already a measure that's currently being used.
7 It's out there.

8 But I think we have to understand that
9 this is not going to be static. And a lot of
10 these measures which you support, they're going
11 to start adding data into it and adding some
12 modifications, that the idea of not supporting
13 them just because we haven't seen the data yet, I
14 don't think it does it fairness to say that we
15 shouldn't support. We should probably
16 conditional support.

17 So I would be in the category or the
18 group that would probably conditionally support
19 on the idea that all these measures are going to
20 change over time because they're going to get
21 better. There's going to be sociodemographic
22 factors that are going to be put in. Every

1 single year they're going to be an iterative
2 process. And it goes to the idea of like
3 throwing the baby out with the bath water. It's
4 a good measure. Let's see what some of the data
5 comes in on it and probably recommend conditional
6 support based on what we see from the data.

7 CHAIR OPELKA: So, I think that's a
8 theme that is carrying over from yesterday as
9 well and Dan's comments earlier this morning;
10 that is, measures are now getting in to use and
11 they're getting updated. We've got to deal with
12 how do we actually go through the MAP process in
13 updating measures? And I think that's kind of
14 the discussion that's circulating around the room
15 right now.

16 And so, Michael, thank you for
17 highlighting that.

18 Nancy?

19 MS. FOSTER: So I really appreciate
20 your motion, Richard, and I'm sort of torn
21 between the do not support or the conditional
22 support because it's clear to me this needs to go

1 through NQF. This needs to be reviewed and
2 careful thought needs to be given to both what's
3 not in there now that should be coded and
4 included in this population that's being measured
5 and what will get swept in when we add these new
6 codes that may not be intended. Lots of thought
7 going to that. So part of me wants to support
8 your do not support motion because I really would
9 want this to come back to the MAP before moving
10 it into the IQR Program with the new specs so we
11 more fully understand what we're doing here.

12 And then to the point you just made,
13 Frank, it seems to me that the other theme that
14 comes out here is there are enormous amounts of
15 communication that are going to have to go on
16 around these new measures, not just when they
17 spring on the interested stakeholders, but
18 starting now. I mean, what are the changes?
19 What should practitioners expect? What should
20 the public expect? What should other users like
21 Leapfrog Group and U.S. News and World -- what
22 should they know about it now so that they are

1 adjusting their thinking in how they use these
2 measures for the changes that are to come?

3 CHAIR OPELKA: Any other comments?

4 All right. So then, Andrea?

5 DR. BENIN: Frank, I think to your
6 comment and to what Emma and Mike were speaking
7 to a little bit, I'm just a little bit disturbed,
8 and perhaps it's my own internal inconsistencies,
9 but sort of the inconsistent perception of
10 metrics as they're changing.

11 So in general, we didn't have a lot of
12 conversation about the NHSN measures, which are
13 undergoing pretty substantial changes, like quite
14 substantial. And I don't think we know how those
15 are going to perform, but in we were I think
16 generally supportive of leaving those. But then
17 this is a different measure and we have a
18 different approach to it.

19 And so I don't know if we do need some
20 overarching way to think about these things as
21 they evolve and think about them a little bit
22 differently and think about the different

1 programs a little bit differently. The IQR has
2 one set of risks to it. The VDP and the
3 readmission reduction have different sets of
4 risks to them. So I don't know if we need a sort
5 of overarching mental model that can help us
6 develop some consistency.

7 CHAIR OPELKA: Thanks, Andrea. The
8 model that's emerging is that you support it and
9 you live with the change, you do not support it
10 and say bring the change back, we'll live with
11 the older measure, or you can conditionally
12 support it and based on those conditions, we will
13 give you our nod. And the measure that we have
14 on the table right now is that we're recognizing
15 this measure in the program. We're recognizing
16 this measure is coming forth with change, and
17 we've heard about the change. And now the
18 question before you is do you support? Do you
19 not support? And we have a do not support
20 motion.

21 Yes, Nancy?

22 MS. FOSTER: Just quickly to Andrea's

1 point, I think for me one of the key ingredients
2 in the difference between a conditional or a do
3 not support is really around NQF endorsement.

4 And I say that recognizing that I said
5 conditional support for the readmission measure,
6 but this measure has not been to NQF, this
7 revamped measure has not been to NQF. The NHS
8 ones have. So we've seen something about those.

9 DR. BANKOWITZ: Well, I mean, the
10 whole tenor of the conversation is moving towards
11 the fact that we want progress to be made here.
12 And clearly trying to update this measure to take
13 into account the biases you claimed is a good
14 thing. We don't want to send the message that
15 that's a bad thing to do.

16 So mindful of that, I would rescind my
17 motion and I'll make a motion we move forward
18 with approval with conditional support of NQF.

19 CHAIR OPELKA: Any further discussion
20 on that?

21 (No audible response)

22 CHAIR OPELKA: All right. So that's

1 the motion we have. It's a conditional support
2 with NQF endorsement. And can we put this motion
3 then forward for a vote?

4 MS. IBRAGIMOVA: So the question is
5 hospital 30-day all-cause with standard mortality
6 rate following pneumonia hospitalization, do you
7 agree with the motion of conditional support
8 pending NQF endorsement? One yes, two no.

9 (Voting)

10 MR. AMIN: Again, just for the record,
11 the motion is conditional support pending NQF
12 review and endorsement of the changes.

13 MS. BAL: Also just so everybody
14 knows, this new voting software, once the slide
15 is in full screen, you can start voting even if
16 Laura's talking. So you don't have to wait for
17 her to tell you to vote. Just for your
18 information.

19 MS. IBRAGIMOVA: The results are 100
20 percent yes, and 0 percent no.

21 CHAIR OPELKA: You see that, Ron?

22 CO-CHAIR WALTERS: Yes.

1 CHAIR OPELKA: You see that?

2 (Laughter)

3 CO-CHAIR WALTERS: In your face.

4 CHAIR OPELKA: Someone get a picture
5 of that on my behalf.

6 Okay. So then we have -- I'm sorry.
7 Mitchell?

8 DR. LEVY: It's a little late in the
9 meeting to ask this, but what does the
10 Coordinating Committee do with the conditional
11 support? Do we have a track record of that? So
12 the Coordinating Committee gets the information
13 that we conditionally support this measure
14 pending X. And in general, do we know what's
15 happened at the Coordinating Committee level with
16 that?

17 CHAIR OPELKA: The Coordinating
18 Committee gets our report and they can accept our
19 report. And they can accept our report as is and
20 it goes to CMS with the conditional support, or
21 they can look at it as a consent calendar and
22 pull off something for discussion at the

1 Coordinating Committee. They rarely do that.

2 We have one unsettled issue from
3 yesterday that will go to the Coordinating
4 Committee and for them to discuss. That was our
5 -- I think it was the advanced air plan issue
6 where we split. It was like 39-17, 40 something,
7 maybe 40 percent. But I think that was our
8 split. That issue will then go to the
9 Coordinating Committee and we'll share with them
10 the collective wisdom of our group.

11 DR. LEVY: Yes, so I guess my question
12 really is for CMS. I mean, being an outcomes
13 person, I'm just wondering are we just making
14 ourselves feel good by doing the conditional
15 versus full support? And so when CMS gets a
16 conditional support measure, has the experience
17 been that they don't incorporate it into IQR
18 until those conditions are addressed or in
19 general, do those still get adopted? Because I
20 think it would be good for us to have some sense
21 of that.

22 I don't know that you're going to be

1 able to answer that right now.

2 CHAIR OPELKA: I think I'm going to
3 let CMS answer too, but I would share with you
4 that the conversation that we have is heard. And
5 I think that is invaluable. It's taken by CMS,
6 by all their teams, very seriously. It's also
7 taken by their measure developers who are working
8 with them who may have missed one of these
9 aspects of all of our concerns. And so they
10 listen to all of that. If we support it, it's a
11 ringing endorsement. If we conditionally
12 support, and it's got NQF endorsement on it, that
13 carries a rigor statement. If it's got other
14 concerns that we want to measure or put up there
15 for them to consider, that carries another set of
16 concerns. So sharing that information from this
17 group actually is extremely important.

18 Pierre?

19 DR. YONG: Sure. Thank you for that
20 question. I think it is an important question
21 and we certainly want the MAP's input. It is
22 taken very seriously. We discuss the MAP's input

1 after we receive it and in the course of our
2 considerations about as we develop measures and
3 as we consider measures for implementation in our
4 programs.

5 I also just want to reiterate that
6 this is not the only opportunity for public input
7 into what measures get implemented into our
8 programs. Certainly all of these programs go
9 through public rulemaking, through proposed and
10 final rulemaking, so there will be further
11 opportunities for the public, including members
12 of the MAP to make and voice any support or
13 concerns around measures we want to implement
14 into our programs and we certainly need to
15 consider those as we finalize the rules and
16 measures in our programs.

17 So there will be multiple
18 opportunities ongoing in the future. And in our
19 rules we actually if you read them, we also do
20 reference what the MAP's recommendations are for
21 each of the measures we put into our programs.
22 And so we acknowledge whether they supported it,

1 whether they said conditional upon NQF
2 endorsement and we acknowledge where it is in the
3 NQF endorsement and process, et cetera.

4 CHAIR OPELKA: Okay. We're now on the
5 cardiac rehab patient referral. And this one was
6 a conditional support pending data. I'd love
7 more.

8 MS. FOSTER: Thank you. The referral
9 to cardiac rehab is certainly consistent with
10 best available guidelines. No doubt, this is the
11 right thing to do. Quite frankly, getting a
12 referral seems like a fairly low bar measure. I
13 know there's some variation in performance.

14 Two things of concern to me, one, I
15 haven't seen the data to know whether there is,
16 in fact, a sort of a rural hospital problem here
17 where there may not be easy access to rehab
18 facilities for rural patients. And I think that
19 ought to be looked at as we think about this
20 going forward.

21 Secondly, and maybe some of those
22 hospitals excluded or adjusted or something. But

1 secondly, the data collection methodology here as
2 I understand it, is through the ACC, Get With The
3 Guidelines registry, which not all hospitals
4 participate in and quite frankly, the thought of
5 having yet another place to send data to with yet
6 a different set of registration requirements and
7 changing requirements, our hospitals,
8 particularly the smaller hospitals, are
9 struggling with getting data to NHSN and to CMS
10 through their vendors on time and HCHPS. Having
11 yet another mechanism will complicate things in a
12 way that I think will unintentionally lead to
13 hospitals failing to get information in when they
14 should.

15 The caveat I'm offering is we either
16 straighten out how to easily make it possible for
17 people to submit these data at no cost, very
18 little cost, and it is totally aligned as a
19 mechanism with the submission to CMS data or we
20 think about a different mechanism for collecting
21 the data. So that's why I offered the data
22 caveat.

1 CHAIR OPELKA: I'm looking at measure
2 specs and it does exclude if there isn't a rehab
3 center within 60 minutes or miles of the
4 patient's home.

5 MS. FOSTER: Thank you. I didn't see
6 that in the specs. So I appreciate it. So I'll
7 take my first off, and we'll just stick with the
8 data submission in the caveat.

9 CHAIR OPELKA: Okay. I understand
10 that one. Is that Michael down there? I've got
11 glare on the card.

12 DR. PHELAN: But Nancy, I think most
13 of the patients that have these cardiac rehab
14 referral are patients with PCI, CABGs, and valve
15 replacement. I'm not sure what percentage of PCI
16 places, but don't they all submit data to the ACC
17 registry if they're doing PCI? I don't know if
18 it's like the ICD, implantable cardiac
19 defibrillator, where it's a mandatory -- you're
20 required if anybody gets an implantable cardiac
21 defibrillator, there's a registry you have to
22 submit it to -- it may be run by the government.

1 But for places that are doing PCI and
2 bowel surgery, those are pretty large hospitals.
3 These aren't small hospitals that are doing that.
4 They may be smaller practices that may be doing
5 it, but is there a concern from them for entering
6 into these registries? I'm just not sure I'm
7 hearing -- because I can see small, rural
8 hospitals, but they're not doing PCI, CABGs, and
9 bowel surgery.

10 MS. FOSTER: CMS may have better data
11 on this, but I think you'd be surprised at what
12 some small, rural hospitals are doing.

13 CHAIR OPELKA: Emma, is your card up?
14 Mitchell, are you in the queue? Brock?

15 MR. SLABACH: Yes, just to follow up
16 on Michael's statement. I think that a lot of
17 these patients get referred back to their
18 communities and then the primary care physicians
19 may be the ones referring them to their cardiac
20 rehab and that may not be immediately available.
21 So it does -- this continuum of care is the
22 problem, I think.

1 DR. PHELAN: But I think it goes to
2 that coordination of care again.

3 MR. SLABACH: Right.

4 DR. PHELAN: You know what I mean?
5 Everything that we're trying to do for our
6 patients here -- to me, here's a measure that
7 seems like a very reasonable measure if there's
8 Class 1 evidence and we have all this, to not
9 help promote something like this, at least from
10 the MAP's perspective even though there's some
11 data issues that Nancy measures, there's not too
12 many Class 1 recommendations out there, guys.

13 I mean, this is one that seems to be
14 a pretty strong reason to get our patients and
15 our patient population to get into cardiac rehab.
16 I don't want to say regardless of the data issues
17 because that's a huge problem which is more and
18 more that we add on to the hospitals, but at the
19 same time there's not many like this that are out
20 there that is pretty clear cut that it makes a
21 difference in patient outcomes. For a process
22 measure, I don't think it's that kind of a

1 measure.

2 MR. SLABACH: I think it would be good
3 documentation, too, going forward and if the
4 evidence becomes more readily available. Part of
5 the problem of lack of cardiac rehab in rural
6 communities is the fact that we have such strict
7 physician supervision requirements for those
8 entities. And if that was relaxed somehow
9 through legislation, I think that could expand
10 the availability of cardiac rehab in many of
11 these rural and underserved areas.

12 CHAIR OPELKA: Cristie, before I call
13 on you, and Nancy, we're trying to sort out the
14 issue of where the data sources are coming from.
15 It's looking like it's registry or EHR or it's
16 just paper and measure specs. So I don't know
17 what that is. I wondered if it was claim based,
18 but it doesn't say that. It doesn't appear that
19 it's that.

20 Cristie?

21
22 MS. TALLANT: I guess that was going

1 to be my question kind of to Nancy about the data
2 issue. I mean, what would we -- if we moved
3 forward with that condition, what would resolve
4 the data issue? I think that's where I'm a
5 little unclear about that. I thought you might
6 have some ideas on that.

7 MS. FOSTER: I think Cristie, the
8 answer for me would be for those organizations
9 already submitting data to the ACC, if CMS can
10 make it easy for ACC to transmit the data to them
11 which they've done with other organizations, so
12 it seems like submit it once, use it multiple
13 times. For those who are not, and I don't know
14 what proportion of hospitals are not, but those
15 who are not, to have an easy way to submit the
16 data directly to CMS would be the way to handle
17 it.

18 It's the challenge of thinking that
19 we're suddenly going to end up with a requirement
20 that all hospitals have to participate in -- have
21 to pay ACC, have to participate in ACC in order
22 to just submit data required by CMS. That gives

1 me angst. Thank you.

2 CHAIR OPELKA: Nancy.

3 DR. HANRAHAN: Speaking as liaison for
4 the dual eligibles, this measure is really quite
5 complicated from that perspective. I think
6 collecting the data is one problem, but the other
7 problem is that people often have transportation
8 problems. It's a major factor, a barrier for
9 them to access these kinds of services. So they
10 may have a referral, but they may not get there.

11 So it's really -- the problem is are
12 we tracking whether simply black and white, do
13 they get a referral and that could come from a
14 database in the hospital, but whether they get
15 there or not is -- and whether they accept that
16 referral is a complicating factor, major, that
17 probably, you know, this was a measure that
18 requires some kind of stratification on a socio-
19 economic vein that -- and I just don't have the
20 specifications or the data to really look at how
21 this measure has been developed or thought
22 through to be able to discern anything more.

1 CHAIR OPELKA: Nancy, it's just the
2 referral. So if they don't accept, you still
3 pass the measure.

4 DR. HANRAHAN: But even making a
5 referral --

6 CHAIR OPELKA: You're identifying a
7 gap, but not a measure.

8 DR. HANRAHAN: People don't
9 necessarily accept the referral. So maybe it
10 would be documented as being made or not made.
11 I'm not sure.

12 CHAIR OPELKA: When you say people
13 don't, you mean the patient?

14 DR. HANRAHAN: The patient, yes, I'm
15 sorry.

16 CHAIR OPELKA: They still pass the
17 measure.

18 DR. HANRAHAN: So a physician makes
19 the referral and that gets documented in the
20 record. And that's my understanding of what
21 you're saying is that's what this measure will
22 measure.

1 CHAIR OPELKA: That's correct. But
2 you're pointing out a gap.

3 DR. HANRAHAN: I think it's a huge gap
4 in the quality of the measure. You know, a
5 physician can make the referral, but whether or
6 not it actually happens is the other process that
7 I think is even more important than making the
8 referral.

9 CHAIR OPELKA: Right. So we can
10 capture that as a gap.

11 DR. HANRAHAN: Yes.

12 CHAIR OPELKA: But the measure still
13 is. We can't re-spec the measure. That is the
14 measure.

15 DR. HANRAHAN: Got it.

16 CHAIR OPELKA: And there's a gap, and
17 I think you're pointing out a disparities gap.
18 So we'll capture that in our comments.

19 DR. HANRAHAN: Excellent.

20 CHAIR OPELKA: Okay? So any other
21 comments on this? All right, so the motion that
22 we have is to conditionally support this based on

1 the data requirements, resolution of the data
2 questions.

3 Michael?

4 DR. PHELAN: In the -- if we don't
5 support it, it stays in the support column, is
6 that correct?

7 CHAIR OPELKA: That's correct. Brock?

8 MR. SLABACH: I guess it raises a
9 question for me. So if a patient goes to a
10 tertiary facility in an urban area and the
11 patient is discharged with a referral, that
12 counts even though there's not a cardiac rehab
13 center within 60 miles of where they're ending up
14 as a patient at home.

15 CHAIR OPELKA: It would not count.
16 Those patients would be excluded.

17 MR. SLABACH: That patient. So then
18 the referring hospital, I mean I go to some of
19 Nancy's comments in terms of data. They're going
20 to have to be getting the map out, I guess, and
21 seeing each patient whether or not there's a
22 referral point within 60 miles of where they

1 live. And you go out West and there's a lot of
2 communities where that could, in fact, be the
3 case. So there's -- it turns down the ability to
4 make this reported correctly.

5 DR. PHELAN: But isn't that kind of
6 their obligation if they're going to be taking
7 care of the patient? There's Class 1 evidence
8 that happens. I know there's an issue with the
9 available resources, but I would imagine if I fix
10 someone's heart that maybe I should find out
11 where the closest rehab facility is where they
12 can get that kind of care and it again goes to
13 this idea of like, how do we push the idea of
14 better coordinated care for our patients, rather
15 than "Good luck."

16 MR. SLABACH: But I'm looking at this
17 as a reporting issue, so the physician writes the
18 order for a referral. The social worker, whoever
19 handles that, then translates it to the patient.
20 The patient then is discharged home and the
21 quality assurance director or whoever is doing
22 the data collection two weeks later has to go

1 through and figure out where this referral source
2 was going and if that patient was within 60 miles
3 of a cardiac center. How do they know -- they
4 may have to have to a map of all the cardiac
5 rehab centers to be able to see if that 60-mile
6 exclusion would be there.

7 It presents some issues and again,
8 we're not here to talk about the -- I guess it is
9 a matter of efficiency.

10 CHAIR OPELKA: I think you raise a
11 good point. I also think it's why God created
12 Google Maps. I can tell you my social worker can
13 do this.

14 All right, so we have the vote. So
15 this to support the motion to move this to
16 conditional given the data requirements.

17 MS. IBRAGIMOVA: So the question is
18 cardiac rehabilitation patient referral from an
19 in-patient setting, do you agree with the motion
20 for conditional support based on data
21 requirements? One, yes; two, no.

22 (Voting)

1 MS. IBRAGIMOVA: The results are 71
2 percent yes and 29 percent no.

3 CHAIR OPELKA: All right. So let's
4 move to Calendar 2. And this was the conditional
5 support for NQF review of testing data the
6 Medicare population and resolution of parsimony
7 concerns within the IQR program. These were the
8 proportion of patients hospitalized with an AMI
9 and a potentially avoidable complication,
10 similarly with pneumonia and similarly with
11 stroke. And it was during the index stay or the
12 30 day post-discharge period.

13 So any -- I'm sorry, Pierre, did you
14 have your card up?

15 DR. YONG: Thank you. I just wanted
16 to provide some background to the committee about
17 why we had put these on the MAP, just to help the
18 committee understand in your discussions.

19 These measures -- let me back up for
20 a second. We, in our discussions, are interested
21 in patient safety. That's a big priority for us.
22 We saw these measures as more encompassing of

1 movement towards sort of a measurement of all
2 cause harm than what we currently have in the
3 program. We understand that these measures have
4 not been tested in the Medicare population as of
5 yet and so there are some issues.

6 We also understand that they do
7 overlap with some insisting measures in the
8 program, but we did want the MAP's input about
9 the direction of these measures as potential
10 areas for the future for implementation in our
11 program.

12 CHAIR OPELKA: Thank you very much.
13 Michael?

14 DR. PHELAN: Pierre, do you mind
15 trying to explain a little bit about these
16 measures? And I think you don't have to do it
17 for one of them because they're all kind of
18 similar, these potential avoidable complications
19 during the index stay for each one. I don't
20 think we have to get into each one, but just like
21 the background of what was the thinking behind it
22 and I know in your comments you mentioned towards

1 all cause harm.

2 Some of us in the emergency medicine
3 field don't feel that patients presenting to the
4 emergency department represents a harm in and of
5 itself. Sometimes the only available resource
6 for many patients to come to in a 24/7 cycle, but
7 besides that, if you could help with me
8 understand a little bit that would be great.

9 DR. YONG: Sure. I'll get started and
10 if we have additional questions, you may ask them
11 and staff also will provide additional input.

12 So essentially, these measures and
13 they're all similar, as you indicated. They're
14 just different conditions, include a variety of
15 safety events that may occur related to that
16 condition. They capture both events that
17 happened during that hospitalization as well as
18 within the 30-day post-discharge, events that may
19 be related to the condition which are cited in
20 the materials include things like hyper- or
21 hypoglycemia, things like coma, things like
22 gastric ulcers which may develop or hemorrhage.

1 They also capture things including safety events,
2 so things like DVTs which are preventable or PEs
3 which are preventable are also included.

4 And they also include re-admissions as
5 well as emergency room visits during the post-
6 hospitalization stay. So they are encompassing
7 of different types of safety events as well as
8 readmission type events.

9 DR. PHELAN: And are they all weighted
10 equally or is there a difference in their
11 weighting?

12 DR. YONG: We have made a measure
13 development -- do you mind repeating the
14 question?

15 DR. PHELAN: How are the different
16 events weighted?

17 DR. RASTOGI: I'm Dr. Amita Rastogi.
18 I work at Francois de Brantes and the Bridges to
19 Excellence. We are the measure developers. And
20 as they were endorsed by the NQF as described by
21 Pierre Yong, exactly right. From the weighting
22 point of view, we just looked at them equally.

1 So there is no weighting. If you have one of
2 these potentially avoidable complications, it is a
3 yes. If you don't, it's a no. So you discount
4 all of the potential avoidable complications one
5 by one. And you just look at the proportion of
6 patients that that condition, say the AMI, how
7 many of them had this complication.

8 DR. PHELAN: Do you weight a hospital
9 readmission the same as a single ED visit with a
10 discharge home?

11 DR. RASTOGI: That's right. Any of
12 these -- if there's a readmission, it's counted
13 once. If they have a urinary tract infection
14 during the hospitalization, it's counted as a
15 one. Yes.

16 CHAIR OPELKA: Mitchell?

17 DR. LEVY: Sorry, I'm just trying to
18 understand. I'm looking for the list of each of
19 the pacts and it says examples. And in
20 particular, on this one for stroke, the idea that
21 an acute MI is an avoidable complication in
22 stroke patients, not necessarily true. And I

1 realize that's why it's a potentially avoidable
2 complication, but I'm just trying to get a sense
3 of how you could sort that out?

4 There are some clear EDT, so we'll
5 agree that that's an avoidable complication. An
6 MI is much harder case to make. And how is that
7 not going to be lumped together especially if the
8 hospital has a more elderly population or at-risk
9 population? Does that come out in the wash in
10 the quartiles? I'm not sure I'm articulating
11 this correctly, but I'm nervous about the P of
12 the pact in this.

13 DR. RASTOGI: That's right. And these
14 questions were debated very extensively during
15 the NQF endorsement process, especially, for
16 example, coma in the setting of stroke. It is
17 listed as a potentially avoidable complication.
18 So the neurosurgeons did not like that. And the
19 question that was raised -- I'm a cardiothoracic
20 surgeon by training myself and I've done heart
21 and lung transplants.

22 And the question that comes is can you

1 avoid one single coma? If yes, then it's
2 potentially avoidable. Just like death. Can you
3 avoid death? Some of the deaths are not
4 avoidable, but some are. So we discount them.
5 It's not that you overtly punished for one of
6 them. That's why it's a comprehensive picture.
7 Each one gets weighted and overall if a
8 particular hospital is having more complications
9 than another, then it is a good measure of a
10 comprehensive performance of that hospital.

11 DR. LEVY: So you're saying it comes
12 out in the ranking of the quartiles in terms of
13 how you perform. If you are performing in the
14 lowest quartile consistently because you have a
15 pact even if seems like not related, the fact
16 that it's coming up a lot raises the question of
17 whether it is avoidable.

18 DR. RASTOGI: That's right. And we
19 don't really stratify by quartiles. We just do a
20 continuous count.

21 CHAIR OPELKA: Just so everyone is
22 clear, I mean this category is a little bit

1 wordy. These are NQF endorsed below 65, so you
2 could say that what we're seeking is that this is
3 a change in the measure specifications that
4 require NQF endorsement as well. That's
5 basically what we're stating in our proposal
6 here.

7 Nancy?

8 MS. FOSTER: So, Frank, the second
9 part of the caveat or the conditions for this has
10 to do with alignment with the -- what word did we
11 use here?

12 CHAIR OPELKA: Parsimony.

13 MS. FOSTER: Parsimony was the
14 existing measures. And I'm struggling here. On
15 one hand, sort of having an over-arching measure
16 may be a good thing, but the fact that these
17 don't -- they identify something that someone
18 calls potentially avoidable but not necessarily
19 avoidable gives me heartburn because we want to
20 focus attention on those things that we know are
21 really avoidable. And we have a series of
22 measures already in programs built on a framework

1 of having readmissions sort of separate from
2 value-based purchasing, separate from hospital-
3 required conditions.

4 So it seems to me it would be really
5 hard to think about how to use these in ways that
6 would add to the dynamic of pushing forward for
7 quality improvement. That in fact, we may be
8 better off with the separate readmission
9 measures, more direct HAC measures and so forth
10 at this stage of our progress, so that we are
11 targeting people's quality improvement efforts on
12 things that we can say with some confidence
13 really need improvement. Is that understandable?

14 CHAIR OPELKA: Dolores?

15 MS. MITCHELL: Just very briefly, I
16 will not have the temerity to deal with the
17 technical issues since the developer is here and
18 it's above my pay grade anyhow. So just to say
19 that I think given the amount of people who are
20 involved or who are patients in these categories,
21 it may not be perfect data and I understand that
22 NQF is doing some further testing on -- not NQF -

1 - CMS is doing further testing, which, on the
2 Medicare data. But if that is, in fact, the
3 case, it seems to me the importance and the
4 widespread nature of the people who are affected
5 by this that we ought to go ahead. I speak as a
6 purchaser because I'm paying for a lot of it.

7 DR. GOODRICH: Just to clarify, so as
8 specified, this is 18 to 65, hospital programs,
9 IQRs and all payer programs, we can use data from
10 multiple age ranges, but we would, of course,
11 need to also include the Medicare age range.
12 This is a measure that as specified at this point
13 in time is not something we could use immediately
14 in the program, but we learned about this
15 measure. We're very intrigued by it and wanted
16 to get the MAP's input on the direction of this
17 measure which ultimately, if we were to use it,
18 would, of course, need to also include and be
19 tested on the Medicare population.

20 CHAIR OPELKA: Emma.

21 MS. KOPLEFF: Thank you, Dolores and
22 Nancy for your comments. I think Nancy offers a

1 useful framing or something to consider that on
2 the one hand we have patient safety which is a
3 priority area and we have a number of individual
4 measures addressing those issues. And what this
5 measure is offering is again to Pierre's summary,
6 more of an all cause harm kind of measure. And
7 just really -- I'm really trying to channel Helen
8 Haskell and do my due diligence here as her
9 representative. For her and Mothers Against
10 Medical Error and other consumer groups that are
11 really focused on patient safety, there is some
12 sort of culture shift, I think, being supported
13 by the idea of having a measure that really
14 addresses a wide range of all encompassing
15 potential safety issues as this measure tries to
16 do.

17 I hear the issues about what is
18 avoidable or not avoidable and I think those are
19 relevant issues for the clinicians. And I'm just
20 offering that from -- on the flip side, a lot of
21 these measures, the measures as we've spoken
22 about, aren't useful for consumers today. I

1 think this one could be. It's getting at that
2 idea that you really have a patient having the
3 ability to ask what are my chances or is X
4 hospital versus Y hospital safer for me and
5 trying to use that information.

6 CHAIR OPELKA: Marty?

7 MR. HATLIE: I totally agree with Emma
8 and I just want to say it more strongly than Emma
9 said it. I do think this is very, very important
10 to consumers. I think there is a culture shift
11 going on. I don't think patients or family
12 members of patients want to see their loved one
13 fear in the hospital. It's really good at one or
14 two or three things, but not good at other
15 things. So I wanted to just strongly support and
16 say that this again reflects a terrific amount of
17 feedback we got during the Partnership for
18 Patients, not just from patients and families,
19 but from hospitals that we should be moving to
20 engage leadership and some of our healthcare
21 workers and everyone in these all across our
22 measures.

1 I know there's a lot of data issues.
2 I'm hopeful that those will be looked at
3 carefully, but I want to support the direction of
4 this very, very strongly.

5 CHAIR OPELKA: So let me just clarify
6 for the committee. The request of you right now
7 is do you want to move this out of its current
8 consent calendar?

9 MR. HATLIE: I do not.

10 CHAIR OPELKA: We're vetting the
11 measures and if we're good with the measures on
12 the consent calendar as they are, that's a
13 different discussion. For now, the question is
14 do you want to keep these in this consent
15 calendar or do you want to move them?

16 MR. HATLIE: I strongly support with
17 keeping it on this consent calendar.

18 CHAIR OPELKA: Okay. Wei, was yours
19 up? You're down. Dana.

20 MS. ALEXANDER: So I would, I guess,
21 support encouraging direction, but I stand with
22 Nancy on this is that while I think it's an

1 interesting measure, I think it has some
2 relevance where are today in all of our
3 priorities in front of us. But I think that
4 there are other measures that are in place with
5 readmission support and so forth that are in a
6 better position.

7 CHAIR OPELKA: So am I hearing a
8 request to move?

9 MS. FOSTER: So I will move that we
10 move this from the current place on the consent
11 calendar to encourage further development.

12 CHAIR OPELKA: Okay, that's Calendar
13 7.

14 MS. FOSTER: That would be Calendar 7.

15 CHAIR OPELKA: Okay.

16 MS. FOSTER: And we've already
17 basically covered my rationale, but I think we
18 may find some surprises in the Medicare
19 population which has not yet been tested that
20 makes this measure further refined.

21 In addition, I note that even when it
22 was submitted to NQF, and endorsed by NQF without

1 this, surprisingly to me, there has been no
2 reliability testing done on this. So to your
3 point, Emma, I don't know if this actually gives
4 patients a signal they can use, a signal that's
5 accurate about which place is safer or not. So
6 we need to work on that.

7 CHAIR OPELKA: All right. Is that a
8 second?

9 DR. ENGLER: I'll second.

10 CHAIR OPELKA: Okay.

11 DR. ENGLER: I'll second. And my
12 second is because of what Nancy just managed and
13 I think is important. This is a very important
14 consideration. I'd be very, very interested in
15 moving this ahead, looking at the results of the
16 tests and the field testing in particular to get
17 to Mitchell's point and also to Marty's point on
18 whether or not this is a big P or a little p. I
19 think that's really important.

20 I also believe, too, that we want to
21 make sure because I've spent a lot of my time on
22 harm reduction activities. And I know we're

1 growing that field outward to encompass more and
2 more potential harm events. And we're all in
3 favor of doing that. I just really would like
4 some testing being done on this. And moving it
5 to a testing category would help us with that.
6 I'd be more comfortable. Thanks.

7 CHAIR OPELKA: Pierre?

8 DR. YONG: Thank you. Can I make two
9 comments? One was we very much appreciate the
10 discussion because I think that's what we wanted
11 to hear was whether this kind of measure was
12 valuable. And going back to, I think, one of the
13 points made earlier about the value of having
14 more targeted measures versus having a more
15 global measure, I would throw out there another
16 idea to consider is that they're mutually
17 exclusive things.

18 You can have potentially a global
19 measure and then also have additional reporting
20 on more specific conditions as well and that way,
21 for those who find the global measure more
22 helpful, that may be one place where you start

1 and for those who want more targeted information
2 may be able to then dig deeper. So that's sort
3 of one point.

4 I think the second point I just wanted
5 to ask a clarification question about this idea,
6 this motion to move to encourage direction
7 because I think my understanding of when we've
8 used that previously it's been used for measures
9 which have not been fully developed. This is a
10 fully developed and endorsed measure has not been
11 tested in the Medicare population.

12 CHAIR OPELKA: It is not endorsed. It
13 is not endorsed in its population, so the measure
14 fails in the Medicare program. It's been
15 endorsed -- measure specs as is have passed, but
16 not for this program. So this would need to be
17 tested for this population, but it would need to
18 be tested to show reliability and validity in
19 this population. So it's NQF endorsed at this
20 level.

21 MR. AMIN: Can I add to that, Frank,
22 as well?

1 CHAIR OPELKA: Yes.

2 MR. AMIN: I was going to raise that
3 as a point as well. Just so that everybody is
4 following along, including members of the
5 audience, we do have three categories for fully-
6 developed measures, two more measures that are
7 under development. Nancy's motion is a category
8 for measures under development. Now the way that
9 we've characterized that is fully developed
10 measures and fully tested measures.

11 And in this case, since we're looking
12 at these measures being tested for the Medicare
13 population, it wouldn't go all the way to the
14 second route. While they're obviously fully
15 endorsed, specified, and tested for the under 65,
16 what this committee is looking for is that to be
17 done for the 65 plus crowd. And as I understand
18 Nancy's motion, that's why it's being moved in
19 addition to other concerns that Nancy has raised
20 to be encouraged for continued development
21 category.

22 Is that clear? I just want to make

1 sure that that's clear. So this is an order.
2 And it is also consistent with our framework for
3 how we've divided measures into fully developed
4 and specified and then those that are quote, I
5 use that term very loosely which is measures
6 under development, and fully tested. And since
7 this measure hasn't been formally reviewed for
8 the testing under the Medicare population, it
9 still fits within the rubric that we've been
10 operating. Thank you.

11 CHAIR OPELKA: Richard?

12 DR. BANKOWITZ: So I want to support
13 this notion that we move it for consideration for
14 further development, particularly because I'm
15 concerned about the reliability testing. This is
16 incredibly important. It's a very important
17 measure. Do we need to understand potentially
18 avoidable compilations? Absolutely. But this is
19 a very difficult thing to measure.

20 And I want to let CMS know that as
21 they consider this measure, they really look at
22 the sensitivity of this measure and the

1 predictive value of this measure. I think it's
2 probably, right now as it stands, a great measure
3 for quality improvement because in the case of
4 the coma that we talked about. Yes, if we find
5 one coma out of five, sure, I would like to know
6 about that. But do I want five comas reported
7 where four of them are false positive? No, I
8 don't think that serves anyone's interest. So we
9 really need to consider the false positives that
10 we're going to acquire here.

11 The other thing that we need to
12 consider is as you look for these complications,
13 and you simply tally them up, a lot of these
14 things proceed in a causal chain. So you may
15 have a pulmonary embolism which may be
16 accompanied be accompanied by atrial fibrillation
17 and there may be a fluid electrolyte disturbance.
18 So you've already gotten three things and
19 probably four if we consider respiratory
20 abnormalities. And we need to tease apart what's
21 real and what's just sort of part of this causal
22 chain that we're going to tally up. So those two

1 things need to be really looked at carefully.

2 CHAIR OPELKA: Michael?

3 DR. RASTOGI: I'd like to add.

4 CHAIR OPELKA: Michael? I don't want
5 to get into measure specs. This has to be
6 pertinent to the discussion of movement from one
7 program to another.

8 DR. RASTOGI: Just a clarification on
9 that last point. If the patient had any of the
10 complications, it's just counted as one. Yes.
11 So if they had five complications or one, it's
12 counted as yes, this patient had a complication.

13 CHAIR OPELKA: Okay. Michael?

14 DR. PHELAN: First, can we just look
15 at the measure itself on this --

16 CHAIR OPELKA: There's three of them.

17 DR. PHELAN: One of them, just in the
18 description at the top of it. I have it on mine.
19 I think a little bit -- right in there. I was
20 looking for -- for some reason I thought there
21 was a weighting scheme. It's 50-50. All right.

22 But just to the point, I think this is

1 incredibly useful data, both for patients and for
2 hospitals. I think hospitals would really like
3 to know, especially the comparative data, to see
4 where they fall to be able to identify places so
5 they can actually do improvements. So I just
6 want to add that as -- I think this is the
7 natural progression of looking at big, you know,
8 HACs and things like that.

9 And then looking at just a much larger
10 data set on disease condition specific. And I'm
11 glad Pierre is talking about even a larger, just
12 all potentially avoidable complications or acute
13 care issues that happen after a 30-day admission.
14 I think this is incredibly important data and I'm
15 hearing at least the patients are going to want
16 this data. And I'm certain the hospitals want to
17 do it so they can try to improve the care they're
18 giving to their patients.

19 CHAIR OPELKA: Emma?

20 MS. KOPLEFF: Taroon, thank you for
21 offering some further explanation on the
22 classifications. I'm still just struggling a bit

1 because I am in thinking about the fact that we
2 will eventually go to a vote on something on this
3 motion, I'm not actually seeing a difference
4 between the motion and what I'm reading in the
5 support guide which says conditional support
6 pending NQF review of testing data in the
7 Medicare population in resolution of parsimony
8 concerns, etcetera, etcetera. You know what it
9 says.

10 So just before we go to the vote, I
11 hope we can clarify. I think we're sort of
12 mincing some words and a lot of us are saying I
13 think the same thing about --

14 CHAIR OPELKA: Let me clarify. So
15 where it stands today, the conditional support
16 with review of further testing really translates
17 into it has to go back to the NQF for
18 endorsement. It's not endorsed. And to do that,
19 they would have to test it in this age group and
20 look for reliability and validity testing in the
21 age group. So that would be the first part of
22 that condition.

1 The second part of that condition is
2 it would then go through a harmonization exercise
3 with current measures in the field. And somebody
4 would fall off. A measure could potentially go
5 away. So it's looking at the current measures
6 that would be looking at these sorts of things
7 and this is to the point that Nancy and Dana were
8 talking about previously. So it effectively
9 would be a harmonization exercise which says
10 would we take a current measure and replace it
11 with this measure once it's had NQF endorsement?

12 The motion that we have is to
13 encourage further development of this measure, of
14 these three measures which really means taking it
15 into the NQF process, having it go through the
16 NQF endorsement and then future, bringing it back
17 to the MAP. So that's the difference.

18 MS. KOPLEFF: I'm still getting my
19 head around that, but thank you.

20 CHAIR OPELKA: Okay. Sean?

21 DR. MORRISON: I'm still getting my
22 head around that, too. I do want to, I think I

1 want to support the measure because I'm very
2 concerned about not so much the reliability, but
3 the validity of this measure in a Medicare
4 population with multi-morbidity that intersect
5 rather than a younger population where it's much
6 easier to tease out what is a complication of an
7 event versus what is a result of a comorbidity or
8 multiple comorbidities.

9 And the fact that this hasn't been
10 tested in the over-65 population, both for
11 reliability and validity, I'd like to see that
12 NQF endorsement, but I think I'd also like to see
13 it come back here.

14 CHAIR OPELKA: Okay. So you're
15 supporting the motion.

16 DR. MORRISON: Yes. I've got my head
17 around it. Yes, I'm supporting the motion.

18 CHAIR OPELKA: Okay. Marty?

19 MR. HATLIE: Frank, so help me with
20 this, too. The reason that I am not supporting
21 the motion and support the original
22 recommendation is that I'm concerned that by

1 supporting the motion it would slow the process
2 down. I don't know if that's an accurate
3 perception on my part. Because I do think this
4 is a movement, a direction that I think many of
5 the hospital associations in this room already
6 support. So I want to send a strong signal that
7 this is the direction that I think patients and
8 hospitals are going and that's why I support the
9 current recommendation.

10 CHAIR OPELKA: You got it right.
11 You're correct. It would add another MAP cycle
12 into it if we just encourage rather than the
13 current proposal which basically states once
14 there's NQF endorsement, it would then go through
15 a parsimonious harmonization process. Let's look
16 at other measures that are similar and decide
17 which one we want in the program.

18 DR. MORRISON: Thank you.

19 CHAIR OPELKA: Okay. Wei?

20 DR. YING: First of all, a
21 clarification question. What is the difference
22 between what we are proposing, no, actually, why

1 can't we put it into Calendar 5 which is
2 conditional support ending in NQF review and
3 endorsement? Isn't that what we're trying to do?
4 We want NQF to look at the data coming from
5 Medicare population and if it works, we will
6 endorse.

7 CHAIR OPELKA: That's a separate
8 motion.

9 DR. YING: Okay. So then to echo some
10 of the comments made earlier, I like this measure
11 because it's at the global level. Just like the
12 readmission measure, ideally we want something at
13 the global level for each individual and each
14 purchaser or hospital to look whether they're
15 having an issue. And if they have an issue,
16 there will be an individual measure downstream
17 for them to figure out where is the most
18 problematic thing that they should be targeting.
19 Without this global view it's very hard for us to
20 know which hospital has an issue as a red flag.
21 We have to look at individual measure which
22 doesn't represent a big picture view from that

1 point of view.

2 And then in terms of the controversy
3 around the potentially avoidable, that has always
4 been the issue from Day 1 of these measures. I
5 think the developer has heard the comments during
6 the years, and they have tried to make that
7 somewhat better and to go back to what Mitchell
8 was saying, if you look at the measure
9 specification, again, the developer can correct
10 me if I'm wrong, did you have a weighting scheme
11 in terms of expected pact rates, is that right?

12 So it's not a straight-forward
13 observed pack. They sort of have an OE ratio
14 type of concept in there. So that may address a
15 little bit in terms of which potentially
16 avoidable complication is outweighing the other,
17 but in terms of the clinical capacity.

18 CHAIR OPELKA: Mitchell?

19 DR. LEVY: Having expressed my
20 concerns, I am very strongly in support of the
21 measure. I do --

22 CHAIR OPELKA: I'm sorry, the motion

1 or the measure?

2 DR. LEVY: So the measure as it stood.
3 What I'm a little lost on is the motion looks
4 like what the calendar is and that's where I'm a
5 little --

6 CHAIR OPELKA: No. The motion --

7 DR. LEVY: So that's not the motion.

8 CHAIR OPELKA: I can't -- see, let's
9 see, conditional support, review --

10 DR. LEVY: That's actually the
11 calendar then.

12 CHAIR OPELKA: That's the calendar.
13 The motion is to remove it and encourage further
14 development.

15 DR. LEVY: Right.

16 CHAIR OPELKA: And it's different from
17 cure NQF endorsement where it currently sits on
18 the calendar, on Calendar 2. The reason it's on
19 Calendar 2 is there are competing measures. So
20 if we promote NQF endorsement, then there's a
21 risk of us adding another measure that's
22 overlapping with other measures in the program

1 and therefore there should be a parsimony
2 exercise, a harmonization exercise to pick best
3 in breed so that we don't have overlap. It
4 didn't go into Calendar 5 which was simple NQF
5 endorsement and put it in the program. It went
6 into Calendar 2 which is NQF endorsement and then
7 harmonization.

8 The motion is to remove it from 2 or
9 5 and put it in 7 which is to encourage this
10 direction, get NQF endorsement and bring it back
11 to the MAP which was Marty's point, "Does that
12 slow it down?".

13 DR. LEVY: Right.

14 CHAIR OPELKA: And it does.

15 DR. LEVY: Yes, great. One more
16 question.

17 CHAIR OPELKA: Did I get all that
18 right?

19 DR. LEVY: Yes, that helped, at least
20 for me that clarified what the question is. The
21 last thing I have is this says review of testing
22 in the Medicare population and the measure is for

1 18 to 65. So is that not a --

2 CHAIR OPELKA: So we would be
3 respec'ing the measure. This is now the measure
4 is spec'd today. The reason it has to go back to
5 the NQF is that it would be respecified to
6 include a new population which requires
7 additional reliability and

8 DR. LEVY: Great.

9 CHAIR OPELKA: Okay? Nancy.

10 MS. FOSTER: Very quickly, if Kate and
11 Pierre are looking for a signal, I think you've
12 heard it from others, but a very clear signal
13 that we'd like to send is we would like a broad
14 based harm measure. I know you're aware of at
15 least one other that's in the process of being
16 developed. There are others in the process of
17 being developed. They are all worthy of
18 consideration. Not all are worthy of
19 implementation simultaneously. That would be
20 problematic. But getting to a place where we
21 have a broad based harm measure would be a good
22 thing.

1 The question, of course, for me are
2 the two that I raised earlier. Are they fairly
3 targetting those things that actually are
4 preventable harm? And are they doing so in a
5 broad population? Because that's the sweet spot.
6 And it's hard to judge these three measures alone
7 when I know others are being developed with the
8 same concept, but very different structures and
9 getting to a place where we know what's the right
10 measure for inclusion in this program, that
11 doesn't step all over the readmission measures
12 and do other things that may be confusing rather
13 than helpful in getting people engaged in
14 reducing harm would be my goal.

15 CHAIR OPELKA: Dolores?

16 MS. MITCHELL: Two factual questions.
17 First of all, who does the harmonization? Us or
18 NQF?

19 CHAIR OPELKA: That's unclear to me.
20 I think it goes to the NQF. I don't think it's a
21 function that we perform.

22 MS. MITCHELL: Secondly, I take it

1 that there's some concern about some other
2 measure, perhaps falling off that list, the
3 current NQF list. I take it it is also possible
4 that this measure, because it's broader might be,
5 in fact, responsible for that because it covers
6 that other existing measure in which case what's
7 the harm? What you've done is accomplish what
8 you wanted to accomplish both (a) -- and it's not
9 an extra step, it takes place simultaneously,
10 doesn't it? Or immediately after if NQF were to
11 vote affirmatively, it would take place before it
12 got sent back here?

13 CHAIR OPELKA: No. If Calendar 2 were
14 the calendar, it wouldn't come back here. It
15 would go to the NQF if it's endorsed. If it's
16 respecified and endorsed, it would then go
17 through a harmonization process that the NQF
18 would have to define.

19 MS. MITCHELL: Endorsed by us or --

20 CHAIR OPELKA: By NQF.

21 MS. MITCHELL: By NQF, yes, okay.

22 CHAIR OPELKA: Not us. So the

1 endorsement process that the NQF would take a
2 respecified measure, look at the testing and
3 reliability and vote on it. Passes that
4 endorsement process, then the NQF would have to
5 take a harmonization process or CMS would have to
6 take a harmonization process to look at like-
7 minded measures to get to a parsimonious step.
8 Apply that rules logic and that would be the new
9 measures in this space.

10 MS. MITCHELL: Okay. But I don't see
11 any harm should it result in some other measure
12 apparently being subsumed under this larger
13 measure falling off the list. It could be a good
14 thing.

15 CHAIR OPELKA: So you're speaking for
16 Calendar 2 against the motion?

17 MS. MITCHELL: I'm speaking what?

18 CHAIR OPELKA: For Calendar 2 against
19 the motion?

20 MS. MITCHELL: Against Nancy's motion,
21 sorry, yes.

22 CHAIR OPELKA: Right.

1 MS. MITCHELL: Yes.

2 CHAIR OPELKA: Okay?

3 MS. MITCHELL: Yes.

4 CHAIR OPELKA: All right, Andrea.

5 DR. BENIN: I think that these types
6 of measures can potentially become very
7 interesting over time and the harm measures are
8 really tricky to try to build and I think that
9 this could be potentially helpful, but it
10 obviously, to me, needs more development.

11 In particular, I would be interested,
12 and this is sort of a note for the measure
13 developers that the ability of this measure to
14 discriminate because in the binary nature of of
15 the numerator makes me, with the number of things
16 that can give you the binary yes, I wonder if 80
17 percent of the patients are going to have this as
18 a yes or what does that ultimately look like.

19 And I don't need to hear that
20 conversation now, but I would just say in your
21 opportunities to develop and improve it, I think
22 that ability to discriminate would be relevant

1 because that is often one of the challenges when
2 we use harm measures in reality and they are
3 these compilations of things, they're not super
4 helpful for improvement and we end up peeling
5 them apart in a lot of different ways, but we use
6 them ultimately anyway, so there's a lot of
7 dichotomies about these types of measures. But
8 sometimes you really lose the ability to
9 discriminate what's going on because you don't
10 actually know if your problem is a bunch of DVTs
11 in your ICU or a bunch of readmissions.

12 So I think that they are sort of --
13 it's a mixed bag, these types of things. So I
14 would put this in the development category for a
15 lot more consideration. I think it's a really
16 interesting concept.

17 CHAIR OPELKA: Richard?

18 DR. BANKOWITZ: So I think again the
19 thing to consider about moving this into the
20 consideration for further development is that
21 this aspect of trying to use ICD-9 coded data to
22 come up with complications is an evolving

1 science. It's work in progress and there is no
2 one acceptable way of doing this. Every time
3 people do it, they come up with numbers of false
4 positives and numbers of false negatives.

5 And I do think the work that Bridges
6 for Excellence is doing this year is very
7 important and needs to continue. But it's not as
8 if we have the standing NQF endorsement. It's
9 not as if we have a universally acceptable way of
10 looking at harm in a way that is helpful to
11 hospitals without generating all kinds of false-
12 positive work. So that's why this needs more
13 development. I don't think it's ready to be
14 moved into reporting even notwithstanding NQF
15 endorsement.

16 CHAIR OPELKA: Thank you. Cristie.

17 MS. TALLANT: Well, my thoughts on
18 this are that I prefer where it sits in Calendar
19 2 and I think that a lot of the questions that
20 are being asked here are the very questions that
21 would be asked during the NQF endorsement
22 process. And I think that the discussion we're

1 having here can actually help inform the
2 endorsement process. So once it's respec'd for
3 the 65 and older population, once it's tested, it
4 has to really answer the very questions that
5 we're all asking here. And if the endorsement
6 process says it's not ready for prime time yet
7 because it needs more development, that is
8 certainly an opportunity that can happen during
9 that endorsement process.

10 So I think that that's really where it
11 sits right now would be what I would support
12 keeping it where it sits.

13 CHAIR OPELKA: Emma?

14 MS. KOPLEFF: I know I've said I
15 support where it sits, but thank you all for
16 helping me think through what that means. And
17 just to spell out sort of the time line thing
18 going on in my head to see if that again helps
19 sort of frame where I'm coming from and where
20 others have been coming from.

21 I am -- by keeping it in Calendar 2,
22 I think we are appropriately putting trust in

1 both the NQF process and CMS processes to say
2 that the endorsement process looks at the
3 scientific robustness of the measure. And as
4 part of the regular process looks at
5 harmonization issues with similar measures. So
6 that's just sort of an amendment, I guess I would
7 make to how it was framed earlier. I felt as if
8 it sounded like it was some special parsimony
9 exercise for the endorsement process.

10 The endorsement process looks at
11 competing measures. So correct me if there's
12 something I'm missing there because I am
13 attributing that trust to the endorsement side.

14 Also, on the CMS side, I'm putting
15 trust in the fact that following endorsement, if
16 there are still concerns or issues about overlap
17 with existing measures which may or may not be
18 appropriate because to Pierre's point there may
19 be specific individual potentially avoidable or
20 avoidable complications where we do want the
21 ability to either drill down within this measure
22 or have existing individual measures.

1 So I'm trusting that either through
2 the MAP process or public comments and the other
3 opportunities CMS always provides that in keeping
4 it in Calendar 2, we're not sort of condemning
5 this measure to a fast track of support without
6 really thorough consideration of the
7 implications, but we're giving it a shot to
8 potentially lead the way in offering more of the
9 all cause harm kind of concept.

10 CHAIR OPELKA: So we've had an awful
11 lot of discussion about this measure and if
12 you've got further comments, brevity is
13 important.

14 Wei, did you have something? Richard?

15 DR. BANKOWITZ: I just wanted to
16 reiterate NQF endorsement looks at whether the
17 measure is useful for a purpose which may be
18 quality improvement which may involve members of
19 false positive. It does not say is this measure
20 suitable for something we want in public
21 reporting. That's not what NQF endorsement does.

22 MS. KOPLEFF: But the current criteria

1 do speak to accountability. So the current NQF
2 criteria actually to my understanding don't look
3 at measures for quality improvement. They are
4 for accountability purposes.

5 CHAIR OPELKA: Thank you, both.

6 MR. AMIN: It looks at quality
7 improvement and accountability applications which
8 includes public reporting and payment
9 applications as well.

10 However, it doesn't look at a
11 particular instance. We're not looking at it for
12 the purposes of IQR. So it doesn't -- that's
13 what it looks at. It's more of a broad question,
14 but it includes both categories.

15 CHAIR OPELKA: It's almost a question
16 of do you want to put this in the measure library
17 and then we are pulling the books out of the
18 library and taking them out for public use.

19
20 All right, Michael?

21 DR. PHELAN: Yes, I think Cristie and
22 Emma spoke eloquently to the process here. We're

1 moving it from the IQR calendar and not relying
2 on the typical NQF process that are going to
3 answer all these questions about is it reliable?
4 Is it valid? Does it work in the 65 and older
5 population? I think it just depends on what kind
6 of message we want to send regarding this.

7 Do we want to say well, we're just
8 going to knock this down the road again for
9 another two years? Are we going to say, you know
10 what, a good measure, patient safety is a big
11 priority. If the NQF committee that's going to
12 review whether this measure that the measure
13 developer is going to propose goes through the
14 process endorsing it to me is really going to be
15 a no brainer because if it gets NQF endorsement,
16 and they say it's pretty reliable, it's valid,
17 it's good for quality reporting, I think it moves
18 right into the category we want it to say when we
19 support it and go forward from there.

20 CHAIR OPELKA: So we need to move
21 forward on a vote on this. The motion is to move
22 this to the encourage for continued development.

1 And it's for all three of them.

2 MS. IBRAGIMOVA: So the question is
3 proportion of patients hospitalized with AMI that
4 have a potentially avoidable complication during
5 the index stay or in the 30-day post-discharge
6 period. The proportion of patients hospitalized
7 with pneumonia that have a potentially avoidable
8 complication during the index stay or in the 30-
9 day post-discharge period hospitalized with
10 pneumonia. The proportion of patients
11 hospitalized with stroke that have a potentially
12 avoidable complication during the index stay or
13 in the 30-day post-discharge period.

14 Do you agree with the motion to move
15 to encourage for further development? One, yes,
16 Two, no.

17 (Voting)

18 MS. IBRAGIMOVA: The results are 33
19 percent yes, 67 percent no.

20 CHAIR OPELKA: So it stays on Calendar
21 2. It's been a rich discussion. I think you
22 need a break. So let's go for ten minutes.

1 (Whereupon, the above-entitled matter
2 went off the record at 11:10 a.m. and resumed at
3 11:35 a.m.)

4 CHAIR OPELKA: Hopefully, you are
5 recovered. Let's grab our seat again.

6 So, the team up here, we are learning
7 a lot about these consent calendars. And I think
8 what we learned in this round today is that we
9 created too many conditional consent calendars.
10 And what we should do is consider just having one
11 conditional consent calendar, and then, capture
12 your conditions, and rather have a subset list of
13 conditions that we can apply to a conditional
14 consent calendar.

15 We think that would be more efficient
16 than what we have been doing. Now we don't know
17 that for a fact. So, we thought we would do some
18 testing.

19 The test is we are now going to
20 collapse the remaining conditional calendars,
21 consent calendars, into one, so that we will have
22 one conditional consent calendar of these

1 remaining three, which were the measures should
2 be quickly replaced with a measure assessing
3 results of a survey of culture of patient safety.
4 And then, the conditional support for the
5 measures that were applicable at the facility
6 level and resolution of the duplicative nature of
7 the measures with falls and trauma, and the
8 component of PSI-90, and the conditional support
9 pending NQF review and endorsement. So, that is
10 calendar 3, 4, and 5.

11 So, these three calendars are now the
12 conditional consent calendar, and we will apply
13 the conditions that you wish to these as they
14 remain on here. So, the question before you is
15 if these are the measures that are conditional
16 supported, are there any you wish to move to the
17 support, do not support, or encourage continued
18 development?

19 Jack?

20 DR. FOWLER: Well, as we were
21 discussing, we don't have access to all the
22 evaluative stuff that has gone on. But I would

1 like to move the patient fall rate to do not
2 support, the total fall, not the one with
3 injuries. I find it implausible to think that
4 anybody can get a reliable measure of how often
5 that happens if it doesn't result in a medical
6 event, and I just don't see how people would know
7 that. And at least from a patient perspective, I
8 would find that implausible as a thing of value.
9 So, that is my motion.

10 CHAIR OPELKA: Okay. Second?

11 (Seconded.)

12 A second. Thank you.

13 Karen?

14 MEMBER FIELDS: I would like to
15 address the spine fusion measure. I thoroughly
16 support the concept of episode-based payment
17 systems. However, without understanding what the
18 risk stratification is in that patient
19 population, it is an undue burden on cancer
20 patients. Spinal fusions are common procedures
21 in patients with spine mets, but to have a
22 bundled payment around chemotherapy and radiation

1 therapy is not an appropriate, without being
2 stratified for that, is not an appropriate
3 stratification -- or bundled piece.

4 CHAIR OPELKA: So, do not support?

5 MEMBER FIELDS: I would say either
6 conditionally support or do not support,
7 depending on if it is a risk stratification that
8 is in there.

9 CHAIR OPELKA: It is in conditional
10 now.

11 MEMBER FIELDS: So, I will say do not
12 support.

13 CHAIR OPELKA: Do not support. Thank
14 you.

15 Andrea?

16 MEMBER BENIN: I have a process
17 question here, Frank, about if we don't like the
18 condition, what do you want us to do, move a
19 different condition or move a removal of the
20 condition or?

21 CHAIR OPELKA: Well, if you want to
22 keep it in conditional support and you would like

1 to clarify the condition, we can.

2 MEMBER BENIN: Okay.

3 CHAIR OPELKA: If you want to move it
4 from conditional support to one of the other
5 categories, we can do that. What we want to
6 capture in your discussion of these is what are
7 your conditions. You can pull from any one of
8 the condition lists, and we will just keep it in
9 there based on your condition.

10 MEMBER BENIN: So, this is essentially
11 a structural measure about participation in a
12 Patient Safety Culture Survey, which is
13 essentially, I believe it is still a Joint
14 Commission requirement to do yearly or every 18
15 months or something, and is routinely done to
16 help move safety culture.

17 But the condition is not appropriate.
18 It is not appropriate to have the results of that
19 survey publicly reported. There are actually two
20 different -- I mean, do you want me to go into it
21 now?

22 CHAIR OPELKA: So, you support the

1 conditional support, but what would be your
2 condition?

3 MEMBER BENIN: I think I don't have a
4 condition in mind.

5 (Laughter.)

6 I am supporting the general idea of
7 it.

8 CHAIR OPELKA: So, you would want to
9 move it to support?

10 MEMBER BENIN: Sure. I think so.

11 CHAIR OPELKA: Okay.

12 MEMBER BENIN: I've been weighing for
13 the past 24 hours which way to go with this, but
14 I'm fine with this measure, only as a structural
15 measure, though. I mean, the condition for me is
16 that it would remain as a structural measure.

17 CHAIR OPELKA: Okay.

18 MEMBER BENIN: Let me put that --
19 conditional support in that it would be sort of
20 remaining as a structural measure in that way.

21 CHAIR OPELKA: It is a structural
22 measure as specified. You would support the

1 structural measure, and you are not in favor of
2 where it stands with the conditional support by
3 opening up the results?

4 MEMBER BENIN: Right. Right.

5 CHAIR OPELKA: Yes.

6 MEMBER BENIN: So, I would -

7 CHAIR OPELKA: Support the measure as
8 specified?

9 MEMBER BENIN: Right, without the
10 addition of the results being added.

11 CHAIR OPELKA: Okay.

12 MEMBER BENIN: That would be my --

13 CHAIR OPELKA: So, I need a second on
14 that.

15 (Seconded.)

16 Second. So, we have a second. Okay.
17 Nancy?

18 MEMBER FOSTER: Thank you, Frank.

19 I would like to move all three of the
20 hospital 30-day, all-cause, blah, blah, blah,
21 blah, blah measures to do not support.

22 CHAIR OPELKA: Okay. Second?

1 MEMBER BANKOWITZ: Second.

2 CHAIR OPELKA: All right.

3 Dana?

4 MEMBER ALEXANDER: Yes, and if you
5 said this, Frank, and I missed it, but are you
6 making a call to move only those calendars on
7 conditional support or any of these such as the
8 do not support and encourage continued
9 development, if we have a change?

10 CHAIR OPELKA: Just the conditional
11 support ones.

12 MEMBER ALEXANDER: Okay. Thank you.

13 CHAIR OPELKA: Jack? Richard?

14 MEMBER BANKOWITZ: I move that we take
15 the 30-day payment, episode-based kidney and
16 urinary tract infection and move that to do not
17 support, as well as the cellulitis clinical
18 episode payment to do not support, as well as the
19 gastrointestinal hemorrhage clinical-based
20 payment to do not support.

21 CHAIR OPELKA: So, that means all of
22 those payment measures because spine was also

1 moved. All four of those are do not support.

2 MEMBER BANKOWITZ: Okay. Well, those
3 are the three I particularly disagree with.

4 So --

5 CHAIR OPELKA: And Karen added the
6 other one. So, that is all four of them. Okay?

7 All right. Yes?

8 MR. AMIN: Okay, let me just make sure
9 that everybody is on the same page and that I'm
10 on the same page.

11 So, the existing calendar 1,
12 participation in patient safety culture, the
13 motion is to move that measure to support.

14 Under the existing calendar 4, the
15 patient fall rate, the motion is to move it to a
16 do not support.

17 On calendar 5, the 30-day, all-cause,
18 unplanned, risk-standardized days for AMI, heart
19 failure, and pneumonia, there is a motion to move
20 to do not support.

21 The one that remains of that category
22 is the episode of care for primary elective hip

1 and knee.

2 For the four that were moved to the
3 fully-developed pathway this morning, all four of
4 those have been moved to do not support, and that
5 includes the kidney/urinary tract infection
6 episode-based payment measure, the spine fusion,
7 refusion, episode-based payment measure, the
8 cellulitis episode-based payment measure, and the
9 gastrointestinal hemorrhage episode-of-care
10 measure.

11 I just want to make sure that that is
12 correct. Please let me know if I have missed
13 anything.

14 CHAIR OPELKA: I'm in agreement. Is
15 everyone else? We captured everything?

16 Okay. So, the first on our list is
17 participation in the Patient Safety Culture
18 Survey, which has a motion to move to support as
19 currently specified.

20 Any further discussion?

21 Cristie?

22 MEMBER TRAVIS: Although I appreciate

1 this measure coming in this way this year, I
2 really do think that, for consumers, purchasers,
3 and for healthcare facilities, it is important to
4 know what the results of the patient culture, of
5 the safety culture measure is. And therefore, I
6 would like to keep it where it is, with the
7 condition with which it is stated, that we
8 quickly move to an outcome measure for this.

9 Because, otherwise, just to know
10 whether you are doing it or not, we know it is a
11 requirement that you do it. So, I think we have
12 got to get beyond the fact-finding phase quickly,
13 so that we can actually understand what the
14 safety culture is in organizations.

15 CHAIR OPELKA: Andrea?

16 MEMBER BENIN: So, thanks for that
17 comment, Cristie.

18 I think that publicly reporting the
19 results of these surveys is really antithetical
20 to what we are trying to do in this country
21 around driving a culture of safety. And I think
22 it will be incredibly harmful for driving that

1 forward. In fact, I think it will be completely
2 counter to anything that we believe in this room
3 to be useful.

4 There are two different surveys.
5 There is some decent data showing that they
6 cannot be sort of cross-referenced. You can't
7 take the results of one -- and there is no sort
8 of single result of either one of them that you
9 could say crosses necessarily into the other,
10 although there is correlation between the results
11 of the two of them.

12 And so, it is not as though everybody
13 in the country uses one single survey. People do
14 submit the AHRQ survey to AHRQ for benchmarking,
15 so that you can anonymously submit -- you submit
16 your data. It is not anonymous to AHRQ, but you
17 can, then, see how you rank up against the rest
18 of the country, of the rest of the people who
19 submit to AHRQ. And certainly, the Children's
20 Hospital Association, they also provide some help
21 with the benchmarking on that.

22 The other survey, I am a little bit

1 less familiar with the ability to benchmark. But
2 there is benchmarking data that has been
3 published and that kind of thing.

4 There are no absolute thresholds from
5 these surveys that help you indicate what they
6 mean. So, if you have a 60 percent or something,
7 you know, there's one survey that was
8 particularly well-validated at Hopkins that may
9 have some information based on what the couplings
10 are, but it is very loose. It is very vague, and
11 it is extremely contextual.

12 So, for example, you change your
13 benefits package, right? And so, you don't have
14 a cycle for your FOIA Opinion Survey, and your
15 survey is very much swayed by your staff have
16 this idea of how they feel about things because
17 your benefits package isn't changed. It may or
18 may not have anything to do with patient safety.

19 There is some contextuality to the
20 surveys and the timing of them, as well as to the
21 response rates. Who you survey, there are some
22 vagaries to who you survey. You can include your

1 doctors or not include your doctors, include your
2 staff or not include your staff. Different
3 people will include their non-clinical or their
4 clinical. It is just not there yet.

5 Because what we want to be doing is
6 encourage people to use these surveys and to use
7 the work internally to drive progress. And I
8 don't think that there is a good way to compare
9 organization to organization super well in a
10 productive fashion across the country right now.

11 CHAIR OPELKA: All right. So, let me
12 remind everybody, brevity. Brevity.

13 I was going to say "Ron," but I'll
14 just say "R".

15 (Laughter.)

16 CO-CHAIR WALTERS: I think I gave this
17 talk last year at the same point in this meeting.

18 Yes, I agree, we always want to go to
19 an outcome measure, and when we don't have an
20 outcome measure, we love a process measure. We
21 are so far behind in this one, let's just get a
22 structural measure in place. I support the

1 motion to move it just to structural.

2 CHAIR OPELKA: Any other comments?

3 (No response.)

4 All right, let's go to a vote.

5 So, the motion is to move the
6 conditional support to support.

7 There is no condition. This goes to
8 support.

9 MS. IBRAGIMOVA: So, the question is
10 participation in a Patient Safety Culture Survey.
11 Do you agree with the motion to move this to
12 support? One, yes; two, no.

13 (Vote.)

14 The results are 71 percent, yes; 29
15 percent, no.

16 CHAIR OPELKA: So, we'll move it there
17 and we will throw in the caveat of the discussion
18 that we just had, that there is really a need to
19 sort through how to bring this to an outcome
20 measure. So, that is in the gap analysis for
21 this.

22 Okay. The next is the patient fall

1 rate has a motion to move to do not support.

2 Marty?

3 MEMBER HATLIE: I think these measures
4 are really important to publicly support because
5 I think patients and families don't understand
6 this risk. I don't think most people even
7 understand that they are at risk for a fall when
8 they are hospitalized. So, just in terms of
9 public information and public education, making
10 them aware of that risk is important. And it is
11 also one of, in my opinion, the low-hanging
12 pieces of fruit for patient and family
13 engagements, that once you are aware of that
14 risk, you can partner with your providers to help
15 prevent these events from happening. Plus, it is
16 frequent. So, I think it plays an important
17 function. And I oppose the motion.

18 CHAIR OPELKA: So, Marty, if I could,
19 and I don't mean to put you in an awkward
20 position, it is in the conditional support. And
21 we have phrased some conditions around this one.
22 So, I am assuming that this conditional support

1 that we have as stated would be applicable.

2 MEMBER HATLIE: Yes. No, I support
3 the calendar that it is on.

4 CHAIR OPELKA: Okay. Thank you.

5 MEMBER HATLIE: I think you should
6 leave it there.

7 CHAIR OPELKA: Jack?

8 DR. FOWLER: Yes, I don't claim to be
9 an expert on this data, except I have worked a
10 lot with things that show up in claims and don't
11 show up in claims. And this seems like one that
12 won't show up in claims reliably. And if the
13 goal is to increase awareness of falls, there are
14 all kinds of ways to do that rather than have
15 this measure that is supposed to be meaningful,
16 which I don't think will be, unless I hear
17 something I haven't heard.

18 CHAIR OPELKA: Nancy?

19 MEMBER FOSTER: So, just to add to
20 what Jack said, because I agree with him, there
21 are challenges in deriving this information
22 accurately, particularly from claims data. There

1 are concerns that have been raised that taking
2 too careful a look at patient falls can inhibit
3 the clinician's desire to get people up out of
4 bed and get them moving because they are more
5 likely to fall. But it is also better for their
6 recovery if they get them going faster.

7 So, on balancing this, it seems to me
8 that keeping the falls with injury, which Jack
9 has proposed, and doing away with the general
10 fall rate, would help, would both keep us
11 accurately focused on where patient harm has
12 occurred and not inhibit people from getting up
13 out of bed. So, I support the motion.

14 MS. PANCHOLI: Hi, there. I am
15 Mamatha Pancholi from the Agency for Healthcare
16 Research and Quality.

17 I just wanted to offer some
18 clarification around this issue around duplicity
19 or duplicativity. The issue around PSI-90, it
20 does contain a falls component. PSI-8, which is
21 the postoperative hip fracture, it is actually a
22 much more narrower definition. It actually

1 captures major falls with hip fracture after
2 surgeries specifically. And I think the measure
3 that is under consideration under the IQR is
4 actually much broader than that. So, AHRQ does
5 not believe that there is any duplicity from that
6 perspective.

7 Just to relate very briefly, so AHRQ
8 does not view the falls measure listed under
9 calendar 4 as duplicative of PSI-90. PSI-90 is a
10 composite measure. Within that, there is a
11 measure, PSI-8, which is the postoperative hip
12 fracture. That is a fairly rare event, as it is
13 really defined as major falls with hip fracture
14 after surgery. It is a much more narrower -- it
15 captures much fewer events than I think what
16 measure is actually considered under calendar 4.

17 CHAIR OPELKA: Dana?

18 MEMBER ALEXANDER: So, I mean, we have
19 had discussion about this, the fall measure
20 within PSI-90 about what has been stated, that it
21 is more narrowly defined. And these measures
22 here are more broadly defined, capturing falls

1 and fall risk.

2 And I would say, in all due respect to
3 Nancy's comments, that the care team delivery
4 members, and particularly nursing, are very in
5 tune to fall prevention and monitoring falls for
6 patients, and that understanding that in
7 parallel, that mobility and getting patients up
8 and walking, and so forth, is equally as
9 important as well for their progress.

10 So, I do not support the motion. I
11 think that this is a measure that is being
12 captured today, is very top of mind within
13 hospital settings for falls, fall prevention and
14 fall reporting.

15 CHAIR OPELKA: So, you support its
16 current position?

17 MEMBER ALEXANDER: Yes.

18 CHAIR OPELKA: Okay. Kelly?

19 MEMBER TRAUTNER: Hello.

20 (Laughter.)

21 Actually, Dana's comments were exactly
22 what I was going to say. I think that this is a

1 very important piece of information for consumers
2 of healthcare to have. I think that it places a
3 bit of market pressure on organizations to ensure
4 that they have adequate mobility programming and
5 that they are engaging the clinicians in
6 developing those programs to ensure that the risk
7 of falls actually goes down in those
8 organizations.

9 CHAIR OPELKA: Thank you.

10 Richard?

11 MEMBER BANKOWITZ: Well, this is a
12 self-reported outcome because it can come from
13 the chart or the medical record. And I think if
14 we want to encourage self-reporting, we need to
15 have people feel safe, to come forward and report
16 when a fall has occurred. I think the best way
17 to push that under the table is to publicly
18 report this and try to compare everybody, because
19 a fall will become a slip, and a slip will become
20 that was just a minor problem. So, if we are
21 going to encourage reporting of this type, I
22 don't think it needs -- it should not be publicly

1 reported because you will just suppress the
2 reporting of it.

3 The second point is, if consumers are
4 going to judge this, given that this is self-
5 reported, I think there is going to be a hard
6 time. I mean, I personally would have a hard
7 time understanding what I was looking at. I
8 probably would say I would not go to any
9 institution with a fall rate of zero. That much
10 I would probably say because that tells me the
11 lot.

12 (Laughter.)

13 Beyond that, I wouldn't know how to
14 interpret it. So, we need to be careful about
15 what we are self-reporting and what we are making
16 publicly reported.

17 CHAIR OPELKA: Thank you.

18 Andrea?

19 MEMBER BENIN: I would like to really
20 strongly agree with what Richard just said about
21 a measure like this having the ability to drive
22 underground reporting.

1 The most important thing for me when
2 I am a patient is that I go to a hospital that
3 knows how to drive a reporting culture and a
4 transparent culture, and this is exactly the
5 opposite. This will drive the opposite of that.

6 I know right now every time a child
7 trips in physical therapy, and I want to know
8 that. And that is because I have people
9 reporting that to me. But that kind of thing
10 gets driven underground quickly.

11 And so, I think that this kind of
12 measure potentially jeopardizes it, and it can be
13 balanced out by the measure with injury, which
14 probably also has some issues, but regardless, I
15 would strongly support the motion.

16 CHAIR OPELKA: Michael.

17 DR. PHELAN: I disagree, and I rely on
18 my nursing colleagues in the room to tell me. I
19 think this is, if I am not mistaken, it is an
20 NCDNI metric, is that correct? The Nursing --
21 what is it? -- NDNQI. And what does that stand
22 for? Because my acronym -- I have reached the

1 limit of the acronyms that I can keep
2 remembering.

3 (Laughter.)

4 What does it stand for? Do you know?
5 National Database of Nursing Quality Indicators.
6 Thank you very much.

7 And I think -- where did that come
8 from? From above?

9 (Laughter.)

10 And I believe it is like one of the
11 magnet quality indicators that they follow. And
12 not every nurse and not every hospital submits
13 that data. But, from a patient perspective and a
14 hospital perspective, again, I think our nurses
15 care a lot about the patients that we're caring
16 for in our hospitals. And I think a measure like
17 this, I think it would be actually the opposite.
18 I think it would drive the culture of safety if
19 these measures were being publicly reported.

20 And especially from our nursing
21 colleagues who really care deeply about the
22 patients that they're taking care of, to have a

1 measure on a patient safety metric like this is,
2 I thought, the purpose of what we were trying to
3 do by organizing under an NQF umbrella and MAP.

4 So, I would support the current
5 calendar location of that and continue from
6 there.

7 Thanks.

8 CHAIR OPELKA: Wei?

9 DR. YING: I would keep it in the
10 current calendar. Just to follow up what Michael
11 was saying, later on, we are going to discuss the
12 nursing hour measure. I imagine it will be a
13 heated discussion at that time.

14 For this type of measure that actually
15 represents an outcome of the nursing quality, it
16 is actually where we want to get to. So, that is
17 a type of discussion.

18 Also, at the same time, one comment.
19 I think a couple of colleagues mentioned earlier
20 about the drawback of the claims data. Actually,
21 this is a measure based on the EMR data and all
22 medical records. So, it is actually better than

1 the one in the PSI-90 composite.

2 CHAIR OPELKA: Thank you.

3 Brock?

4 MEMBER SLABACH: I am speaking in
5 support of the motion because, if I'm
6 understanding this correctly, the internal
7 measures, the acronym which you failed at
8 thinking about -- and I can't repeat it even now
9 -- it would be terrific for internal reporting
10 and for process improvement within my own
11 facility. But I think this is going to public
12 reporting, which is a whole other level of
13 consideration. And I think that that really
14 makes this problematic for me, and that is why I
15 would support the motion and its passage.

16 CHAIR OPELKA: Cristie?

17 MEMBER TRAVIS: So, just in response
18 to a comment that was made earlier about driving
19 a transparent culture, if this is only used
20 internally versus publicly reported, you know,
21 the question that I would have is, transparent to
22 whom?

1 And I do understand that there is a
2 lot of good information that can be used
3 internally, and I think that it should be used
4 internally. I have a continued concern when we
5 say that when people are going to publicly report
6 information, then somehow they don't report it,
7 period, which, quite honestly, comes back to me
8 as unethical.

9 And I have a problem with that, and I
10 don't know how to resolve that because I
11 understand the implications of reporting it, and
12 if it is publicly reported, then it goes out to
13 consumers and to purchasers, may end up being
14 used in a payment. But what happened to wanting
15 to get to the truth?

16 And I have a hard time by saying that
17 people will not report it when it is going to be
18 publicly reported or used in payment because,
19 then, that comes down to, you know, the honesty
20 of the people in the reporting system.

21 So, I am afraid that, if we keep it
22 the way we are talking about it, we never get to

1 be transparent with the people who are the
2 patients or the purchasers. And I think fall
3 rate is a very important measure, and we should
4 move it forward, because I think that those
5 people are at risk for the ones with the
6 injuries. And I think together they make a whole
7 lot of sense.

8 CHAIR OPELKA: Dolores?

9 MS. MITCHELL: Well, Cristie already
10 said it. I would just add one other thing to
11 that, which is I keep hearing about concerns -- I
12 don't just mean today, but, you know, in the
13 whole quality measurement business -- about the
14 dangers of underreporting if anybody finds out
15 what you reported, which always strikes me as
16 appalling.

17 But, in addition to that, I think the
18 culture of safety, as has been mentioned by a
19 couple of other people, demands it. And I don't
20 know, you know, those two surveys that Andrea
21 told us you all get include -- you know does your
22 Board get every one of these reported to it? And

1 what actions do they take, and so on?

2 It points me to the question of, who
3 is responsible for dealing with the question of
4 underreporting? It seems to me it is the
5 leadership of the profession. It is the leader
6 of the hospital. It is the chairman of the board
7 of the hospital. It is the structure of
8 governance. It is the agenda for board meetings.

9 To say that there is a danger of it
10 happening or to ignore that there is a danger of
11 happening is probably a misunderstanding of the
12 frailty of human beings. But, since we do know
13 that -- and I'm not denying that there is that
14 potential -- it seems to me that the solution is
15 not to say, well, we won't report it to anybody.
16 The solution is to say to the leadership of the
17 industry, "Get moving on this one."

18 CHAIR OPELKA: Marty?

19 MEMBER HATLIE: Quickly, I think there
20 is a tension that Nancy acknowledged between
21 mobility and the fall instructions that a lot of
22 patients get. But this is a perfect place to

1 start a conversation about patients and families
2 partnering and resolving that tension.

3 I don't think patients and families
4 are going to make a single decision based on this
5 rate. They are going to factor it into a
6 conversation they need to be having about risk in
7 general. So, for that reason, I think it is
8 really important.

9 Thank you.

10 CHAIR OPELKA: Sean?

11 DR. MORRISON: Yes, I hear that people
12 say, "I am clear this is really important
13 measure." I think what I am struggling with is I
14 don't have enough information about other
15 measures that might harmonize with it.

16 Because if we take fall rate by itself
17 in the absence of, for example, rates around not
18 getting people out of bed, rates around restraint
19 use, both chemical and others, it is hard to
20 interpret a fall rate.

21 However, if I had percentage of
22 patients who were gotten out of bed, percentage

1 of patients who were moved, percentage of
2 patients who are harmonized with this in
3 conjunction, that to me would be a much more
4 relevant measure and one that I could interpret.

5 I completely agree with the falls with
6 injury. This one, isolated by itself without
7 companion measures to evaluate, I have trouble
8 with.

9 CHAIR OPELKA: Okay. Nancy?

10 MEMBER HANRAHAN: Again speaking from
11 a dual-eligible perspective, this measure is an
12 important red flag of an environment that may put
13 a patient at risk. And there are measures that
14 are associated with this one, two measures that I
15 know of. One is nursing staffing and nursing
16 skill mix.

17 So, if you have poor nurse staffing
18 and poor skill mix, meaning the right qualified
19 nurses to take care of the acuity level of
20 patients, you are going to have higher fall
21 rates. And that evidence is really strong in the
22 literature.

1 So, I would really encourage you to
2 think about this being one of those consumer red
3 flags that inform about the quality of the
4 environment that the person is moving into and
5 the risks that they are going to be taking.

6 CHAIR OPELKA: Okay. A lot has been
7 said. So, let's be brief. If it is something
8 new that you need to bring up, let's hear it.

9 Andrea?

10 MEMBER BENIN: I will just really
11 briefly say I don't think that having this in or
12 out of IQR sort of makes or breaks our national
13 benchmarking in looking at this. I think this
14 data goes to NDNQI for most places, many places.
15 It goes other places. It is part of the HAC. It
16 is part of this other stuff. There's lots of
17 ways that this gets looked at. So, it is not
18 that these things don't get where they need to
19 go. Whether this is the right place for it is a
20 different question.

21 CHAIR OPELKA: Emma?

22 MEMBER KOPLEFF: I appreciate Andrea's

1 comment. Just sort of grounding myself -- and
2 thank you for the opportunity to share with
3 others -- if we harken back to the program goals
4 we agreed upon for this program, we did speak to
5 providing an incentive for hospitals to publicly
6 report quality information about their services.

7 And so, to me, if we ground ourselves
8 there, then this measure continues to be really
9 important and some of the concerns about
10 transparency don't stand.

11 CHAIR OPELKA: So, the motion that we
12 have is a motion to do not support, to move this
13 to the do not support calendar.

14 MS. IBRAGIMOVA: So, the question is
15 patient fall rate, do you agree with the motion
16 to move the measure to do not support? One, yes;
17 two, no.

18 (Vote.)

19 The results are 42 percent, yes, and
20 58 percent, no.

21 CHAIR OPELKA: So, it stays.

22 Next, we have three measures that I

1 am hoping we can discuss together. It is the 30-
2 day, all-cause, unplanned, risk-standardized
3 stays in acute care for AMI, heart failure, and
4 pneumonia, all of which have been moved to the do
5 not support calendar.

6 MS. O'ROURKE: I just wanted to jump
7 in, Frank. Our CMS colleagues had asked if they
8 could make some comments about these measures
9 before the conversation begins.

10 CHAIR OPELKA: Great. Thank you.

11 DR. YONG: Thank you.

12 We are going to have Susannah Bernheim
13 come back to the table and just provide you with
14 a little bit of explanation as to how the
15 measure's intent is.

16 DR. BERNHEIM: We had slides. I don't
17 need to work with them, but it looks like you
18 guys are moving to pull them up. Okay.

19 MS. O'ROURKE: We're getting those up
20 right now.

21 DR. BERNHEIM: They're very brief
22 here. I will try, in the spirit of time, to just

1 start talking while those are coming up because I
2 don't think you really need them in front of you.

3 Let me make sure I'm looking at the
4 right ones. Yes. Okay.

5 So, high-level -- in fact, I am going
6 to move through these quickly. Who is going to
7 control the --

8 The concept behind these measures is
9 to complement the current readmission measures by
10 providing additional information that you can't
11 get. It is really meant to be thinking about
12 other things that patients would want to know
13 about the 30 days post-admission for AMI, heart
14 failure, or pneumonia.

15 I am now seeing if I can control this.
16 Which way am I pointing with this? Oh, okay.

17 MS. O'ROURKE: We have a PDF of the
18 slides. So, we will scroll down for you.

19 DR. BERNHEIM: Okay, great. So, go
20 ahead and move to the next one.

21 So, this slide just talks about the
22 importance of both readmissions, but also the

1 occurrence of ED visits and observation stays in
2 the 30-day period after index admission.

3 You can go to the next slide.

4 So, the purpose of this measure is to
5 broadly evaluate the quality of transitions from
6 hospitalized patients to a non-acute setting and
7 to let consumers and providers understand a more
8 complete picture of post-discharge outcomes.

9 So, it includes ED visits, observation
10 stays, and readmissions. It is trying to capture
11 all post-discharge care, and therefore, enhance
12 post-discharge acute care reduction efforts.

13 You can move to the next one. I hope
14 that gets to it.

15 So, the key thing to know is that we
16 have harmonized the current measure with the same
17 cohort and risk adjustment and approach to the
18 readmissions and the same measurement period.

19 Next slide.

20 But the focus of the outcome now is
21 days. So, rather than just "Yes, no, was there a
22 readmission?", which tells you some important

1 things about your post-discharge period, this
2 measure will tell you more.

3 We look at the number of days that
4 you're back in a hospital or an ED setting or an
5 observation care setting. They are not formally
6 weighted, but, essentially, informally weighted
7 because the hospitalizations tend to be for
8 longer; the observation stays are billed based on
9 the number of hours you're there divided by 24.
10 So, we get an account day. And the ED visits are
11 considered a half-a-day. That was with input
12 from our TAP.

13 This just captures more fully the
14 burden of acute care to patients.

15 I'm going to keep moving.

16 So, just quickly, the way this will be
17 reported is a little bit different than our other
18 measures. It is risk -- I am going to get this
19 wrong -- risk-standardized acute care, but it is
20 actually a difference in days. So, what we look
21 at is what, given your case mix, will be expected
22 as the post-discharge days and whether you have

1 greater or fewer than that. And there is quite a
2 wide range among hospitals.

3 I think I will stop there because I
4 know you are short on time, and I just want
5 people to have a flavor of this measure. I am
6 happy to answer questions and I have some more
7 slides, if people have further questions.

8 CHAIR OPELKA: Okay. The measure as
9 it is put forward is do not support.

10 Cristie, is your card up?

11 MEMBER TRAVIS: Yes.

12 CHAIR OPELKA: Well, then.

13 (Laughter.)

14 MEMBER TRAVIS: I just have a
15 question, a clarifying question. Is this only
16 for patients that are readmitted?

17 DR. BERNHEIM: Great question. No,
18 not at all. So, any patient who is admitted with
19 AMI or heart failure or pneumonia, we look at all
20 of the post-discharge events.

21 CHAIR OPELKA: Richard?

22 MEMBER BANKOWITZ: So, I think it is

1 a great idea to try to capture all of the events
2 that take place after a hospitalization, and
3 knowing how many observation visits and how many
4 ED visits is extremely important.

5 Why I think this measure needs to be
6 sent to the do not support category is because it
7 is blending all of the events into one number.
8 And it is difficult to interpret what a seven-day
9 event would be. If a patient stays in the
10 hospital for a seven-day readmission, is that the
11 same as going back to the hospital for four days
12 and, then, coming back to the obs room for three
13 separate occasions?

14 It seems to me that there is a
15 difference in patient-centered care, and we are
16 just lumping it into one uninterpretable number,
17 in my estimation. So, if we want to understand
18 these, why not just measure and report obs days
19 and ED days in addition to readmission? It seems
20 much more logical to do it that way.

21 DR. BERNHEIM: So, just a quick answer
22 to that, because it something that our team has

1 thought a lot about. And the problem is, if I
2 just tell you obs days, I don't know whether that
3 means -- or I'll use ED days. I don't know
4 whether that means a hospital, it has high ED
5 days. Does that mean a hospital is really
6 effectively triaging patients, getting them back
7 out to the care setting sooner? And that might
8 be a hospital that has low readmission rates.

9 In fact, we see that hospitals that do
10 particularly well on this measure often have much
11 higher readmission rates and higher lengths of
12 stay for the readmissions, and they do really
13 poorly on this measure. Sorry. But the often
14 have lower ED visit days, and vice versa, which
15 is what I was really trying to get at. A lot of
16 the hospitals that -- let me say this clearly
17 this time -- do well on this measure overall,
18 where patients are coming back for fewer total
19 days, actually have slightly higher rates of ED
20 visits. And we suspect, but we don't know, that
21 they are getting patients in sooner, when they
22 are less sick, and the burden on patients of the

1 days is fewer.

2 And it is true that seven days can
3 parse out differently. But we are trying to
4 capture the sense of sort of, what is the patient
5 likely to experience in the next 30 days? How
6 many days are they likely to be back in acute
7 care? We think that is valuable.

8 MEMBER BANKOWITZ: So, thank you for
9 that clarification. And I think, in a way,
10 you're making my point because you actually look
11 and parse out the events, which I think is what
12 you need to do. But, not having all that
13 information, consumers or interested parties will
14 see one number. So, I think you just made my
15 point. It is useful to look at the individual
16 events.

17 CHAIR OPELKA: Wei?

18 DR. YING: I actually like this
19 measurement because it actually addresses one of
20 the concerns while we work with hospitals, the
21 readmission measure. What we found is hospitals
22 are trying very hard to keep patients out of

1 acute settings, so they don't count as
2 readmissions to be reported out. So, we see a
3 jump in the observation stay during the 30-day
4 post-discharge period.

5 For our internal program, we actually
6 modify the Yale measure or try to except for
7 that, count them as readmission for our
8 hospitals. So, I think this set of measures is
9 trying to address the issue of making sure our
10 hospitals, no matter how they get paid, depending
11 on the program, patients are getting quality of
12 care during the post-discharge period.

13 CHAIR OPELKA: Thank you.

14 Mitchell? All right. Nancy?

15 MEMBER FOSTER: Oh, sorry.

16 MEMBER HANRAHAN: These measures are
17 designed for age 65 years and older. And one of
18 the issues with dual-eligibles is many of them
19 are under 65. So, this is a real gap in
20 application of these measures.

21 CHAIR OPELKA: Thank you very much.

22 We'll capture that.

1 David?

2 MEMBER ENGLER: Thank you.

3 I made a similar comment that Richard
4 just made last time we met, talking about all-
5 cause readmission. And my comment related to
6 lumping all cases and all patients coming back
7 into a hospital into an all-cause readmission
8 rate.

9 At the time -- and I still argue -- I
10 argued this case that condition-specific
11 readmission rates from a quality improvement
12 standpoint are very, very important. And
13 practitioners and folks that work in quality
14 improvement know what to do with those rates.
15 They can make specific recommendations. For
16 instance, cardiac rehab is an important predictor
17 of readmissions in AMI, et cetera.

18 But, when you lump it all together, I
19 think when I mentioned this last year I said I
20 wasn't quite sure what I could do with it from a
21 quality improvement perspective. I didn't know
22 what I could do with it.

1 And over the last year, we engaged in
2 the PFP program and had some success on the
3 hospital-acquired conditions, quite a lot. We
4 reduced the events by about 4,000 events in our
5 network. But we weren't really able to move the
6 ball or the needle on all-cause readmissions.

7 And it turned out to be just that. We
8 weren't able to further drill into the
9 information and the data to really capture and to
10 get really granular as to what our hospitals that
11 wanted to drive the readmission rates down were
12 to do. So, I just once again raise that as a
13 concern from the field regarding all-cause
14 readmissions.

15 I sort of like what you have done here
16 with the days issue. It sort of reminds me of
17 the days between events on CLAPSI. I think that
18 is a very clever addition to the measure.

19 But my concern is, when I know it,
20 outside of just knowing it, which is important I
21 suppose -- that's what was argued by CMS last
22 year, that it was important to know -- but, from

1 a quality improvement standpoint, from really
2 working in the field, what do I do with that?

3 So, I would just continue to add that,
4 my words of caution about all-cause.

5 CHAIR OPELKA: All right. Well, let's
6 be brief.

7 Kate?

8 DR. GOODRICH: Just a quick response
9 to that. I think one of the things we certainly
10 do here -- and I think you're get at it, at least
11 in part -- is the data lag. So, being able to
12 give feedback on measures such as readmissions
13 and a measure such as this in a more timely
14 fashion than we are able to do now.

15 Having said that, we do give hospital-
16 specific reports on these measures and would be
17 able to do the same on this measure. That allows
18 you to drill down to every patient that meets
19 this measure, to know whether they were
20 readmitted, came back for obs or came back to the
21 ED. So, that would be something we would be able
22 to provide.

1 CHAIR OPELKA: Michael?

2 DR. PHELAN: Again, I think this is
3 like the natural progression of some of these
4 metrics that are being developed. There is some
5 concern that, you know, there is unplanned acute
6 care was like looking at emergency department
7 visits as a negative. I think looking at this, I
8 think patients and hospitals who desperately want
9 to have this data, and in a much shorter
10 timeframe. And I don't think rolling it up into
11 one single number excludes the fact that CMS can
12 provide much more rich detail to that number to
13 the providers who get that number.

14 So, I think the idea that, oh, it is
15 just going to be a single number and I am not
16 going to know what to do with it, I don't think
17 that exclusively says you can't get all this data
18 like Kate said; that whatever we want that data
19 to format from a hospital, they can give it. But
20 I think it would be very rich data for hospitals
21 to be able to be more focused on where to address
22 the concerns.

1 Or they are having patients having
2 higher acute unplanned care in one category.
3 They may want to focus their efforts on it.

4 So, I see this being a plus, and I
5 also see it as patients being able to look at
6 data like this and saying, because it is a
7 negative number, "It looks like they do a little
8 bit better job taking care" of X, Y, and Z. "I
9 think I want to go there for my hip." Some of
10 the acute stuff is difficult to select your
11 hospital, but it would be nice to have that data
12 for them.

13 CHAIR OPELKA: Nancy?

14 MEMBER FOSTER: So, I know I'm
15 sounding like a broken record at this point. But
16 I think this is one of those measures that would
17 be exquisitely responsive to socioeconomic
18 factors.

19 I mean, we know in some communities
20 patients don't have any other place to go other
21 than to the hospital to get care and followup
22 care from a hospitalization. They may choose to

1 go to the ER. We may try to redirect them to a
2 clinic, but depending on how they come to us and
3 at what time of day they come to us, we may just
4 see aberrations that are completely
5 understandable if you know the context of the
6 care. And without that kind of careful look, I
7 feel like moving this measure forward would be
8 premature, to say the least.

9 CHAIR OPELKA: So, I just want to be
10 clear.

11 MEMBER FOSTER: I support the motion.

12 CHAIR OPELKA: Pardon me?

13 MEMBER FOSTER: I support the motion.

14 CHAIR OPELKA: Okay.

15 Sean?

16 DR. MORRISON: I really like this
17 measure, I mean it's creativity, because it
18 addresses an acute problem that we have seen with
19 the all-cause hospital readmission measure, which
20 is hospitals rapidly building obs units,
21 essentially to game the system.

22 And this really addresses that by

1 lumping it all together. And I, quite honestly,
2 from a patient perspective, it is not much
3 different to me whether I am sitting overnight in
4 an ED, in an obs unit, or in a hospital bed
5 versus the number of days. They are probably the
6 same, and I would argue, you know, I would
7 probably rather be in the hospital bed as a
8 readmit.

9 So, I actually think this is a very
10 creative measure to begin to address this issue
11 that we have seen. It is not perfect, but I
12 think it is better than what we have.

13 CHAIR OPELKA: Be brief.

14 MEMBER FOSTER: To that point, I just
15 want to say --

16 CHAIR OPELKA: Go ahead, yes.

17 MEMBER FOSTER: -- the data actually,
18 Sean, don't support the fact that hospital beds,
19 obs beds are being used as the safety valve here.
20 Even CMS's own analysis, which was recently
21 published in MMRR, says they are seeing no bump
22 there.

1 So, I know it was a concern, but --

2 DR. PHELAN: The same point, to Wei's
3 point and to Sean's point, I think that CMS has
4 looked at this, and there hasn't been that --
5 even though I think there is an impression that
6 that is happening, it doesn't seem to bear out.

7 I don't know if Kate wants to comment
8 on it or any of your team wants to comment on
9 that Geoffrey Gerhardt paper.

10 DR. GOODRICH: I don't know the report
11 Nancy is referencing. I know I have seen some of
12 our data internally that do show that there is an
13 uptick in observations. It is not an enormous
14 bump, like 10 or 20 percent, but there has been
15 an uptick.

16 I apologize, I don't know which one
17 Nancy is referencing, but we have seen that.

18 CHAIR OPELKA: Okay. We are looking
19 for new comments.

20 Emma? Brief new comments.

21 MEMBER KOPLEFF: I know we are not in
22 the habit of proposing new motions. So, that is

1 not what I'm doing.

2 Just to be clear where I stand, I hear
3 Nancy's concern about risk adjustment. I do
4 think that is separate from the motion that has
5 been made, which is a do not support.

6 Per the conversation we have already
7 had around SDS, I would value some consideration
8 from this group of a motion that mixes the
9 conditional support of the measure, based on the
10 reasons we have heard and the importance of this
11 measure in filling a gap and telling us something
12 new about what is happening with patients during
13 their care continuum.

14 CHAIR OPELKA: So, let me just help.

15 MEMBER KOPLEFF: Yes.

16 CHAIR OPELKA: The location of this
17 measure is conditional support. If the motion on
18 the table passes, it moves to do not support. If
19 the motion fails, the conditions can be listed,
20 including NQF endorsement and the socioeconomic
21 condition that we previously described.

22 But the motion that is out there is do

1 not support. So, we have three measures taken
2 together, which are on the table currently in
3 conditional support, and the motion is to move to
4 do not support.

5 Can we bring this up for a vote?

6 MS. IBRAGIMOVA: The question is
7 hospital 30-day, all-cause, unplanned, risk-
8 standardized days in acute care following acute
9 myocardial infarction, AMI hospitalization;
10 hospital 30-day, all-cause, unplanned, risk-
11 standardized days in acute care following heart
12 failure hospitalization, and hospital 30-day,
13 all-cause, unplanned, risk-standardized days in
14 acute care following pneumonia hospitalization.

15 Do you agree with the motion for do
16 not support? One, yes; two, no.

17 (Vote.)

18 The results are 25 percent, yes, and
19 75 percent, no.

20 CHAIR OPELKA: Okay.

21 Next, we have four measures that were
22 also on this same calendar which we will lump

1 together. These are the four episode-based
2 payment measures. One was kidney/UTI. One was
3 spine fusion/refusion. One was cellulitis, and
4 one was GI hemorrhage. All of these were moved
5 to do not support.

6 MS. O'ROURKE: We have additional
7 comments from CMS for these measures as well.

8 MS. PAVELKA: Hi. I'm Jennifer
9 Pavelka, and I'm from Acumen. We are the
10 contractor that supported CMS's development of
11 the clinical episode-based payment measures.

12 And if we could skip ahead just
13 quickly? Great. Thanks.

14 Basically, CMS's hospital-based
15 episode measures are designed to assess the
16 efficiency of clinically-related services
17 provided within an episode of care. It is
18 important to note that these measures are payment
19 standardized to allow comparison for Medicare
20 payments across the country, and these measures
21 are risk-adjusted for the clinical presentation
22 of the beneficiaries who are treated.

1 Their construction is designed to
2 generally parallel the NQF-endorsed Medicare
3 Spending Per Beneficiary measure, or MSPB, and
4 they were developed to be used in conjunction
5 with measures of quality.

6 As mentioned, there are four. One is
7 lumbar spine fusion/refusion. The second one is
8 kidney/urinary tract infection. The third is
9 cellulitis, and fourth is GI hemorrhage.

10 A quick note about episodes of care.
11 These include a set of discrete medical services
12 that are typically involved in managing a
13 particular health event or condition. And they
14 allow a single unit for comparison of these
15 services across all providers to measure
16 efficiency-of-practice patterns.

17 Next slide, please.

18 A basic model of an episode of care
19 begins with a trigger event. This is something
20 to indicate the presence of the health event or
21 condition that is the focus of interest.

22 Next, within the episode, clinically-

1 relevant conditions and procedures are grouped or
2 included in the episode if they represent a
3 sufficiently-high share of cost, occur within the
4 time window, which is the inpatient
5 hospitalization period 30 days after and for some
6 episodes up to a few days before, if we need to
7 capture events that should be associated. And
8 finally, the episode ends when there is a break
9 in service or after a fixed time period after the
10 trigger event.

11 CMS's goals for episode cost reporting
12 are primarily to encourage efficient practice
13 patterns of care. Inclusions of these measures
14 in hospital inpatient quality reporting enables
15 CMS to consider them for future inclusion in the
16 Hospital Value-Based Purchasing Program, where
17 stakeholders have specifically requested a more
18 robust measure set, especially for clinically-
19 cohesive measures such as these to complement the
20 more global MSPB measure.

21 Next slide.

22 The clinical episode-based measures

1 fulfil in part CMS's quality strategy to improve
2 beneficiary health and quality of care while
3 lowering medical costs. They meet a requirement
4 in the Social Security Act that calls for the VDP
5 Program to include measures of efficiency. And
6 as mentioned, they are designed to align with the
7 endorsed Medicare Spending Per Beneficiary
8 measure.

9 The four conditions were chosen for
10 development based on data analysis and expert
11 clinical consultation because they can be linked
12 to near-term outcomes, have high variation in
13 post-treatment expenditures, account for a large
14 share of total Medicare spending, and have a
15 large share of expenditures that are attributable
16 to post-acute care.

17 CMS has vetted the measures by asking
18 for public comment on the measures in both the
19 fiscal year 2015 inpatient prospective payment
20 system and long-term care hospital proposed rule,
21 and the fiscal year 2015 physician fee schedule
22 proposed rule.

1 And all four of these measures were
2 reported in the 2012 Supplemental Quality and
3 Resource Use Reports, which are confidential
4 feedback reports that are delivered to medical
5 group practices with 100 or more physicians in
6 the practice.

7 I understand that there might be some
8 questions. So, please let me know if there is
9 anything I can help answer.

10 CHAIR OPELKA: All right. Karen?

11 MEMBER FIELDS: So, the main question
12 is -- and I am not certain it is appropriate for
13 today's discussion -- which are, what are the
14 risk stratifications and what are the exclusion
15 criteria in specifically management of spinal
16 fusion in a patient with underlying malignancy
17 that would require chemotherapy and radiation
18 therapy as part of the total management of that?

19 But it also would apply in cellulitis,
20 renal, any kind of other kind of planned therapy
21 for treatment of an underlying malignancy can't
22 be included in that bundle. That's my question.

1 CHAIR OPELKA: We are not going into
2 measure specification. There is an NQF process
3 which they haven't gone through. The measure
4 work is completed. And now, they are ready to go
5 into the NQF process. We can review the risk
6 stratification here. That is for the NQF
7 endorsement process.

8 MEMBER FIELDS: And I understand. The
9 only one that I put on the table was spinal
10 fusion, and I just need to know if I would take
11 it off the table as a do not support based on
12 that question.

13 CHAIR OPELKA: Right. And it is
14 purely, the question you are asking about, is it
15 adequately risk-stratified, is an NQF endorsement
16 question, which is not yet completed. The
17 measure is developed and I understand moving
18 toward that, but we cannot go through measure
19 specification and endorsement here.

20 Richard?

21 MEMBER BANKOWITZ: So, let me speak to
22 the three UTIs, cellulitis, and GI hemorrhage. I

1 understand the logic of measuring the efficiency
2 of a discrete well-planned, elected episode, like
3 a hip replacement, where you can standardize the
4 care.

5 I think it is problematic to try to
6 measure the efficiency of acute, unplanned
7 episodes like UTI, cellulitis, and hemorrhage.
8 One important consideration is that, especially I
9 would say for UTI and cellulitis, but probably GI
10 bleed, the most efficient cost is zero. Those
11 patients should not be admitted or most of them
12 should not be.

13 So, by focusing on a very biased
14 sample of very ill, presumably ill patients, and
15 trying to see if we can somehow judge the
16 efficiency of care just seems misguided to me. I
17 don't understand how that will help us in any
18 way.

19 We should be looking, if we are very
20 concerned about the efficiency of UTI, looking at
21 all UTIs. The same is true with cellulitis. The
22 same is true of GI bleed. We should take steps

1 to prevent GI bleeding from ulcers and other
2 preventable conditions.

3 So, to focus on these special-cause
4 admissions and try to standardize the efficiency
5 seems to be illogical.

6 CHAIR OPELKA: Currently, the measures
7 are in the conditional group, which would require
8 NQF endorsement, and that is our condition. And
9 the motion is to move them to do not support.

10 And I would ask a couple of questions
11 that maybe you can help clarify for me. And I am
12 taking my Chair hat off to do this.

13 There's cellulitis and, then, there's
14 cellulitis. It seems to be a highly-variable
15 measure. And so, I am a little concerned as to
16 variation could be due to the variation in the
17 cellulitis itself and not the treatment or cost.

18 And likewise with GI bleed, there is
19 upper GI bleed and there's lower GI bleed. Which
20 GI bleed is this? Is it both? And I think there
21 is high variability in those two.

22 And yet, the UTI, kidney, and the

1 total joint, to me, are much more narrow in their
2 scope, as is the spinal fusion. So, I can see
3 those, if they have got adequate NQF endorsement.
4 I am struggling with the cellulitis and the GI
5 bleed because those groups are so highly variable
6 clinically.

7 MS. PAVELKA: The measure development
8 process used clinician input to narrow the
9 services and procedures that are grouped, once
10 the trigger occurs, so that they would be
11 clinically-relevant to the treatment and the
12 hospital's course of treatment for that episode
13 within the time period.

14 Once the services are grouped, the
15 payments are risk-adjusted for the clinical
16 presentation of the patients who are being
17 treated. And I won't waste your time with the
18 details on the risk adjustment because I
19 understand that is not the purview here.

20 CHAIR OPELKA: So, a lower GI bleed is
21 not grouped with an upper GI bleed in the
22 measure?

1 MS. PAVELKA: My colleague, Camille
2 Chicklis, is on the line.

3 Camille, can you comment on the lower
4 and upper GI bleed?

5 MS. CHICKLIS: Oh, sure. This is
6 Camille Chicklis from Acumen.

7 Yes, both lower and upper GI bleeds
8 are part of this measure specification, and the
9 measure does not currently distinguish between
10 the two.

11 Is that your question?

12 CHAIR OPELKA: Correct.

13 Okay. Thank you.

14 Michael?

15 DR. PHELAN: You know, from a point of
16 view is the direction we want to move in looking
17 at these episodes of care. I have a feeling that
18 the variability will wash out because, for the
19 very narrow defined ones, then it is very narrow
20 and everyone has got a narrow category. For the
21 very broadly-defined ones, well, everyone is
22 going to be thrown in the same categorization.

1 So, the really low-cost cellulitis are going to
2 be washed out, and the really high-cost ones will
3 wash out on both ends. But it will be a number
4 in the end that they can actually look at and
5 see.

6 So, I am not sure -- and I am not a
7 methodological expert -- but I think that may be
8 what you are worried about. But I think it is
9 going to be a washout in the end.

10 But I am in the category of supporting
11 these measures because, without having these
12 kinds of episode-based care of the direction we
13 want to go in, what measures are we going to
14 start looking at? These are, I think, our first
15 foray into it.

16 And again, I will say I am going to
17 trust in the NQF process. If they find issues
18 with the methodology or with the specifications,
19 how it is currently developed, I think that the
20 Technical Expert Panels that are kind of given
21 that task to follow with that will give us the
22 answer that we want for that.

1 So, I would vote for continuing on
2 conditional support, based on NQF endorsement.

3 CHAIR OPELKA: Nancy?

4 MEMBER FOSTER: So, probably a
5 question I should have asked about a number of
6 other measures, but these are specified with
7 ICD-9 codes?

8 MS. PAVELKA: We use a mix of
9 different procedure and diagnosis codes to
10 identify DRGs, HCPCs, and CPTs.

11 Camille, can you comment whether ICD-9
12 is in the list of diagnosis and procedure
13 identifiers?

14 MS. CHICKLIS: Yes, that's ICD-9
15 codes. I am guessing your question is getting at
16 whether we will be ready to move to ICD-10. And
17 that is something that we are working on to
18 develop for the future.

19 MEMBER FOSTER: Well, the first
20 payment program or the first public reporting
21 program this could go into will be an era when we
22 are working off of ICD-10. So, yes, that would

1 be a key question.

2 CHAIR OPELKA: Andrea?

3 MEMBER BENIN: I have a similar
4 question to your question, Frank, about the
5 kidney metric. Does that include both
6 pyelonephritis as well as lower tract infections?
7 Are those lumped in that way? Because they are
8 different.

9 MS. PAVELKA: Camille, can you check
10 through the list and confirm that?

11 MS. CHICKLIS: I'm sorry, could you
12 repeat the question? I couldn't hear you.

13 MS. PAVELKA: Does the kidney/urinary
14 tract infection metric include both kidney
15 infections and lower urinary tract infections?

16 MS. CHICKLIS: Yes, we do include
17 both. So, the measures are specified based on
18 the MSGRG of the hospital admission, and the DRG
19 for kidney and urinary tract infection includes
20 both kidney and urinary tract infection.

21 MS. PAVELKA: So, then, does it take
22 into account if there are other sort of like

1 resistant organisms? Because you can code for,
2 in ESBL, you can code for some of the resistant
3 organisms. So, some of those things really
4 impact the -- but that comes into your risk
5 stratification discussions, I think. I think
6 there is a lot of information that will need to
7 be fully ascertained and understood by the panel,
8 when it gets there, around the ability to
9 appropriately risk-adjust using claims data on
10 these kinds of things. Because there are reasons
11 why you might need to be in the hospital for a
12 bad pylo with an ESBL E. coli that is going to be
13 very expensive.

14 CHAIR OPELKA: Richard?

15 MEMBER BANKOWITZ: Yes, I think
16 because this is the first foray into this area,
17 we need to be careful and we need to be
18 thoughtful and send the right message.

19 I just think everyone needs to
20 understand, if I'm an institution that is
21 particularly good at preventing and treating UTIs
22 in the outpatient setting, it is not surprising

1 if very sick patients are the ones left to be
2 admitted, and those costs may be, indeed, high.
3 But we are missing the spectrum.

4 So, if we want to look at efficiency
5 of something that is normally treated as an
6 outpatient condition, we need to look at the full
7 spectrum, not just the special-cause patients
8 that get admitted. Otherwise, we are going to
9 possibly let no good deed go unpunished by
10 keeping the less sick people out of the hospital.

11 The second point is I'm not surprised
12 there is a lot of variability in these conditions
13 because, as we are discussing now, these patients
14 can be all over the map in terms of their
15 severity, and it doesn't necessarily mean we are
16 being inefficient.

17 CHAIR OPELKA: Karen?

18 MEMBER FIELDS: One other comment. I
19 think that Value-Based Purchasing is an important
20 step forward to improve coordination of care,
21 quality of care, decreased cost. However, the
22 attribution model needs to be carefully looked

1 at. If the hospital gets paid starting with the
2 hospital admission, but gets attributed costs for
3 the three days preceding that, that creates some
4 problems with how do you improve the quality of
5 cost and payment. So, the attribution model may
6 not be appropriate in these settings.

7 CHAIR OPELKA: Mitchell, is that
8 yours?

9 DR. LEVY: Yes, just briefly, I would
10 just speak again, as Michael did, in support of
11 trusting the NQF process on this measure. So, I
12 am still against the motion.

13 CHAIR OPELKA: Okay. All right. So,
14 the motion is that these measures move to do not
15 support. There is a group of them. They are all
16 the episode-based payment measures. And they are
17 coming off conditional support, and the condition
18 was really the NQF endorsement process.

19 MS. IBRAGIMOVA: The question is
20 kidney/urinary tract infection clinical episode-
21 based payment measure; spine fusion/refusion
22 clinical episode-based payment measure;

1 cellulitis clinical episode-based payment
2 measure, and gastrointestinal hemorrhage clinical
3 episode-based payment measure. Do you agree with
4 the motion to move to do not support? One, yes;
5 two, no.

6 (Vote.)

7 The results are 48 percent, yes, and
8 52 percent, no.

9 CHAIR OPELKA: So, they stay on
10 conditional.

11 So, here's where we are: we have
12 walked through all our consent calendars for the
13 IQR. We have a support calendar. We have a
14 conditional support calendar which has an array
15 of conditions to be applied, as per your
16 conversation today. We have a do not support
17 calendar, and we have the encourage for continued
18 development calendar. So, those are our four
19 calendars.

20 We are going to open up for public
21 comment on those calendars, and then we will vote
22 on those calendars.

1 THE OPERATOR: At this time to make a
2 public comment, please press 4, then, the number
3 1.

4 MS. O'ROURKE: Hello, Operator. Could
5 just hold off on public comment one minute? We
6 are having a procedural question. Thank you.

7 (Pause.)

8 CHAIR OPELKA: Cathy?

9 THE OPERATOR: Yes, sir?

10 CHAIR OPELKA: Would you seek public
11 comment, please?

12 THE OPERATOR: Okay. Once again, as
13 a reminder, you may press *1 to make a comment.

14 (No response.)

15 Okay. At this time there are no
16 public comments from the phone line.

17 CHAIR OPELKA: Any in the room?

18 Please. And introduce yourself.

19 MS. JONES: Hi. My name is Stacie
20 Jones. I am giving public comments on behalf of
21 the American College of Emergency Physicians in
22 regards to the three measures on 30-day, all-

1 cause, unplanned, risk-standardized days in acute
2 care following hospitalization for AMI, heart
3 failure, and pneumonia.

4 I did submit some of these comments
5 earlier, and I just wanted to reiterate that,
6 actually, within acute care there is a continuum
7 of care. There are patients who are admitted for
8 an inpatient stay. There is care that is
9 delivered in the ED, and there are severity
10 indexes within the emergency department patients.

11 And there are four different types of
12 observation units within acute care settings.
13 There is protocolized clinical decision unit in
14 the outpatient part of the hospital, and there
15 are also different types of observation within
16 the inpatient range in the hospital.

17 And each one of those is slightly
18 different. And several studies have been done
19 that highlight the savings that can be realized
20 with observations stays. Some studies have cited
21 950 million per year for some of these stays, and
22 some studies, 5.5 to 8.5 billion per year.

1 It is also important to acknowledge
2 that emergency department stays are generally
3 about one-tenth of the cost of a hospital
4 admission. So, I think that to count an
5 emergency visit as half a day of an inpatient
6 stay is not necessarily accurate or reflective of
7 the burden to the system. In addition, many
8 people will not necessarily be in the emergency
9 department for 12 hours instead of 24. So, I
10 think all these are important to take into
11 account.

12 In addition, appreciating the fact
13 that the measures are risk-adjusted, I think that
14 the community resources in the catchment area for
15 these hospitals needs to be taken into account,
16 too. Because many times the reason for the
17 emergency department visit is simply because it
18 is open and that there will be, although 92
19 percent of all visits are urgent or emergent, now
20 with many Medicare and Medicaid patients having
21 to wait for a number of days to get in to a
22 primary care physician, in some of these

1 catchment areas there may not really be very many
2 office-based physicians available.

3 So, I think looking at the number of
4 primary care physicians available per number of
5 beneficiaries in that catchment area would also
6 be helpful and also looking at the urgent cares
7 in that area.

8 So, I did just want to elucidate that
9 not all acute care is the same.

10 CHAIR OPELKA: Thank you.

11 All right. The team has brought to my
12 attention that we have to highlight the do not
13 support consent calendar. So, that has two items
14 on it, the skill mix, which is the first one, and
15 the nursing hours per patient day. And the
16 question is, is there any request to move any of
17 these items on this calendar?

18 Dana?

19 MEMBER ALEXANDER: So, yes, I have a
20 request. On the skill mix and nursing hours per
21 patient day, to move that to conditional support
22 pending NQF endorsement.

1 CHAIR OPELKA: Both of them?

2 MEMBER ALEXANDER: Yes.

3 CHAIR OPELKA: The two measures?

4 Okay. A second?

5 DR. PHELAN: Second.

6 CHAIR OPELKA: Second. All right.

7 So, that is open for discussion.

8 They are endorsed?

9 MEMBER ALEXANDER: Yes, not at the
10 facility level, and I will speak to that.

11 CHAIR OPELKA: Okay. So, we do have
12 a second. So, if you wish to speak to that, go
13 ahead.

14 MEMBER ALEXANDER: So, just some brief
15 comments here on both of these measures, that
16 they focus on higher levels of nurse staffing,
17 which has been found to be associated with better
18 patient outcomes, things such as shorter length
19 of stay, lower rates of mortality, failure to
20 rescue, hospital-acquired infections, medication
21 errors, and pressure ulcers, to name a few.

22 It is a structural measure. They are

1 structural measures that have high impact on
2 quality, safety, and patient outcomes.

3 These measures have been well
4 researched and they are evidence-based, and they,
5 again, greatly implicate the staffing impacts on
6 quality and safety and outcomes for patients.

7 These measures are currently being
8 used in over 2,000 hospitals across the country.
9 And while originally reported at the patient care
10 unit level, they have now been tested at the
11 hospital level by NDNQI, who you heard about
12 earlier, and are ready to submit for endorsement
13 during maintenance review with NQF, I believe at
14 the 2015 Safety Subcommittee review.

15 Also, I believe that these measures do
16 fill a gap, even though it was stated in the
17 preliminary analysis by NQF that that wasn't
18 necessarily viewed. Because it was noted in the
19 2014 MAP report to Health and Human Services that
20 multiple stakeholders voiced a gap in nurse
21 staffing skills mix, along with some other
22 conditions as well.

1 I also understand that the MAP dual-
2 eligibles were grouped, and I will leave that to
3 Nancy to speak to, if she chooses, had a rather
4 robust discussion about the importance of nurse
5 staffing and skill mix for safety in vulnerable
6 populations as well.

7 So, it is also my understanding -- and
8 again, I would turn to my CMS colleagues here --
9 that these measures that would be reported, then,
10 and incorporated into the CMS five-star rating of
11 the reporting. And that way, then, these results
12 could really be translated into a meaningful
13 information for consumers and purchasers and
14 others outside of the individual hospital using
15 those reporting measures as well.

16 It is also my understanding, though,
17 that the NQF staff did not have this information
18 regarding how CMS would incorporate that into the
19 five-star rating at the time of review and
20 preparation for this meeting.

21 So, again, I know that we have NDNQI
22 subject matter experts on the phone, actually in

1 the audience as well, and those that actually had
2 conversation with CMS about how this could be
3 incorporated.

4 Lastly, I would suggest that this is
5 a parsimonious measure that impacts outcomes,
6 given the measure is clearly associated with
7 safety, quality, and patient outcomes.

8 Thank you.

9 CHAIR OPELKA: Karen, is your card up?
10 All right.

11 Any other comments from the group?

12 Pierre?

13 DR. YONG: Thanks, Dana, and thanks
14 for the opportunity.

15 I just want to clarify that in terms
16 of what Dana was referencing in terms of a STAR
17 rating for hospitals, that is the current project
18 that we are working on. We have a TEP in process
19 that is currently underway that is reviewing the
20 measures currently in Hospital Compare and making
21 recommendations about which measures would be
22 appropriate to include in a STAR rating.

1 So, that process is underway, and
2 those comments will be available for public
3 review and for public comment as well. So, those
4 decisions, final decisions, on which specific
5 measures would be included in STAR ratings has
6 not been made.

7 I just wanted to offer that
8 clarification.

9 Thank you.

10 CHAIR OPELKA: Thank you.

11 Jack?

12 DR. FOWLER: Yes, actually, I have to
13 say, when I looked at the list, I was surprised
14 that these were not supported.

15 From a user perspective, first of all,
16 I have to say this is one of the most easy-to-
17 understand measures around; that is to say, what
18 is the ratio of nurses, et cetera. Those seem
19 very transparent and nice.

20 The notion that it is more used -- I
21 understand outcomes and how you use your staff
22 can affect how things turn out. But, having lots

1 and lots of outcomes, almost all of which are
2 negative complications, which is all we can do,
3 again, from an evaluation and user perspective,
4 it is not nearly as helpful, it seems to me, as
5 one or two measures that says, what does the
6 nursing staff look like?

7 So, I think from a user point of view,
8 this is a pretty useful measure and parsimonious
9 in the sense that it can be a lot simpler than a
10 lot of the other ways we have to evaluate
11 material.

12 So, I am going to vote for this.

13 CHAIR OPELKA: Nancy?

14 MEMBER FOSTER: So, I have lots of
15 questions about the measure, the measures, but
16 really more appropriate for the endorsement
17 process. So, I will hold for that when that
18 comes up.

19 But my only comment is that there is
20 also a data transmission issue that, in fact, is
21 the same issue as before. If the registry that
22 is currently collecting the data can easily

1 transmit it to CMS, and CMS can accept it in a
2 way, so that we are reporting it once and using
3 it twice or more times, great. If not, we need
4 an easy-to-use mechanism that all hospitals,
5 including those who choose not to report through
6 the nursing database, can report the data if this
7 measure moves forward.

8 CHAIR OPELKA: Mitchell? Is your
9 microphone on?

10 DR. LEVY: I want to echo what Jack
11 said. Of all the measures, the recommendations,
12 this is the one that I was surprised at the
13 decision by staff, the recommendation by staff.

14 So, I guess, for me, it would be
15 helpful to hear again why the recommendation not
16 to support it. I can read, and I understand
17 about that there are measures, but I am still not
18 understanding fully the recommendation not to
19 support. And it is just counterintuitive for me.

20 CHAIR OPELKA: I asked the same
21 question. I said, why is this here? Yes, that's
22 what the question is to the staff: how did this

1 land in the do not support?

2 MR. AMIN: I will just say that the
3 preliminary analysis by the staff is driven by
4 the programmatic guidance, the measure selection
5 criteria that specifically states what types of
6 measures we're looking for.

7 And staff put it up as a straw person
8 for reaction. We have no skin in the game.

9 (Laughter.)

10 So, if you have an interest in
11 changing it --

12 DR. LEVY: Was this like late at night
13 after a lot of them, and you're saying, "I don't
14 like this one."?

15 (Laughter.)

16 MR. AMIN: It is what it is. If you
17 guys want to change it, it is your decision. I
18 mean, we just put together a straw person for you
19 to react to. So, if you would like to change it,
20 feel free.

21 (Laughter.)

22 CHAIR OPELKA: There's no defense for

1 them.

2 (Laughter.)

3 MEMBER FOSTER: I think the fact that
4 we had explicitly indicated a preference for
5 outcome measures and a lesser degree to process
6 measures, and really expressed a lack of
7 enthusiasm for structural measures, was probably
8 what drove their decisionmaking here, just out of
9 defense for their decision.

10 CHAIR OPELKA: Don't give them any
11 cover.

12 (Laughter.)

13 DR. LEVY: Yes, exactly.

14 CHAIR OPELKA: Don't give them any
15 cover.

16 Andrea?

17 MEMBER BENIN: Do we have a sense of
18 how the data will be, like the targets, the
19 benchmarks, like how would that be used? Like
20 how would that be reported? Because like what is
21 good, right?

22 So, every patient has 24 hours. Is it

1 8? Is it 17? Is it 12?

2 And I know that the NDNQI report comes
3 out by unit, but what are we aiming for here when
4 we see this data come up on Hospital Compare, or
5 wherever it is going to come up? Like what are
6 we -- that's my question.

7 CHAIR OPELKA: Dana?

8 MEMBER ALEXANDER: So, that was a
9 question that I had as well, and that is where we
10 need the measure steward to really speak to that,
11 and in terms of how the mechanics, and, then,
12 what might be the plan for CMS to incorporate
13 that into the five-star rating. So, I don't know
14 if the measure steward is available to speak.

15 CHAIR OPELKA: Very briefly.

16 MEMBER ALEXANDER: Okay.

17 MS. CRAMER: Hi. This is Emily
18 Cramer. I am with NDNQI, as the measure
19 developer. The American Nurses Association is
20 actually the steward, and I think they have got
21 folks in the audience.

22 Currently, we report this as sort of

1 quartile percentages of staffing, and it is
2 adjusted for expectations for different staffing
3 levels across different unit types. Of course,
4 you expect higher staffing on acute care than you
5 would on a medical unit, and so forth.

6 And so, that is how we sort of
7 calculate for the whole hospital, is to adjust
8 for those expectations of different staffing
9 across settings. And so, the adjustment that we
10 are making, proposing to make for the five-star
11 rating is to move pretty easily from the quartile
12 reporting to quintile reporting. So, you would
13 actually be able to see who is in the top versus
14 the lowest levels of nurse staffing across
15 hospitals.

16 Does that help --

17 CHAIR OPELKA: Thank you.

18 MS. CRAMER: -- answer the question?

19 CHAIR OPELKA: That was brief.

20 Any other?

21 (No response.)

22 All right. So, there are two measures

1 that are proposed to conditional support pending
2 NQF endorsement, as respecified for a facility.

3 All right, that's the motion.

4 The motion is to move from do not
5 support to conditional support, and the condition
6 is NQF endorsement. And it is a respecification.

7 MS. IBRAGIMOVA: So, the question is
8 skill mix, registered nurse, licensed
9 vocational/practical nurse, and unlicensed
10 assistive personnel and contract, and nursing
11 hours per patient day. Do you agree with the
12 motion to move it from do not support to
13 conditional support pending NQF endorsement?

14 One, yes; two, no.

15 (Vote.)

16 The results are 71 percent, yes, and
17 29 percent, no.

18 CHAIR OPELKA: All right.

19 So now, we have consent calendars, and
20 we have a support calendar, a conditional support
21 calendar. We do not have a do not support
22 calendar, and we have an encouragement for

1 continuing development. So, we have three
2 calendars to vote on.

3 So, first, the support calendar.

4 Oh dear. Something is happening to me.
5 I need a telescope. It used to be binoculars.
6 I'm angry. I'm getting angry over here.

7 (Laughter.)

8 MS. IBRAGIMOVA: IQR Consent Calendar

9 1. Support National Healthcare Safety Network
10 central-line-associated bloodstream infection
11 outcome; National Healthcare Safety Network
12 catheter-associated urinary tract infection
13 outcome, and participation in a Patient Safety
14 Culture Survey.

15 CHAIR OPELKA: All right.

16 MS. IBRAGIMOVA: Do you agree with the
17 support calendar? One, yes; two, no.

18 (Vote.)

19 The answers are 100 percent, yes; zero
20 percent, no.

21 CHAIR OPELKA: We are going to go in
22 a minute to the conditional support group. And

1 there were lots of different comments about the
2 conditions. Instead of repeating all those
3 conditions, we are just going to list the
4 measures. We captured your conditions in your
5 comments. So, for this next vote, we will go
6 through the list of those that have conditional
7 support.

8 MS. IBRAGIMOVA: IQR Calendar,
9 Conditional Support. Falls with injury; patient
10 fall rate; hospital 30-day, all-cause, unplanned,
11 risk-standardized days in acute care following
12 acute myocardial infarction hospitalization;
13 hospital 30-day, all-cause, unplanned, risk-
14 standardized days in acute care following heart
15 failure hospitalization; hospital 30-day, all-
16 cause, unplanned, risk-standardized days in acute
17 care following pneumonia hospitalization;
18 hospital-level risk standardized payment
19 associated with an episode of care for primary
20 elective total hip and/or total knee
21 arthroplasty; kidney/urinary tract infection
22 clinical episode-based payment measure; spine

1 fusion/refusion clinical episode-based payment
2 measure; cellulitis clinical episode-based
3 payment measure; gastrointestinal hemorrhage
4 clinical episode-based payment measure; hospital
5 30-day, all-cause, risk-standardized readmission
6 rate following pneumonia hospitalization;
7 hospital 30-day, all-cause, risk-standardized
8 mortality rate following pneumonia
9 hospitalization; cardiac rehabilitation patient
10 referral from an inpatient setting; proportion of
11 patients hospitalized with AMI that have a
12 potentially-avoidable complication during the
13 index day or in the 30-day post-discharge period;
14 proportion of patients hospitalized with
15 pneumonia that have a potentially-avoidable
16 complication during the index day or in the 30-
17 day post-discharge period; proportion of patients
18 hospitalized with stroke that have a potentially-
19 avoidable complication during the index day or in
20 the 30-day post-discharge period; skill mix,
21 registered nurse, licensed vocational/practical
22 nurse, unlicensed assistive personnel and

1 contract, and nursing hours per patient day.

2 Do you agree with the conditional
3 support calendar? One, yes; two, no.

4 CHAIR OPELKA: Laura, you need a
5 break.

6 (Laughter.)

7 Okay.

8 (Vote.)

9 MS. IBRAGIMOVA: The results are 79
10 percent, yes; 21 percent, no.

11 CHAIR OPELKA: All right. There is
12 one calendar that remains. There is nothing on
13 the do not support. The calendar that remains is
14 the encourage for continued development. Nothing
15 was pulled from here.

16 These were the adverse drug events;
17 hospital-wide all-cause, unplanned readmission;
18 the timely evaluation of high-risk in the ED; the
19 perinatal C-section. All of these I believe we
20 had also discussed yesterday as well. So, these
21 are all, as yesterday, they were in the encourage
22 for continuing development. They remain there

1 today. So, we are voting on these.

2 MS. IBRAGIMOVA: IQR Consent Calendar
3 7, Encourage for Continued Development. Adverse
4 drug events; inappropriate renal dosing of
5 anticoagulants; hospital-wide all-cause,
6 unplanned readmission; hybrid eMeasure; timely
7 evaluation of high-risk individuals in the
8 emergency department, and perinatal care;
9 cesarean section; PC O2; nulliparous; women with
10 a turned singleton baby in vertex position
11 delivered by cesarean section.

12 Do you agree with the encourage for
13 continuing development calendar? One, yes; two,
14 no.

15 (Vote.)

16 The results are 96 percent, yes; 4
17 percent, no.

18 CHAIR OPELKA: All right. Lunch.

19 (Laughter.)

20 So, at 1:30 we are going to reconvene,
21 but please grab your lunch. And then we will
22 start again at 1:30.

1 (Whereupon, the above-entitled matter
2 went off the record at 1:11 p.m. and resumed at
3 1:34 p.m.)

4 CHAIR OPELKA: So, we're going to ease
5 you back in just a little bit, I hope, by
6 shifting gears just a second going to the last
7 program that you have on your agenda called the
8 Hospital Readmission Reduction Program. That has
9 one measure which is currently classified as
10 support, and then we'll loop back to Value-Based
11 Purchasing in the Cancer Program. So, Hospital
12 Readmission Reduction Program. Would you describe
13 the program, please?

14 MS. BAL: Okay. So, we'll be talking
15 about the Hospital Readmissions Reduction
16 Program, also known as each readmissions.
17 Basically, pay-for-performance and public
18 reporting, payments are based on information
19 publicly reported on the Hospital Compare
20 website.

21 This is going to --- the incentive
22 program is for the last related group, so DRG

1 payment rates will be reduced based on a
2 hospital's ratio of actual readmissions. The main
3 critical program objective as determined in
4 October are to reduce the number of admissions to
5 an acute care hospital following discharge from
6 the same or another acute care hospital, engage
7 patients and their families as partners in care,
8 improve patient care and reduce overall health
9 care costs, exclude planned readmissions for the
10 measures in the program, encourage hospitals to
11 take a leadership role in improving care beyond
12 their walls to care coordination across providers
13 since the cause of readmissions are complex and
14 multi-factoral. Also, to improve care transitions
15 by reducing readmission rates to optimizing
16 processes under the hospital's control, and
17 acknowledging that factors affecting readmissions
18 are complex, and they include environmental,
19 community-level, and patient-level factors.

20 Lastly, just recognizing that multiple
21 entities across the health care system including
22 hospitals, post-acute care facilities, skilled

1 nursing facilities, and others all have a
2 responsibility to insure high-quality care
3 transitions to reduce unplanned readmissions.

4 CHAIR OPELKA: And I realize that if
5 everybody is in agreement and the one consent
6 calendar and one agenda item is unanimous we
7 don't need to do this, but Kelly and David spent
8 some looking at this, so, Kelly, would you like
9 to provide any comments?

10 MS. TRAUTNER: Only that I'm ready to
11 vote.

12 CHAIR OPELKA: Good. David, would you
13 like to provide any comments?

14 DR. ENGLER: Well, I've been told to be
15 brief, so I'll be brief. Let's vote for it.

16 CHAIR OPELKA: Okay. Boy, I tell you.
17 So, there is one measure and does anybody have a
18 motion to move that measure from the support
19 category? Nancy.

20 MS. FOSTER: So, I assume this is the
21 same measure we discussed this morning that
22 actually is being respecified and needs to come

1 back through NQF endorsement, so I'm not sure why
2 it ended up in support here, but I would think
3 that this falls in the --- at the very least
4 support with condition of NQF endorsement. And I
5 want to get clarity from staff on that point.

6 MR. AMIN: That is correct. It is
7 internally consistent. So, this isn't updated to
8 the finalized measure, and in that case it would
9 fall into the conditional support based on NQF
10 endorsement.

11 MS. FOSTER: So, I would like to
12 propose that we move this into the conditional
13 support pending NQF endorsement. And as I did
14 this morning, I would also like to add the
15 condition that the --- I'm sorry, whatever
16 Taroon's wonderful language was, but essentially
17 there be appropriate consideration of risk
18 adjustment, whether that's stratification or
19 anything else, appropriate considerations.

20 MR. AMIN: Let me just clarify that for
21 everybody else. It would be --- there would be a
22 re-review by NQF and endorsement, and then also

1 consideration for SDS adjustment in the upcoming
2 NQF trial period.

3 CHAIR OPELKA: Motion has been
4 seconded. Richard, did you have your card up?

5 DR. BANKOWITZ: I think Nancy covered
6 my thoughts on that. Thank you.

7 CHAIR OPELKA: Is there any other
8 discussion about this motion, and the entire
9 calendar, and all the measures? Okay, is there
10 any --- would we open it up --- oh, I'm sorry,
11 Nancy.

12 DR. HANRAHAN: This is a gap. Most of
13 these measures are --- have been developed on age
14 65 and older. And I know that there's a focus on
15 accommodating or including socioeconomic status
16 and disparities, so that's a whole area of gap in
17 relationship to this Hospital Reduction
18 Readmission Program, and I'd really encourage us
19 to put that as a high priority in some ways for
20 NQF to really take a look at that.

21 CO-CHAIR WALTERS: So noted. Any
22 comments in the room? Okay, Cathy, can we open it

1 up to public comment?

2 OPERATOR: Yes, sir. At this time if
3 you would like to make a comment please press
4 star then the number one. There are no public
5 comments at this time.

6 CO-CHAIR WALTERS: Comments in the
7 room? Would you tee up the vote, please? So, the
8 motion is to move it into conditional support. We
9 heard the conditions earlier. A yes vote will
10 mean you favor that movement.

11 MS. IBRAGIMOVA: So, the question is
12 hospital 30-day all cause risk standardized
13 readmission rate following pneumonia
14 hospitalization. Do you agree with the motion to
15 move to conditional support pending NQF
16 endorsement? One, yes; two, no.

17 (Voting)

18 MS. IBRAGIMOVA: The results are in, 96
19 percent yes and four percent no.

20 CO-CHAIR WALTERS: Thanks very much.
21 Okay, now we'll go back to the Value-Based
22 Purchasing Program. The Value-Based Purchasing

1 Program also has one calendar, all five measures
2 are classified as support, so we'll need details
3 of the program.

4 MS. BAL: Okay, so this is the Hospital
5 Value-Based Purchasing Program, also known as
6 VBP. This is a pay-for-performance program, and
7 the main goals are to improve health care quality
8 by realigning hospital's financial incentives and
9 to provide incentive payments to hospitals that
10 meet or exceed performance standards.

11 The critical program objectives
12 determined in October were to include measures
13 where there is a need or opportunity for
14 improvement. Focus on areas of critical
15 importance for high performance and quality
16 improvement, and I link clinical quality and cost
17 measures to capture value. NQF endorsed measures
18 are strongly preferred. Keep the program measure
19 set parsimonious to avoid diluting the payment
20 incentives, and some of the gaps that were
21 identified were to include medical error, mental
22 and behavioral health, emergency department

1 throughput, hospital's culture of safety, and
2 patient and family engagement.

3 CO-CHAIR WALTERS: Okay, the lead
4 discussants now. Michael. Sorry I caught you off
5 guard there.

6 MR. AMIN: Maybe we can walk through
7 the preliminary analysis, Ron, while he's getting
8 prepared.

9 CO-CHAIR WALTERS: Okay, walk through
10 the preliminary analysis first.

11 MR. AMIN: So, we won't go into detail
12 on the first --- let's give everyone a moment
13 here. We're still looking for it here, as well.
14 So, we have the 30-day risk standardized COPD
15 hospitalization mortality measure. Again, the VBP
16 Program currently includes 30-day readmission
17 rates for AMI, heart failure, and pneumonia. COPD
18 is another leading cause of death and
19 hospitalization. This measure is also currently
20 used in IQR supporting alignment and parsimony.

21 I would just point out that there were
22 two comments that were generally supportive on

1 this measure. We have the pneumonia
2 hospitalization risk standardized mortality rate
3 following pneumonia hospitalization measure. This
4 measure addresses critical program objectives
5 that have been identified. It is tested at the
6 appropriate level of analysis, NQF endorsed, and
7 it remains a critical area for measurement.

8 There was one comment that was
9 generally supportive on this measure. I don't
10 think there's a need, necessarily, to go through
11 the CLABSI measure. I think we've gone through
12 that measure quite a number of times. There were
13 no public comments received on this measure as it
14 relates to this program.

15 The quality measure, again, this is an
16 update to the finalized measure, and this was ---
17 there were comments on this measure similar to
18 what we've discussed before very much focused on
19 the spinal cord injury patients.

20 And then, finally, the final measure
21 on the VBP list here is the death among surgical
22 inpatients with serious treatable complications

1 which is PSI-4. This measure is NQF endorsed, and
2 has been prioritized by the MAP for inclusion in
3 the VBP Program, and addresses many of the
4 important improvable patient safety concerns.
5 There was one comment that was generally
6 supportive on this measure, so there are five
7 measures for consideration. All five are on the
8 support calendar.

9 CO-CHAIR WALTERS: Okay, Michael.

10 DR. PHELAN: You know, to me all these
11 just seem to be exactly as Taroon described, and
12 the idea that we support them kind of speaks to
13 where we want to go with quality measures going
14 forward. So, I would actually move to vote on
15 this support column, and do we need a whole lot
16 of discussion around these? Some of these have
17 been mentioned already. Can I move to make a
18 vote?

19 CO-CHAIR WALTERS: Okay. So, right now
20 there's a motion on the table for all five to
21 move to support. Hold that a second. Mitchell?
22 Mitchell is not here. Okay. Other discussion?

1 Nancy Foster.

2 MS. FOSTER: Thanks. Not to be
3 disagreeable, Michael, but there are a couple of
4 things I need to understand about these measures.
5 But, also, I would like to suggest that we pull
6 the death among surgical inpatients measure for
7 further discussion, and the --- and perhaps do
8 not --- I would recommend do not support. And the
9 --- I'm sorry, the mortality measures because
10 they're being retooled, I think we need to think
11 about conditional support there with bringing it
12 back once we've had a year of public reporting.
13 So, that would be my recommendation.

14 CO-CHAIR WALTERS: Michael? I'm just
15 wondering if you wanted to change your motion or
16 not?

17 DR. PHELAN: I'll support --- second
18 Nancy's recommendation to move --- to listen to
19 the discussion on these and see where we go with
20 it.

21 CO-CHAIR WALTERS: Okay. So, we have
22 number one and number two, motion to move to

1 conditional support, and number five to move to
2 do not support. Now we'll continue the
3 discussion. Richard?

4 DR. BANKOWITZ: Yes. With regard to the
5 pneumonia mortality my question was are we going
6 to move into Value-Based Purchasing the old
7 measure at a time when we're beginning to explore
8 the newer measure? That doesn't make sense to me,
9 so I agree with Nancy, we need to let this
10 measure move through the process, and then
11 publicly report the newer measure before it goes
12 into Value-Based Purchasing, unless we want a
13 disconnect between what's being measured in
14 various programs, which I think -- which would
15 be incredibly confusing, I think.

16 MS. FOSTER: Ron, I'd appreciate
17 clarity from CMS about --- to Richard's point,
18 what are we moving here?

19 CO-CHAIR WALTERS: Okay. Emma, or
20 Pierre.

21 DR. YONG: What's currently on the MUC
22 list are the measures that are already in the

1 program in IQR, so these are the current measures
2 that were previously reviewed by the MAAP.

3 MS. KOPLEFF: I'm sorry. So, we're ---
4 we never reviewed them for this program, though.
5 Correct?

6 DR. YONG: Correct.

7 MS. KOPLEFF: Okay, thank you. And just
8 a clarifying question for Nancy regarding the
9 COPD measure. You mentioned a need to publicly
10 report for a year first, but I'm just staying
11 with the --- how this program works. Wouldn't we
12 already have the --- we would have reporting ---
13 we'd have included in IQR for a full year before
14 the Value-Based Purchasing Program, so I'm just
15 clarifying the condition, if you will.

16 MS. FOSTER: So, I have to admit I was
17 confused. I thought we were trying to move
18 retooled measures, so I'm with Richard. I don't
19 understand why we'd be moving measures that
20 aren't up --- that CMS has declared not up to
21 snuff and has engaged in a process of retooling
22 to a Value-Based Purchasing Program.

1 CO-CHAIR WALTERS: So, your previous
2 motion was to move it into conditional support.

3 MS. FOSTER: Correct.

4 CO-CHAIR WALTERS: Is that motion
5 modified in any way?

6 MS. FOSTER: Yes, at this point I would
7 think that it --- do not support, I would move
8 that we do not support moving these into
9 Hospital Value-Based Purchasing with the
10 expectation that the appropriate measures would
11 come back after they've been included in IQR.

12 MR. AMIN: Well, I think Nancy has
13 brought up an important point that I think we
14 need some clarification on, because I think what
15 --- you've gone conditional support if it was the
16 updated version, and you've gone do not support
17 on the prior --- on the old version. So, if CMS
18 can clarify this measure that we're reviewing, is
19 it the original version, or is the one that's
20 going up --- undergoing updates?

21 DR. YONG: Yes, I apologize. So, the
22 COPD measure is not in the program, so that would

1 be a new measure for the program. The pneumonia
2 mortality measure is currently in the program.
3 What's up on the MUC list is the same measure we
4 reviewed before with the cohort change, so that
5 was the expanded to include aspiration pneumonia,
6 as well as pneumonia with sepsis. So, that was
7 the same discussion we had earlier.

8 CO-CHAIR WALTERS: I believe you
9 probably want to modify your motion again. Right?

10 MS. FOSTER: I need an aspirin. So, let
11 me see if I have this right. The COPD measure is
12 the one that's currently in IQR and is not being
13 retooled? Okay. So, let me modify my motion to
14 say I am no longer including COPD in my motion. I
15 am only focusing on the pneumonia measure, and in
16 my --- and I go back to conditional support on
17 the pneumonia measure conditioned on getting NQF
18 endorsement of that retooled measure having a
19 year's worth of data on it, and then bringing it
20 back here because at that point, you know, things
21 will have moved on. So, bringing it back for
22 potential inclusion in the program.

1 CO-CHAIR WALTERS: Yes, number one,
2 number three, and number four currently are in
3 the support bucket, and number two now has been
4 moved to conditional support, and number five is
5 still --- the motion is to move to do not
6 support. Is that your motions?

7 MS. FOSTER: Thank you for streaming it
8 so well, yes, that is my motion.

9 CO-CHAIR WALTERS: It does require a
10 little accountancy to keep track of these things.
11 Is there any other discussion at all about the
12 pneumonia --- let's take the pneumonia first. Is
13 there any other --- before we vote on that
14 motion, is there any other discussion about
15 moving the pneumonia measure to conditional
16 support for the reasons that Nancy said, and
17 Pierre agreed to? Okay, hearing none, want to do
18 a vote? Yes. Oh, sorry. Vote on the measure?

19 MR. AMIN: So, the vote is on your ---
20 pneumonia.

21 CO-CHAIR WALTERS: Measure two.

22 MR. AMIN: Okay. Nancy, I thought we

1 were on the same page.

2 CO-CHAIR WALTERS: This vote is on
3 measure two to move to conditional support.

4 MR. AMIN: Okay, yes. It's the
5 pneumonia mortality rate, the hospital 30-day all
6 cause risk standardized mortality rate following
7 pneumonia hospitalization moving to conditional
8 support.

9 CO-CHAIR WALTERS: Correct.

10 MS. IBRAGIMOVA: So, the question is
11 hospital 30-day all cause risk standardized
12 mortality rate following pneumonia
13 hospitalization. Do you agree with the motion to
14 move to conditional support? One, yes; two, no.

15 (Voting)

16 MS. IBRAGIMOVA: The results are 96
17 percent yes, and four percent no.

18 CO-CHAIR WALTERS: Okay, that just
19 created another calendar. And then the second
20 motion was to take measure five, death among
21 surgical inpatients and move it to do not
22 support.

1 MS. FOSTER: So, let me be clear about.
2 The concept of being able to accurately measure
3 death among surgical inpatients or any other
4 group of inpatients is incredibly important.
5 However, this AHRQ PSI by CMS' own analysis as
6 they contracted with Mathematica to do, has
7 extremely low levels of reliability, and that ---
8 so low that you really can't suggest that this
9 is an accurate and fair measure. And for that
10 reason, I don't think this measure should be
11 used. Personally, I don't think it should be used
12 for public reporting, but certainly not moving it
13 into a pay-for-performance program where we
14 cannot accurately assess performance, either
15 improvement or actual performance.

16 MS. OWENS: This is Pam Owens from
17 AHRQ. Can I speak?

18 CO-CHAIR WALTERS: Yes. Go ahead.

19 MS. OWENS: Okay, sorry. Nancy, I'm not
20 sure which report you're referring to about
21 Mathematica's analysis. Isn't this the one that
22 was brought up several years ago?

1 MS. FOSTER: To the best of my
2 knowledge, Pam, there hasn't been another one
3 done, so yes.

4 MS. OWENS: Okay. So, that one actually
5 has a lot of details that don't make this
6 actually appropriate --- well, appropriate not
7 the word. Completely accurate to this discussion.
8 That was trying to make a distinction between six
9 months of data and two years of data. And, in
10 addition, additional analyses both with
11 Mathematica and our other contractors actually
12 show higher reliability, so I could go back and
13 I'd be happy to come back to the Committee with
14 the full details of why that particular memo
15 actually doesn't adequately reflect what was
16 going on, the reliability was calculated
17 differently than the way that we calculate
18 reliability. For instance, it was based on six
19 months of data, AHRQ actually doesn't recommend
20 using six months of data. I mean, there's lots of
21 details here that are not quite consistent, so I
22 don't want to put --- I understand where you're

1 coming from, Nancy, but I think at some point
2 we've got to come to some conclusion regarding
3 that memo, in particular, because it doesn't ---
4 on the surface it might look like it's
5 representing what you're talking about, but in
6 its detail it actually doesn't give a fair
7 picture.

8 MS. FOSTER: So, Pam, I appreciate
9 that, but our read was that they were using 24
10 months worth of data, so there's a lot of
11 information that needs to be clarified here. And
12 until that is clarified, I cannot suggest going
13 forward with this measure.

14 CO-CHAIR WALTERS: Pierre, or Richard?

15 DR. BANKOWITZ: Yes. So, Premier uses
16 this measure in its own improvement
17 collaboratives as a measure we report on. There's
18 a lot of concern about this measure, I will say
19 that. Our members are not particularly convinced
20 it's measuring what it's intending to be
21 measuring, and we're in the process of trying to
22 actually validate some of it, so I do think there

1 is some concern about whether or not this measure
2 accurately captures these surgical patients with
3 treatable conditions, so I have to support Nancy
4 and say this is not yet ready to go to a Value-
5 Based Purchasing model.

6 CO-CHAIR WALTERS: Sean.

7 DR. MORRISON: Just another concern
8 that's been brought to my attention by a number
9 of people in the palliative care field where the
10 majority of surgical deaths are not due to
11 complications. This has had a chilling effect on
12 palliative care consultation because the surgeons
13 are worried, very worried about the mortality
14 rates. Not specifically this one, but the 30-day
15 mortality rates, what we're seeing is
16 consultations on day 31, so that this has had a
17 very, very strong affect on people having a
18 comfortable death in the hospital because of
19 worries about the mortality rates.

20 MS. OWENS: This is Pam Owens again
21 from AHRQ. I just want to speak to this notion of
22 reliability just so that we can deal concretely

1 with some numbers. When we look at it with the
2 HCAHP databases using version 4.5, our
3 reliability estimate is on the average signal to
4 noise ratio is .704, just so that's --- I didn't
5 have that number when I was talking before.

6 DR. PHELAN: Can you tell us what that
7 means?

8 MS. OWENS: Well, that's a good
9 question. Let's see. So, the metric regarding
10 reliability that we use is a signal to noise
11 ratio, which is the ratio between the hospital
12 variance which is a signal to the within hospital
13 variance which is the noise. So, the formula that
14 we're using is signal over signal plus noise. It
15 is --- we use an empirical base variance
16 shrinkage estimator, and what it's saying is that
17 the percent of signal variance that is explained
18 by performance score is around 70 percent.

19 DR. PHELAN: Meaning that 30 percent of
20 the time you're getting a lot of noise, so a
21 number closer to 100 percent or closer to one is
22 considered a reliable measure. Correct?

1 MS. OWENS: Well, not necessarily
2 reliable. That would be a perfect measure which
3 is not possible. But, you know --- so, if you
4 think about it above .65, you know, between .65
5 and .70 is really actually very good reliability.

6 CO-CHAIR WALTERS: Cristie had her hand
7 up next.

8 MS. TALLANT: I just wanted to know, is
9 this measure already being reported in IQR? And
10 do we have any information from IQR as to how
11 this measure is performing, and any variation or
12 any information from the IQR reporting that would
13 help us with this discussion?

14 DR. YONG: We'd have to check into
15 that.

16 MS. TALLANT: Thank you.

17 CO-CHAIR WALTERS: Nancy?

18 MS. FOSTER: And, Pam, I appreciate the
19 data you just shared, but the HCAHP database is
20 an all-payer database, and what we're talking
21 about here is calculating it on Medicare-only ---
22 Medicare fee-for-service only patients, which

1 has a much smaller sample size, which usually
2 decreases the level of reliability of the data,
3 and the published results that I'm referring to
4 suggest that the measure has a .32 level of
5 reliability.

6 MS. OWENS: Right. Well, so, Nancy,
7 you're absolutely right in terms of reliability
8 as a function of a sample size. So, when you deal
9 with reliability on six --- which is one of the
10 reasons why AHRQ doesn't suggest using it on six
11 months of data. However, you're 100 percent
12 correct in that what Medicare is --- what this --
13 - what Value-Based Purchasing and IQR refer to as
14 the Medicare fee-for-service population, and then
15 there's IPPS Hospitals. And what the HCAHP
16 analysis is, is an all-payer database and it's
17 community non-rehab hospitals, so there's a
18 little bit of distinction between the hospitals
19 included in one versus the hospitals included in
20 the other.

21 That being said, AHRQ and CMS are
22 actually working very collaboratively to try to

1 better align so that going in both in terms of
2 when it goes to NQF, and you all know at the MAP
3 in the future what is the reliability as
4 estimated not on six months of Medicare fee-for-
5 service data but actually estimated on the two-
6 year reporting period, and what is the
7 reliability of an all-payer database? So, we
8 understand exactly what that translation is.

9 CO-CHAIR WALTERS: Michael?

10 DR. PHELAN: Would it be possible to
11 get some data, some reliability data on just the
12 Medicare database? Would that help move this from
13 a do not support to a conditional support based
14 on what that data shows? And if the reliability
15 is within a reasonable expected range, you can --
16 - I'm not sure for this type of quality metric
17 what kind of reliability is necessary or wanted.
18 Would that be helpful to you, Nancy, because I'm
19 hearing two distinct differences. I'm hearing oh,
20 we've got a huge database and it says this, and
21 I'm hearing well, you know, it's an all-payers
22 but we have data on the Medicare, the reliability

1 on the Medicare database, and would that help you
2 move from a do not support to a support, because
3 I think this is an important area that I want to
4 at least see if we can get some data out around
5 it?

6 CO-CHAIR WALTERS: Richard?

7 DR. BANKOWITZ: It wouldn't help me
8 because I think the reliability data is
9 interesting as a measure of the precision of the
10 measure. It's not a measure of the accuracy of
11 the measure. What we want to know is how
12 accurately does this classify patients correctly,
13 and for that you need to go to the chart and make
14 a decision as to whether, in fact, this was death
15 from a treatable complication. So, to my
16 knowledge it hasn't been done yet. We're actually
17 starting to look at that because we think this is
18 an important measure to explore, but I think
19 reliability is only secondary to the accuracy of
20 this measure to accurately classify.

21 CO-CHAIR WALTERS: So, if I can
22 summarize the last 20 minutes or so today there

1 are concerns about the validity and the
2 statistical application of the data that's
3 available to this program. We're not going to
4 resolve that today. We're not going to --- the
5 statisticians can go on forever about things like
6 that. So, is there any other discussion from
7 anyone? Emma?

8 MS. KOPLEFF: I'm wondering if NQF
9 staff can comment or the developers on if and
10 when this measure is due for endorsement
11 maintenance, because I think that could reflect
12 on our desire as we've discussed to sort of see
13 some of the updated research specific to the
14 Medicare population.

15 MR. AMIN: Yes. Unfortunately, I was
16 just looking around to see if my colleague Andrew
17 --- oh, actually, he is. Okay. No, okay. So, yes,
18 it's not clear when this measure would be up. We
19 can find that information out, but we don't have
20 that in front of us. This measure is currently
21 endorsed, and that process does have a sense of
22 looking at reliability.

1 MS. OWENS: This is Pam Owens from
2 AHRQ. We are planning on submitting AHRQ's
3 perspective for Fiscal Year 2016, so that would
4 be the next year. It is currently --- PSIs are
5 the focus of all refinement, the major
6 refinements for the AHRQ QI program. Every
7 indicator goes through an annual review, and then
8 we do deep dives into particular modules or
9 particular indicators, so that's an ongoing
10 process, as well. We will bring all of that
11 information back to the NQF. My understanding is
12 that it has already been reviewed twice by NQF
13 and endorsed twice by NQF. That's why it's up
14 again. So, I hope that helps.

15 CO-CHAIR WALTERS: Nancy?

16 MS. FOSTER: In response to your
17 question, Michael, what would --- I don't think
18 this particular panel is constituted in a way to
19 judge the reliability, and validity, and accuracy
20 of the measure, but if the condition were that
21 it go through NQF for consideration of
22 endorsement as used in the Medicare program, I

1 could live with that. I could live with that. So,
2 if that is something that people feel more
3 comfortable with, I'm happy to change my motion
4 from do not endorse to endorse conditional upon
5 review by NQF as a Medicare fee-for-service
6 measure with particular consideration for
7 reliability, validity, and accuracy given all of
8 the clinical concerns, as well as statistical
9 concerns that have been raised about this
10 measure. I know that technically NQF always looks
11 at those things, but this one needs an eagle eye.

12 CO-CHAIR WALTERS: Any other
13 discussions? Okay. Any public comments about ---
14 not yet, not yet. So, we have a motion we have
15 not voted on yet. The motion about measure five,
16 death among surgical inpatients, has been
17 modified now to conditional support with the
18 conditions as mentioned by Nancy and discussed
19 around the table. Are we ready to set up a vote
20 for that?

21 MS. IBRAGIMOVA: So, the question is
22 death among surgical inpatients with serious

1 treatable complications, PSI 4. Do you agree with
2 the motion to move to conditional support pending
3 NQF review and endorsement? One, yes; two, no.

4 (Voting)

5 MS. IBRAGIMOVA: The results are 91
6 percent yes, and nine percent no.

7 CO-CHAIR WALTERS: Okay, that leaves us
8 now with two calendars, calendar one on the
9 Value-Based Purchasing Program which is support,
10 and calendar two which is conditional support.
11 Before voting on the calendars we would like to
12 open up the lines for public comment. Cathy,
13 would you --- or Andrea.

14 DR. BENIN: Before it didn't seem like
15 it was the moment to bring it up, but I would
16 move that we pull off the NHSN measures off of
17 the Value-Based Purchasing with the rationale
18 that they are in a lot of flux right now. They're
19 going to be in the IQR anyway. Is now the right
20 time to put them in the VBP? Sorry, I didn't get
21 a chance to make that movement before the other
22 discussion.

1 OPERATOR: I'd like to ask for public
2 comment, press star one on your telephone key
3 pad.

4 DR. BENIN: I would just stick it in do
5 not support for now, and then it'll get figured
6 out in the next cycle. That's my proposal. Me and
7 HAC and 50 million other things.

8 CO-CHAIR WALTERS: Yes, are there any
9 public comments?

10 OPERATOR: There are no public comments
11 on this time.

12 CO-CHAIR WALTERS: Are there any
13 comments in the room? Okay, there are no comments
14 in the room.

15 First, let's --- just a second. So, I
16 understand now that you withdrew your previous
17 comment about pulling them off?

18 DR. BENIN: Specifically put it into do
19 not support. There wasn't a moment before for me
20 to say that.

21 CHAIR OPELKA: So, just so we're clear,
22 these measures are in the program.

1 DR. BENIN: But not in the new format.
2 This is the new format version where there are
3 like different ways of reporting it, and the new
4 definitions.

5 CHAIR OPELKA: So, the vote do not
6 support what you're supporting is keeping the old
7 format in, because those measures ---

8 DR. BENIN: I would propose ---

9 CHAIR OPELKA: --- are in. They're in,
10 so now you're voting to supplant those with new
11 ones. If you want a do not support, you're
12 leaving the old ones in.

13 DR. BENIN: It would be a conditional
14 do not support with CMS to figure out how to make
15 it all right.

16 CHAIR OPELKA: No, there isn't a
17 conditional do not support. There's a conditional
18 support.

19 DR. BENIN: I would do --- then I would
20 do not support on both sets of measures.

21 CHAIR OPELKA: You can't do ---

22 DR. BENIN: The ones out of there.

1 CHAIR OPELKA: The other --- the old
2 measures are not up. They're in the program.

3 DR. BENIN: Okay. Then why don't I
4 express my concerns in form of commentary because
5 I don't --- there's no motion then that I can
6 make, Frank, that will get us there. So, I will
7 say to you that I think that having measures that
8 are currently under flux ---

9 CHAIR OPELKA: You can make a
10 conditional support.

11 DR. BENIN: What is the condition?

12 CHAIR OPELKA: You can't do a
13 conditional do not support.

14 DR. BENIN: I can't think of what the
15 condition is, though. The condition is that they
16 get appropriate IQR exposure as they normally
17 would, as opposed to --- like it doesn't make
18 sense to me to do it this way. I'll just say that
19 I think that these measures would need to have
20 their usual --- help me out, Nancy.

21 MS. FOSTER: If I can, I think Andrea
22 is raising a very important question. Right?

1 Which is the timing of moving these into Hospital
2 Value-Based Purchasing. You've got to have a
3 year's worth of data collected as they are
4 specified in the new way in order to move them
5 into Hospital Value-Based Purchasing, so my
6 assumption, and I guess I should be very clear
7 about that and get confirmation from CMS, is that
8 they are proposing these for Hospital Value-Based
9 Purchasing at this point knowing that they will
10 not move in for a couple of years.

11 CHAIR OPELKA: That can be the
12 condition.

13 MS. FOSTER: Until the ---

14 CHAIR OPELKA: That they meet the
15 statute.

16 MS. FOSTER: Okay.

17 DR. BENIN: That they meet the statute
18 and in that pending time take down the measures
19 that conflict with the other reporting
20 mechanisms.

21 CHAIR OPELKA: No, that's not ---

22 DR. BENIN: Because we've now ---

1 CHAIR OPELKA: --- in order. Those
2 measures are in the program. We're not removing -
3 --

4 DR. BENIN: I'm persistent, I'm very
5 persistent.

6 MS. FOSTER: But I think the ---we're
7 going to be in this funny flux and that ---
8 because these measures are already in Value-
9 Based Purchasing under the old specification.

10 DR. BENIN: They are? I thought they
11 were not.

12 MS. FOSTER: Yes. Yes.

13 CHAIR OPELKA: They are.

14 MS. FOSTER: They are in the program
15 under the old specification. You can't continue
16 to run them under the old specification and the
17 new specification to judge improvement. You have
18 to have this sort of strange year. I don't know -
19 -- or two. So, I'll be very curious as to how CMS
20 handles that.

21 CO-CHAIR WALTERS: We talked about this
22 yesterday morning, but yes, looking for some sort

1 of guidance about how you would phase these in
2 and phase the other ones out.

3 DR. YONG: So, I think this is an
4 important question that's been raised, and we did
5 just talk about this yesterday. And just to
6 repeat what I said yesterday, I think we are
7 aware that there is potential confusion when, you
8 know, we have two different rates up. I don't
9 think we have at this point figured out exactly
10 how to phase it in, and how to minimize --- but
11 the goal would be to minimize confusion. And,
12 certainly, that would be done through rulemaking,
13 as well, so there would be opportunities for
14 transparency and for public comment.

15 Just related to sort of the concern
16 here, you know, I think what Nancy's motion,
17 which was approved earlier, which was moving the
18 pneumonia measure with the expanded cohort from
19 support into conditional support after one year
20 of public reporting was my understanding of that
21 motion, seems like maybe the idea that would
22 address Andrea's concern would be to move these

1 measures into that same sort of condition.

2 CO-CHAIR WALTERS: Would you like to
3 make a motion?

4 DR. BENIN: Okay. I move that we move
5 the measures --- the two NHSN measures to
6 conditional support on the condition that they go
7 through the appropriate duration of reporting and
8 evaluation through the IQR and other processes.

9 CO-CHAIR WALTERS: Is there a second?

10 DR. BANKOWITZ: Second.

11 CO-CHAIR WALTERS: There's been a
12 recurrent theme for two days now. Take a vote on
13 the motion about the CAUTI's and CLABSI's moving to
14 conditional support.

15 MS. IBRAGIMOVA: So, the question is
16 National Health Care Safety Network's central
17 line associated blood stream infection outcome
18 and National Health Care Safety Network catheter-
19 associated urinary tract infection outcome. Do
20 you agree with the motion to move from support to
21 conditional support? One, yes; two, no.

22 (Voting)

1 MS. IBRAGIMOVA: The results are 91
2 percent yes, and nine percent no.

3 CO-CHAIR WALTERS: Okay, thank you.
4 Assuming that no one has any last minute changes
5 about measure one, we have one measure left in
6 calendar one, the support calendar. We can now
7 subject that to a vote. Support calendar one.

8 MS. IBRAGIMOVA: The Value-Based
9 Purchasing consent calendar one support hospital
10 30-day all cause risk standardized mortality rate
11 following chronic obstructive pulmonary disease
12 hospitalization. Do you agree with the support
13 calendar? One, yes; two, no.

14 (Voting)

15 MS. IBRAGIMOVA: The results are 87
16 percent yes, and 13 percent no.

17 CO-CHAIR WALTERS: Thank you for that
18 vote. Now we'll proceed to the vote of what would
19 be calendar two, which didn't start out this
20 session as a calendar but has become a calendar
21 with four measures in it. Do you have those lined
22 up?

1 MS. IBRAGIMOVA: Value-Based Purchasing
2 consent calendar conditional support. Hospital
3 30-day all cause risk standardized mortality rate
4 following pneumonia hospitalization, death among
5 surgical inpatients with serious treatable
6 complications PSI-4, National Health Care Safety
7 Network central line-associated blood stream
8 infection outcome, and National Health Care
9 Safety Network catheter-associated urinary tract
10 infection outcome. Do you agree with the
11 conditional support calendar? One, yes; two, no.

12 (Voting)

13 MS. IBRAGIMOVA: The results are 96
14 percent yes, and four percent no.

15 CO-CHAIR WALTERS: Thank you for your
16 votes. Okay, that's ---

17 (Off microphone comment)

18 CO-CHAIR WALTERS: Okay, that concludes
19 Value-Based Purchasing. Now we'll proceed with
20 the PPS-Exempt Cancer Hospital Quality Reporting
21 Program. Would you delineate the details of the
22 program, please?

1 MS. BAL: So, this is the PPS-Exempt
2 Cancer Hospital Quality Reporting Program. It is
3 a reporting program with information publicly
4 reported beginning in 2014, so this year. There
5 is currently no financial incentive for the 11
6 hospitals in this program, and CMS plans to
7 create an incentive program in the future.

8 The main critical program objectives
9 are include measures appropriate to cancer
10 hospitals that reflect the highest priority
11 services delivered by these hospitals, align
12 measures with the Inpatient Quality Reporting
13 Program, and the Outpatient Quality Reporting
14 Program, where appropriate and relevant. And the
15 following gaps should be considered, cancer care
16 --- I'm sorry, in cancer care quality are pain
17 screening and management, patient and family care
18 giver experience, patient reported symptoms and
19 outcomes, survival, shared decision making, cost,
20 care coordination, and psycho social and
21 supportive services.

22 MR. AMIN: So, we'll start off with at

1 least 12 regional lymph nodes are removed and
2 pathologically examined for resected colon
3 cancer. This measure, the preliminary analysis
4 summaries of this measure, these are all within
5 the support calendar, so there are eight measures
6 in the support calendar, and one measure in the
7 measure under development pathway where we're
8 encouraging continued development.

9 The first is at least 12 regional
10 lymph nodes are removed and examined for colon
11 cancer. This measure addresses critical program
12 objectives identified for the PPS-Exempt Cancer
13 Hospitals. It has been tested to the appropriate
14 level of analysis. This is NQF endorsed and
15 promotes alignment across programs.

16 This measure received two public
17 comments. The Alliance of Dedicated Cancer
18 Hospitals noted that there are very high rates of
19 performance in cancer centers, particularly the
20 performances between 95 and 99 percent with
21 minimal opportunity for quality improvement. And,
22 further, there was concern around the exclusion

1 criteria that needs to be clarified and evaluated
2 for comprehensiveness for this patient
3 population.

4 Second is the post-breast conservation
5 surgery irradiation. So, the measure addresses
6 critical program objectives for PPS-Exempt Cancer
7 Hospitals, been tested to the appropriate level
8 of analysis, is NQF endorsed, and supports
9 alignment.

10 There was commenters that were very
11 supportive but noted the inclusion criteria needs
12 to be both clarified and evaluated for
13 comprehensive before application to this program.
14 Again, the comments are from the Alliance for
15 Dedicated Cancer Centers, noted that this measure
16 is topped out in the 90 percent range with
17 several centers reporting 100 percent.

18 Third is a needle biopsy to establish
19 diagnosis of cancer, so this measure addresses
20 critical program objectives for PPS-Exempt Cancer
21 Hospitals, also tested for the appropriate level
22 of analysis, NQF endorsed, and supports

1 alignment.

2 So, there was one comment on this
3 measure noting that this measure assesses
4 adherence to important standard of care, but does
5 not support this measure due to its exclusions.

6 Further, there was concern that this
7 metric might be discriminatory toward PPS-Exempt
8 hospitals that have a high rate of volume of
9 external referrals where diagnostic biopsy is not
10 necessarily by core needle biopsy.

11 Moving on to number four, hospice and
12 palliative care treatment preferences. This
13 measure is also appropriate for the level of
14 analysis, NQF endorsed, and promotes alignment
15 across programs.

16 There was one comment again by the
17 Alliance of Dedicated Cancer Centers that was not
18 supportive of this measure since only three of
19 the eleven centers have inpatient palliative care
20 units limiting the scope of application of this
21 measure.

22 So, we have the MRSA outcome measure.

1 This has been tested to the appropriate level of
2 analysis, this is NQF endorsed, and also supports
3 alignment.

4 Again, we got another --- we have a
5 similar comment from the ADCC, the Alliance of
6 Dedicated Care Centers, that generally supports
7 this measure, but believes stratification for
8 cohorts of cancer patients should be applied.
9 ADCC also noted that this would be duplicative
10 reporting through lab ID.

11 Moving on we have the C. diff outcome
12 measure. Again, preliminary analysis stated that
13 it meets the program objectives, is appropriate
14 for the level of analysis, and is NQF endorsed.

15 So, we received one public comment
16 that was not supportive, noting multiple
17 concerns, primarily noting that ADCC Centers have
18 patient populations that are uniquely at risk for
19 C. diff infections given underlying factors
20 associated with the diagnosis and treatment of
21 cancer.

22 We have two influenza measures,

1 influenza immunization, and influenza vaccination
2 among health care personnel. The first one,
3 again, meets the program objectives, is endorsed,
4 and is in alignment.

5 There were two comments that were
6 generally supportive of this measure. There are
7 concerns that the target population should be
8 clearly identified and additional exclusion
9 criterias --- exclusion categories should be
10 applied to this measure. And there were some
11 specific recommendations around exclusions
12 related to patients receiving anti-B cell
13 antibodies and patients receiving intensive
14 chemotherapy.

15 For the influenza vaccination coverage
16 among health care personnel, again that was
17 supported for the appropriate level of analysis,
18 NQF endorsed, and supporting alignment across
19 programs.

20 And there were two comments generally
21 supportive on this measure with the ADCC noting
22 that contraindications and exceptions for this

1 measure should be clarified to insure reporting
2 compliance.

3 And then, finally, if it's okay, Ron,
4 I'll just also include the measures under
5 development for the sake of ease. So, this
6 measure is still under development, and yet to be
7 included in the program. Upon submission and
8 recommendation of NQF endorsement, this should be
9 reviewed again by this group. So, it generally
10 was encourage continued development.

11 We did receive one comment on this
12 measure from the ADCC that was strongly
13 supportive of this measure, and encouraged
14 continued final testing.

15 So, those are the eight measures that
16 are in consent calendar one for support. And then
17 we have one measure under consent calendar number
18 two, which is encourage continued development.

19 CO-CHAIR WALTERS: Before we go to the
20 lead discussants, I will ask for any request to
21 pull anything from the calendar? Karen?

22 DR. FIELDS: So, we would like to

1 discuss needle biopsy, E0221, palliative care,
2 E1641, MRSA, E1716, C.diff, E1717, influenza
3 immunization, E1659, and influenza vaccination,
4 E0431. And we'd also like to discuss the measure
5 in development.

6 CO-CHAIR WALTERS: Where did ---where
7 are you planning on pulling those to? Would you
8 run through that?

9 DR. FIELDS: Do you want to go through
10 them individually?

11 CO-CHAIR WALTERS: For now where you'd
12 like to pull them to.

13 DR. FIELDS: So, I'd like to put the --
14 - we would like to discuss hospice in the do not
15 support category. We would like to discuss C.diff
16 in the do not support category, although I need
17 the comments from the Committee to further
18 categorize that. And then the remainder would be
19 into the support under certain conditions, or
20 support with conditions, conditional support. And
21 then I would like to propose changing the
22 hospitalization measure to conditional support

1 pending NQF endorsement.

2 MR. AMIN: Can I just clarify that
3 last one? So, that's the unplanned readmissions?

4 DR. FIELDS: Yes.

5 MR. AMIN: So, just for clarification,
6 since it's a measure under development there's
7 only two decision categories currently. The
8 encourage continued development, and you could
9 put additional conditions around that which we
10 will capture. The other option there is the do
11 not support continued development.

12 DR. FIELDS: Although earlier today we
13 took several under development conditions and
14 moved them into conditional support.

15 MS. O'ROURKE: So, I think you're
16 referring to the episode-based payment measures.
17 We have received additional data that they were
18 further along in the process. Has this gone
19 further in its development process?

20 DR. FIELDS: Yes, and we'd like to
21 discuss that.

22 MR. AMIN: It's fully developed and

1 tested, this measure?

2 DR. FIELDS: Do you want to discuss
3 that one now, or do you want ---

4 CO-CHAIR WALTERS: No, not now.

5 DR. FIELDS: Yes, we've discussed some
6 new information.

7 CO-CHAIR WALTERS: Nancy, do you have
8 your card up?

9 MS. FOSTER: No.

10 CO-CHAIR WALTERS: Okay. So, the first
11 two have not been pulled. Oh, Cristie, yes.

12 MS. TRAVIS: Well, just to make it
13 complete. You know, I would like to consider
14 these for do not support with the rationale of
15 the fact that they're already topped out, and
16 that there's not a gap.

17 CO-CHAIR WALTERS: Meaning the first
18 two?

19 MS. TRAVIS: Yes, I'm sorry. Yes, the
20 first two. It would be 0225, and 0219.

21 CO-CHAIR WALTERS: Well, I don't think
22 there's any more that can be pulled from the

1 calendar one. Okay. Lead discussant, Sean.

2 DR. MORRISON: So, Ron, I completely
3 missed that I was the discussant on this, and I
4 can't believe this. I'm really sorry, just missed
5 it.

6 CO-CHAIR WALTERS: No problem, wanted
7 to give you a chance to talk. Shelley?

8 MS. FULD NASSO: So, I actually think
9 it might be more helpful if I --- if we can hear
10 and respond to some of the reasons for taking it
11 off.

12 CO-CHAIR WALTERS: And off the top of
13 my head I don't remember who's here for Louise.
14 Okay. Let's take the first measure then since
15 everything is going somewhere.

16 The 12 regional lymph node measure
17 which has been --- Cristie has suggested be
18 pulled to conditional support.

19 MR. AMIN: Yes, do not support.

20 CO-CHAIR WALTERS: Do not support, yes.
21 I've got to get that down. Cristie?

22 MS. TRAVIS: Just reiterate I think

1 that the information that was provided indicated
2 that this measure is pretty much topped out
3 between 95 and 99 percent, and I'm looking for
4 where the performance gap is that including it in
5 a reporting program would help improve the
6 measure.

7 CO-CHAIR WALTERS: Karen?

8 DR. FIELDS: NQF agrees with the fact
9 that it's --- that this is a topped out measure.
10 We shouldn't want to bring every measure for
11 discussion. We feel that this an important
12 quality measure because it's associated --- no
13 dissection is associated with improved outcomes.
14 However, it's a topped out measure and we would
15 encourage the development of outcome measures, so
16 we would feel supportive either way to not report
17 this, or to report this.

18 CHAIR OPELKA: Karen, where --- we're
19 trying to find where the NQF said it's topped
20 out.

21 DR. FIELDS: We're talking about the
22 ADCC Centers that all report outcomes of measures

1 in the range of 95 to up to 100 percent, so that
2 --- or not up to 100 percent in this measure. I
3 apologize, but high compliance, always over 90
4 percent, so it's probably just the max that one
5 could achieve based on the anatomy of patients at
6 the ADCC Centers. So, that's why we feel that
7 these --- this measure is topped out for the ADCC
8 Centers. Nationally we think this is a very
9 important measure, and we're happy to continue to
10 report this measure, but ---

11 CHAIR OPELKA: I don't think this is
12 topped out. I mean, my --- I have a question
13 about these first two, and it may be a problem
14 with all of these, that major cancer centers,
15 these are probably topped out, but everywhere
16 else they're not. So, the 12 regional lymph nodes
17 are not topped out across the country. They may
18 be topped out in these 11 hospitals; in fact, I
19 suspect that they are. And we kind of put them
20 into the program to get these measures into a
21 cancer culture anticipating these would be
22 benchmark hospitals that everyone else could

1 target, so if we're going to take them out of
2 this program that's fine, but we put them in here
3 fully expecting they would be topped out. And
4 then we were going to consider rolling them over
5 into national programs, and using this as part of
6 the benchmark pool.

7 DR. FIELDS: And we agree with that
8 rationale as a benchmark. I think that there is -
9 -- remains a gap nationally, not just at academic
10 centers, but around the country as a gap, so we
11 defer to --- we'll continue to report those.
12 That's why we did not ---

13 CHAIR OPELKA: So, let me just check.
14 Is the NCDB on the phone?

15 MS. McNAMARA: Yes, we are.

16 CHAIR OPELKA: Do you have --- I'm
17 looking at two measures, the 12 regional lymph
18 nodes and the post-breast conservation surgery
19 irradiation. Actually, I guess I'm looking at
20 three, the needle biopsy to establish the
21 diagnosis of cancer precede surgical excision. Do
22 we know from cancer centers reporting to the NCDB

1 if there's a gap in these measures?

2 MS. McNAMARA: So, I'll start with the
3 PPS-Exempt Program. For the 12 regional lymph
4 node measure there is -- for 2013 the minimum
5 compliance rate was 89.5 percent all the way up
6 to 100 percent with an average of about 97
7 percent within those centers. Overall for
8 programs participating in the rapid quality
9 reporting system which is where this measure is
10 drawn from for this project, the compliance rate
11 was at 90 percent.

12 For the post-breast conserving surgery
13 irradiation measure, the minimum in the ADCC
14 hospitals was 82 percent with a maximum of 100
15 percent. This is for 2012, which is the last year
16 that we have complete data because 2013 hasn't
17 completed yet until the end of this year. The
18 average for the ADCC hospitals was about 94
19 percent, and the average overall in reporting
20 facilities was around 87 percent.

21 In the needle biopsy measure within
22 the ADCC hospitals for 2012, which is the most

1 recent year that we have complete, data for this
2 measure, it's in --- it's not in our charts. We
3 don't have current data for it. The mean for the
4 ADCC hospitals was 86 percent compliance, the
5 minimum started out at around 60 percent
6 compliance all the way up to a maximum of 97
7 percent. And the overall for all COC-accredited
8 facilities is at 86 percent. And that was pulled
9 just a couple of weeks ago.

10 CHAIR OPELKA: Great, thank you. That's
11 very helpful.

12 MS. McNAMARA: You're welcome.

13 CHAIR OPELKA: So, that shows you that
14 there's an awful lot of compliance but there are
15 some tails there, and that was just to try and
16 make sure as you're thinking about this where you
17 want it to land.

18 DR. FIELDS: So, we kept one and two on
19 the list for reporting, but we defer to the rest
20 of the group discussion on those.

21 Concerning needle biopsies, we have
22 just a few --- we wanted to ---

1 CO-CHAIR WALTERS: Hold that just a
2 second because I wanted to make sure we stay
3 focused. Right now we're on the first measure
4 which is the 12 regional lymph nodes, one. We'll
5 get that background information you just heard is
6 important as we work our way through this, but
7 we'll never get through them if we don't get
8 through them in some sort of organized fashion.
9 Nancy?

10 MS. FOSTER: So, especially given the
11 data we've just heard, I'm wondering if Cristie
12 would consider an amendment to her motion to make
13 this a conditional support, and the condition be
14 that CMS consider rolling them into the broad-
15 based IPPS Program for --- the IQR Program either
16 simultaneously or very quickly thereafter.

17 MS. TRAVIS: I would fully support
18 that, which is what I have actually had a
19 position on prior to this MAAP, and so my only --
20 - just to give you the rationale, was I was
21 thinking of them only as applicable to the PPS-
22 Exempt Cancer, but I would definitely support

1 Nancy's revision. I think we've got to move these
2 cancer measures out into the community-based
3 hospitals, as well as with the PPS-Exempt.

4 MS. TRAVIS: I would like it recorded
5 that I proposed a couple of measures being moved
6 into IQR.

7 CO-CHAIR WALTERS: No longer Nancy the
8 destroyer, she's Nancy the creator.

9 MS. TRAVIS: Let it be known this is
10 the second time in two years that Nancy and I
11 have been on the same page.

12 CO-CHAIR WALTERS: Michael, were you
13 going to say something?

14 DR. PHELAN: Just supporting that. I
15 mean, it's a great idea and there's a gap. That's
16 where we need to identify where the gap is, and
17 we need to move that and probably more rapidly
18 than the standard fare.

19 CHAIR OPELKA: So, the only thing that
20 --- and I agree with what was just said. To me,
21 though, the lesson learned is that while these
22 PPS-Exempt cancer hospitals serve as a great

1 benchmark and incentive, and we still need to
2 find where are the opportunities for gap
3 measurement and improvement in those exempt
4 hospitals. So, we're finding their sweet spot
5 here in cancer, and they're setting a bar that
6 everyone else has to achieve, but we still have
7 to identify a subset, so there's a gap -- because
8 they're performing so well on these areas,
9 there's a gap in their measurement system that we
10 have to figure out and close.

11 CO-CHAIR WALTERS: Any other discussion
12 about the first measure? Okay, we'll open up for
13 a vote on the motion to move the measure from
14 support to conditional support. You heard the
15 condition.

16 MS. FOSTER: Just for clarity, I
17 thought Cristie's motion was around both, but
18 maybe I was just misunderstanding.

19 CO-CHAIR WALTERS: We're going to get
20 to that second one.

21 MS. FOSTER: You want to take them one
22 at a time? That's fine.

1 CO-CHAIR WALTERS: I do.

2 MS. IBRAGIMOVA: So, the question is at
3 least 12 regional lymph nodes are removed and
4 pathologically examined for resected colon
5 cancer. Do you agree with the motion to move from
6 support to conditional support? One, yes; two,
7 no.

8 MR. AMIN: Just for clarification just
9 for the record, the condition is that the measure
10 be considered to be rolled into a broader
11 community of hospitals, not just PPS-Exempt
12 hospitals.

13 (Voting)

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

16 CO-CHAIR WALTERS: There's that Frank
17 vote again. Okay, proceed now to measure two,
18 which you have heard two pieces of it so far. The
19 post-breast conservation surgery irradiation, the
20 proposal there was originally to move in do not
21 support, and then it was modified to move it into
22 conditional support. Do I have that right,

1 Cristie? With the same condition that we just
2 heard. Is there any discussion regarding measure
3 two? Okay, we'll vote on that motion.

4 MS. IBRAGIMOVA: So, the question is
5 post-breast conservation surgery irradiation. Do
6 you agree with the motion to move from support to
7 conditional support on the basis of moving it to
8 broader community hospitals not just for PPS
9 hospitals. One, yes; two, no.

10 (Voting)

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

13 CO-CHAIR WALTERS: Okay, thank you for
14 your votes. We'll now move to measure three,
15 which is needle biopsy to establish diagnosis of
16 cancer preceding surgical excision resection. And
17 the motion on the table made by Karen is to move
18 that to conditional support. Is there further
19 discussion about that? Nancy?

20 MS. FOSTER: If I could get clarity on
21 what the condition is?

22 CO-CHAIR WALTERS: Before we take the

1 NCDB, Karen, would you state your condition?

2 DR. FIELDS: So, we feel that this is
3 a very important measure. All patients should
4 have a needle biopsy, preferably a closed biopsy
5 prior to undergoing surgical interventions;
6 however --- and, also, the ADCC Centers, as you
7 heard, are not yet topped out in this measure.

8 We wanted --- the two conditions that
9 we wanted to bring to this group's attention were
10 that as freestanding cancer hospitals that see a
11 large number of referrals, many of the --- some
12 patients that come to us have already had
13 excisional biopsies, and that is required to be
14 reported as an excisional biopsy from our center
15 which would detrimentally affect our scores in
16 that measure.

17 Additionally, there's been over the
18 years not much clarification about needle ---
19 about biopsies that remove all of the tissue.
20 There's finally a clarification around that
21 measure recently updated, and we recommend
22 postponing the adoption of this measure until

1 further validation by each registry to assure
2 that no false positives exist for that measure.
3 All of these are outlined in our comments.

4 I would also say that this isn't a
5 measure that we're actively reporting through
6 AHRQ QRS, so it does pose some additional
7 resources to report this measure. In general,
8 though, we support this measure. We think it's a
9 very important quality measure for breast
10 surgery.

11 CO-CHAIR WALTERS: Okay, thank you. I
12 believe there was a comment on the phone?

13 MS. McNAMARA: Yes. I thank the ADCC
14 for their comments. We are actually in the annual
15 update for this measure through the NQF, and we
16 are making some changes, one of which we only
17 include patients where the breast cancer was
18 actually diagnosed within that facility, so that
19 should remove the issue of referrals.

20 We're also including this to be that
21 patients who receive image or palpitation get a
22 biopsy for the diagnosis of breast cancer, so

1 we're making a couple of changes to include the
2 exclusions that were in the public comments,
3 which are that just areas that cannot be captured
4 within the cancer registry for medically ---

5 clinically relevant reasons why a needle biopsy
6 would not be performed to establish diagnosis of
7 breast cancer. And those will be reported and
8 submitted to the NQF by the end of this month.

9 CO-CHAIR WALTERS: Would you say that
10 those changes are in line with the conditions of
11 the conditional support that were stated?

12 MS. McNAMARA: Yes, it includes the
13 only including patients diagnosed within that
14 facility, which we actually have in our measure
15 rules right now, and all of the exclusions that
16 were in the public comments.

17 CO-CHAIR WALTERS: Discussion? Karen?

18 DR. FIELDS: Question, but I'd like to
19 modify my motion then. I'd like to --- my
20 conditions would be upon finalization of the
21 updated NQF endorsement.

22 CO-CHAIR WALTERS: Nancy?

1 MS. FOSTER: And that was exactly my
2 question. I don't know if these changes are
3 significant enough to require a re-review, but
4 whatever the NQF decides, as long as it --- if it
5 does require re-review, then we wait for that.

6 CO-CHAIR WALTERS: So, the condition on
7 --- you heard the condition on the motion. It's
8 dependent on NQF endorsement of a slightly
9 retooled measure. Ready for a vote on measure
10 three, and the motion is to move it to
11 conditional support?

12 MS. IBRAGIMOVA: Needle biopsy to
13 establish diagnosis of cancer precedes surgical
14 excision/resection. Do you agree with the motion
15 to move to conditional support pending review and
16 NQF endorsement? One, yes; two, no.

17 (Voting)

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

20 CO-CHAIR WALTERS: Okay, thank you
21 again. Now we move now to measure four in this
22 set, which is hospice and palliative care. Karen

1 made a motion to move that to do not support.

2 Karen?

3 (Off microphone comment)

4 CO-CHAIR WALTERS: It's close? We get
5 a few more chances to practice voting. Measure
6 four, any other discussion? Karen?

7 DR. FIELDS: So, we have put this in
8 the do not support category, but I wanted to
9 clarify that we think that advanced directives
10 are some of the most important things that we can
11 do for cancer patients. And only three of the
12 eleven ADCC Centers have a formal inpatient
13 palliative care unit, or an inpatient hospice
14 unit. The remainder, and also the --- all 11
15 cancer centers have an approach of early
16 discussions about palliative care, quality of
17 life, supportive care, goal setting that's
18 pervasive throughout the time of care and
19 throughout the diagnosis. So, the other centers
20 all have very strong palliative care teams. It's
21 not clear whether being followed by a palliative
22 care team would constitute being in a palliative

1 care unit.

2 And the other clarification is that it
3 defines patients as seriously ill, which is not a
4 --- always a good description of who's the
5 appropriate patient for goal setting, quality of
6 life, and palliative care interventions. So, we
7 feel that this is an important measure, and we
8 endorse the concept of advanced care planning;
9 however, we don't think that this measure applies
10 to enough of our cancer centers to make it a
11 valuable measure for reporting.

12 CO-CHAIR WALTERS: Okay, Sean.

13 DR. MORRISON: I figured you'd call on
14 me. So, Karen, just a couple of brief comments.
15 First of all, 11 of your sites do have active
16 palliative care teams and 87 percent of NCI-
17 designated cancer centers do, so palliative care
18 units are actually a small segment of palliative
19 care delivery.

20 Number two is that the measure applies
21 to people followed by palliative care teams or
22 hospices, if you look at the specs. So, this

1 would apply to patients who have been followed by
2 either palliative care consultation teams or
3 admitted to units.

4 Number three, it's not about advanced
5 care planning, it's actually about goals of care
6 discussion, which I would suggest are critically
7 important for anybody with cancer. And I would
8 suggest that anybody with cancer get themselves
9 into a comprehensive cancer center probably has a
10 serious illness.

11 And number four is, if you would ever
12 suggest --- if you ever need a reason for this
13 measure, I refer you to Bwanda's new book when he
14 talks about how his father is cared for at one of
15 our designated cancer centers. I just can't see
16 any reason why we wouldn't endorse this measure.
17 It's like --- it's as American as apple pie.
18 People with serious illness, people followed by
19 palliative care, they need to have their wishes
20 discussed. They need to have it addressed, and we
21 need to know what their goals of care are.

22 CO-CHAIR WALTERS: Nancy?

1 MS. FOSTER: Sorry. So, here's my
2 ignorance about the COPs for the cancer care
3 hospitals, the 11. Do they fall under the same
4 Conditions of Participation as general acute care
5 hospitals? No? Oh, you don't know either.

6 So, I'm curious about this measure as
7 a standalone measure because I would have assumed
8 that for inpatient care that the first step was
9 making sure everybody had an opportunity to
10 articulate their advanced care directives, and
11 that question would come up every time. If it's
12 not a COP for cancer hospitals, I would assume
13 that measure might be something you'd consider.
14 And then I join Sean in supporting this as a
15 critically important aspect of care for these
16 patients.

17 CO-CHAIR WALTERS: Go back to Shelley.
18 Shelley?

19 MS. FULD NASSO: I also agree with what
20 Sean said, and how important it is to have
21 patient's goals of care documented. I do --- I
22 find the denominator for this a little bit

1 confusing that you have to enrolled in hospice or
2 receiving palliative care. It just seems to me
3 anybody who's in a cancer hospital should have
4 this, period. It does --- so, I understand the
5 concern about those two conditions, and maybe you
6 can speak better to that, but it seems to me that
7 the denominator should be anybody who's inpatient
8 in a cancer hospital. I mean, if you're there you
9 should have had these discussions about goals of
10 care, so I think it's really important.

11 I just don't want it to get lost over
12 --- but I do think it's important that we clarify
13 that because I'm confused by that.

14 DR. MORRISON: Ron, I can clarify that,
15 if you'd like.

16 CO-CHAIR WALTERS: Okay. First, I'm
17 going to go to Michael.

18 DR. MORRISON: Just having been here
19 long enough and chaired the NQF Committee that
20 actually reviewed this, the reason --- that was
21 discussed when this came up for NQF endorsement.
22 It had only been tested in a hospice or

1 palliative care consultation team setting, and
2 couldn't be applied more broadly, although that
3 was discussed by the panel that endorsed it.

4 CO-CHAIR WALTERS: Okay. Michael?

5 DR. PHELAN: I think this is one of
6 those critical measures that we're trying to get
7 to, especially surrounding patient engagement.
8 And, you know, for some small little issues
9 surrounding it, I think it's --- we're going to
10 lose the greater picture here of trying to get
11 these kind of measures to the kind of measures
12 that we want to have our hospitals engaged with.
13 It's an EHR retrieved data point, so making it
14 aware, making it a priority for this Committee in
15 supporting something like this, I see as one of
16 our crowning achievements, so I strongly support
17 this measure.

18 CO-CHAIR WALTERS: You would not
19 support moving it to do not support. Yes. Karen?

20 DR. FIELDS: So, I would clarify that
21 we support the concept of advance directives in
22 all patients, and most of our hospitals have a

1 strategy to discuss advanced care measures with
2 every patient that comes through the door.

3 The way this metric is written, the
4 numerator and denominator don't define the
5 patient population adequately. And many of the
6 cancer centers have moved towards combining
7 supportive care and palliative care into a team
8 so that patients have early supportive care
9 interventions. So, are you going to ask the teams
10 to go back and say no, you have a supportive care
11 consult, and you have a palliative care consult
12 when the most important thing is goals, and
13 setting goals, and discussion, and quality of
14 life for all of our patients that come through.
15 So, I think that this measure doesn't capture the
16 spirit of what we should all be doing, which is
17 defining patient's goals and objectives of their
18 care from the very beginning. And when we're
19 talking about pain control, and symptom relief,
20 and everything else, that's why we support ---
21 that's why we have these early palliative care
22 support team interventions, rather than the way

1 this measure says seriously ill patients should
2 have discussions of their advance directives.

3 I think this is --- I think we agree
4 completely that this is the way we should manage
5 and treat all of our patients, and that's the ---
6 and we should be the lead in doing this, rather
7 than trying to look at only the end of life which
8 is implied by this measure, and offer advance
9 care directives.

10 DR. MORRISON: So, we don't back and
11 forth, but a clarifying, just a clarifying point.
12 Palliative care in 2014 is provided to improve
13 quality of life for any person with a serious
14 illness whatever the diagnosis, as the same time
15 as disease directed or curative treatments. In
16 many cancer centers because of marketing to
17 oncologists it is often called supportive care.
18 Don't argue with me, Karen. And it's been about
19 marketing to oncologists having sort of them
20 doing that research.

21 Again, if we think about it from the
22 time of diagnosis in concert with others, it's

1 very, very appropriate, and I think this is the
2 time to start. I would love to say that all goals
3 of care discussions should happen with every
4 cancer patient, but this is, as Michael said, a
5 really good starting point.

6 CO-CHAIR WALTERS: Is your card still
7 up? Yes. Karen, is your card --- Richard?

8 DR. BANKOWITZ: So, in an effort not to
9 let the perfect be the enemy of the good, I'll
10 ask Karen if she would consider amending her
11 motion so that we move this to conditional
12 support, that the condition be that CMS be highly
13 encouraged to apply this over the entire spectrum
14 of patients in the cancer care center.

15 DR. FIELDS: I guess --- can I --- no
16 one called on me yet. And, Frank, this is going
17 to be your favorite question, but you're not ---
18 Ron's leading right now, which is I think that
19 what our issues with --- are the specifics of the
20 inclusion and exclusion criterion, how we
21 appropriately define patients. The words
22 "seriously ill patients" doesn't give us enough

1 information. We think that this measure doesn't
2 adequately capture that --- the spirit of early
3 interventions, or life setting goals of therapy
4 and outcomes, and early discussions about
5 advanced care. This talks about seriously ill
6 patients.

7 Now, if you're going to define every
8 single patient with cancer as seriously ill, then
9 we'll have to come up with a measure to address
10 that. So, I think it's difficult for centers that
11 are very sophisticated, have extensive palliative
12 care programs to understand how to meet the
13 spirit of this measure. So, I would entertain ---
14 and I defer also to Ron, who's also a member of
15 an ADCC Center, if there's any other comments.
16 But we could entertain a conditional measure upon
17 further clarification of the metrics that that's
18 --- otherwise, I think it doesn't necessarily get
19 to the spirit of a lifetime of palliative care
20 and supportive care for patients diagnosed with
21 cancer.

22 CHAIR OPELKA: Yes, this is --- I'm

1 trying to put the right filter on this
2 conversation because I think everyone agrees the
3 concept of this measure has just got to be. But,
4 Karen, you're raising really valid points about
5 the measure as it's currently constructed, and I
6 don't this is the simple retooling of the
7 measure. I'm getting a sense that it's bigger
8 than that, so I'm a little bothered by
9 conditional, unless we're going to really put
10 some tight conditions on it. And I understand
11 where you're coming from, by do not support the
12 message is this is an important area. We need a
13 better measure than this, go rewrite it. And
14 that's a bigger statement than conditional
15 support, move it into a Medicare age, or fix a --
16 - tweak a few things in the risk adjustment.
17 That's a little bit different.

18 It's almost as if we support the
19 direction, but this needs work. And I'm not -- I
20 don't want to put words in your mouth, but I'm
21 hearing a very strong message from everybody, we
22 want this measure, but it's not spec'd in a way

1 that makes it work. Karen, that's what I'm
2 hearing you say.

3 CO-CHAIR WALTERS: I don't think
4 there's any more points that can be made about
5 this measure. The motion on the table is to move
6 it to do not support. Let's open up the voting
7 for that motion.

8 MS. IBRAGIMOVA: Hospice and palliative
9 care treatment preferences. Do you agree with the
10 motion to move from support to do not support?
11 One, yes; two, no.

12 (Voting)

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

15 CO-CHAIR WALTERS: So, the motion to
16 move it to do not support did not --- is no, and
17 so it remains in the support.

18 Let's move on to measure five, which
19 is ---

20 DR. BANKOWITZ: I don't know if you'd
21 entertain a motion. Is that in order?

22 CO-CHAIR WALTERS: Probably depends on

1 what the motion is.

2 DR. BANKOWITZ: Well, the motion is
3 that we move this measure to support with
4 conditions, we put some conditions on it around
5 the numerator and denominator, and make it known
6 that there are some serious concerns about how
7 it's defined.

8 CO-CHAIR WALTERS: So, that's very
9 close to measure development that Frank was
10 alluding to. The measure steward from this is
11 CMS. It's North Carolina, University of North
12 Carolina, so that's right. I remember, I looked
13 at this before. I understand what you said. I
14 just don't ---

15 CHAIR OPELKA: The way to say this,
16 Richard, if I could would be there's one of two
17 ways, and you would have to think about what's in
18 your heart and pick one of those two. One would
19 be to support the direction and continue
20 retooling this measure. The other one would be a
21 conditional support pending updating this measure
22 and resubmitting for NQF endorsement. So, it's --

1 - they're very similar to each other, but you're
2 --- the second one has a higher bar of rigor
3 because it requires the NQF endorsement to it.

4 DR. BANKOWITZ: Then let me amend my
5 motion to reflect the second option that Frank
6 just mentioned, which is to encourage th is be --
7 - condition this upon being updated, resubmitted,
8 and reviewed by NQF.

9 CO-CHAIR WALTERS: Second?

10 DR. FIELDS: Second.

11 CO-CHAIR WALTERS: Is there any further
12 discussion?

13 MR. AMIN: I think the only question we
14 have is that we just want to make sure that the
15 conditions are really clear, so I have heard the
16 condition around clarifying the denominator
17 statements, but if there could be additional
18 comments around specifics about what the
19 conditions would be, that would be helpful in our
20 handoff to CMS and to the developers, just to
21 make sure that they were clear.

22 (Off microphone comment)

1 DR. FIELDS: Yes, I think that many of
2 them are in our comments, but I would also say
3 that we'd want to clarify what a palliative care
4 team is versus supportive care consults, since
5 hospitals blend those two. So, somehow to
6 describe that issue.

7 DR. MORRISON: I mean, I just respond
8 to Karen, you know, there is a national consensus
9 project definition of what palliative care and
10 palliative care teams are that's been in
11 existence for now 10 years and three revisions.
12 There's a Joint Commission Certification Program
13 that defines what palliative care is. Please
14 let's not redefine palliative care, or ask the
15 NQF to do that given that people in the field
16 have done that, and defined what a palliative
17 care team is in the patient population they see.
18 So, I would really argue strenuously against
19 redefining that once more.

20 DR. FIELDS: I'll withdraw that, and
21 many of the NQF centers or ADCC Centers are Joint
22 Commission Palliative Care.

1 CHAIR OPELKA: That's really helpful,
2 but since you were involved in this measure
3 previously, any guidance that you have specific
4 that would help us in terms of the numerator and
5 denominator?

6 DR. MORRISON: Yes, the Committee
7 really wrestled with this, Frank, and the issue
8 was that everybody wanted to get away from a
9 prognostic-based definition, because in that
10 case, as we know with hospice, nobody knows when
11 people are going to die except right before
12 death. So, that's why the compromise with serious
13 illness.

14 There was a strong feeling from the
15 Committee that if you were being seen by a
16 palliative care team, and sort of not a symptom
17 management team, or enrolled in hospice then by
18 definition you probably had serious illness. And
19 serious illness was looked at as a combination of
20 functional impairment, multi-morbidity, disease-
21 specific data, or high symptom burden. And that's
22 why the denominator was either being followed by

1 hospice or palliative care team. Serious illness
2 was to get away from both the disease-specific,
3 or prognostic-based measure.

4 The Committee really wrestled with
5 this for a number to get a better specific
6 denominator, and this is the best they could come
7 up with. And this was a lot of people who were --
8 - I would say that the North Carolina group did
9 present some very good data on reliability and
10 validity about capturing this.

11 CO-CHAIR WALTERS: Karen?

12 DR. FIELDS: I don't think that serious
13 illness adequately defines the patient population
14 in the cancer patient.

15 CO-CHAIR WALTERS: Shelley?

16 MS. FULD NASSO: I don't think anybody
17 with cancer doesn't have a serious illness,
18 especially if they're at a --- I mean, it seems
19 to me this is defined for a broader hospital
20 population, not just cancer hospitals, but it
21 seems to me anybody with cancer has a serious
22 illness.

1 It's still limited also by who has the
2 hospice or palliative care, so it's --- I mean,
3 if you are seeing any --- a palliative care
4 specialist or in hospice, you have a serious
5 illness.

6 CO-CHAIR WALTERS: Okay, these are
7 complicated issues. I want to take this to a
8 vote, so the motion that's on the table by
9 Richard is to do a conditional support based on a
10 bunch of magic occurring.

11 DR. BANKOWITZ: I don't think it's a
12 bunch of magic. I think that we have some
13 concerns about the precision of the definition
14 which can, I'm sure, be addressed, and we have
15 some concerns about if the denominator can be
16 broadened, which I'm sure can be addressed. So,
17 those are, I think two valid conditions we could
18 put upon this.

19 MS. IBRAGIMOVA: So, hospice and
20 palliative care treatment preferences. Do you
21 agree with the motion to move from support to
22 conditional support pending updates,

1 resubmission, and NQF endorsement? One, yes; two,
2 no.

3 (Voting)

4 MS. FOSTER: Ron, while we're waiting
5 for the results to come up, is it appropriate
6 after we get the results to suggest something for
7 the gap list or hold?

8 CO-CHAIR WALTERS: Perhaps we can do
9 that after we get all through all the measures
10 that exist, just so we keep things on. So, the
11 motion carries.

12 MS. IBRAGIMOVA: So, the results are 68
13 percent yes, 32 percent no.

14 CO-CHAIR WALTERS: Measure five is meth
15 resistant staph aureus, which the motion on the
16 table by Karen is conditional support. Would you
17 restate what those are?

18 DR. FIELDS: So, the main condition is
19 that we think that because of the immune
20 compromised nature of the patients in our centers
21 we would like to --- we will see a higher rate of
22 complications, but if we could have this --- we

1 recommend that this measure be stratified for
2 liquid tumors versus solid tumors and bone marrow
3 transplant patients so that we're reporting in
4 those three different stratifications rather than
5 overall.

6 CO-CHAIR WALTERS: Is there discussion
7 about that? Shelley, is that your card? Any
8 discussion, going once, going twice?

9 MS. FULD NASSO: Which one was that,
10 the C. diff or the MRSA one?

11 CO-CHAIR WALTERS: This is the
12 methicillin resistant. Okay, we'll put the motion
13 up for a vote.

14 MS. IBRAGIMOVA: National Health Care
15 Safety Network facility-wide inpatient hospital
16 onset MRSA bacteremia outcome measure. Do you
17 agree with the motion to move from support to
18 conditional support?

19 MR. AMIN: The condition is that the
20 measure be reported based on stratification of
21 the cancer type.

22 MS. IBRAGIMOVA: One, yes; two, no.

(Voting)

MS. IBRAGIMOVA: The results are 72 percent yes, 28 percent no.

CO-CHAIR WALTERS: Okay, thank you. We'll move on to measure six now, which is the C. diff measure. The motion on the table from Karen was do not support. Would you repeat your reasons why?

DR. FIELDS: So, this one I wanted to get feedback from the group on. The ADCC Centers recognize that reporting C. difficile is an important problem. All ADCC Centers are engaged in routinely monitoring for C. difficile infections; however, our patient populations are at unique risk for C. diff infections because of the underlying factors associated with diagnosis and treatment. All of our patients have had prior hospitalizations, prior antibiotics, advanced stage is common. Up to 50 percent of patients admitted to an inpatient facility are carriers of C. diff and many of the infections are --- thus, the patients are predisposed. And the Society for

1 Health Care Epidemiology of America, and the
2 Infectious Diseases Society don't recommend
3 screening in asymptomatic patients. They also
4 don't recommend treating asymptomatic patients,
5 so there's --- our recommendation is that our
6 patient --- for reporting purposes, reporting C.
7 diff in a patient population that's very high
8 prevalence of C. diff doesn't necessarily meet
9 the goals. We recommend that we develop measures
10 that focus on improved infection control, and
11 decrease the incidence of --- to decrease the
12 incidence of hospital-acquired infections, as
13 well as the development of rigorous antibiotic
14 stewardship programs, which are the key to
15 solving this problem.

16 We also would like to at least have a
17 condition that PCR measurement is --- varies from
18 institution to institution, some with high
19 degrees of sensitivity and specificity and,
20 therefore, infection rates may vary from center
21 to center. So, we --- I put it in the do not
22 support category, although I think there's some

1 conditions under which we could support it. And
2 recognizing that it does --- that our patient
3 population is at uniquely high risk of developing
4 this infection.

5 CO-CHAIR WALTERS: Thank you. Emma?

6 MS. KOPLEFF: I'm not going to address
7 all those things, but just on the point about the
8 unique risk for infection of these patients.
9 There is something philosophical there where it
10 seems to me that the unique risk makes it even
11 that more important that this is being measured
12 consistently. And I think we need to identify
13 where things stand, and have that measure as a
14 basis for improving. So, if we could address that
15 through the discussion, that would be great.

16 CO-CHAIR WALTERS: Dan, we thought we'd
17 hear from you.

18 DR. POLLOCK: Yes. Well, just a point
19 of clarification that the type of testing is
20 taken into account in the risk adjustment
21 process, so we're well aware of differences,
22 differences in sensitivity, and that is factored

1 into what's reported out.

2 I mean, I have to agree with the
3 notion that because this is a vulnerable
4 population, and because there's a great deal of
5 antimicrobial use, it makes it that much more
6 incumbent upon is to conduct sound surveillance
7 in that patient population.

8 CO-CHAIR WALTERS: Richard is next.

9 DR. BANKOWITZ: Yes. Thank you, Dan,
10 for those comments. And I wanted to add the
11 definition is looking at hospital onset of C.
12 difficile, so looking at carriers and treating
13 carriers doesn't really, I don't think, come into
14 the picture.

15 CO-CHAIR WALTERS: Andrea?

16 DR. BENIN: I think for better or for
17 worse we're already reporting on this for all of
18 the other hospitals, and so for the sake of some
19 standards it would be wise to have this be
20 consistent across all of them.

21 CO-CHAIR WALTERS: Nancy?

22 MS. FOSTER: So, I'm not sure it rises

1 to the level of a condition, but I think the
2 point that Karen is making is really important as
3 we think about the comparisons people might make
4 coming to Hospital Compare. So, I guess as I ---
5 given the fact that these 11 cancer hospitals
6 have such a different population, a much more
7 vulnerable population for this measure, and
8 perhaps for some others, I would think that we
9 would want them sort of reported separately so
10 that there can be an opportunity to explain to
11 the viewing public that you can't just take the
12 C. diff rate at Sloan Kettering and compare it to
13 the C. diff rate at St. Mary's in Iowa and think
14 you're comparing apples to apples.

15 CO-CHAIR WALTERS: In favor of the
16 motion or against the motion?

17 MS. FOSTER: I believe it is against
18 the motion but in favor of intelligent use of the
19 concerns that led to the motion.

20 CO-CHAIR WALTERS: Thanks. Karen?

21 DR. FIELDS: So, having feedback from
22 the CDC was helpful since we don't get to see all

1 the risk stratifications and numerator and
2 denominator. And if that's taking into account
3 that measures --- that addresses one of our
4 issues.

5 And I also think that to change this
6 from a do not support to support conditionally so
7 that our --- either the results are stratified by
8 our patient population, or reported separately,
9 both of those would be acceptable to at least put
10 our public reporting of this into light, change
11 it to conditional support.

12 CO-CHAIR WALTERS: Emma? So, the motion
13 has now been changed from do not support to
14 conditional support. Emma?

15 MS. KOPLEFF: I just would be remiss
16 not to express a little bit of concern that this
17 is a second infection measure we're discussing
18 for this program, and we're putting a lot of
19 conditions on a lot of these measures, which I
20 think has been a really valuable discussion. But
21 I'm not necessarily disagreeing with this
22 direction we're going, but I think there needs to

1 be a strong message that still says even if we're
2 voting conditionally we absolutely support these
3 outcome measures as priority areas to address in
4 the short term.

5 CO-CHAIR WALTERS: Any more discussion?

6 Oh, where am I? Frank. Oh, Frank.

7 CHAIR OPELKA: I guess I'm
8 uncomfortable. I --- Karen, I hear what you're
9 saying. I don't know that I'd buy it. I don't
10 know how different, and if you're statistically
11 different from other hospitals. Everybody is at
12 high risk for C. diff, and that's pretty clear,
13 and we heard it yesterday that that's the number
14 one problem out there. And MRSA is right behind
15 it, and everyone is at high risk for MRSA. And I
16 don't think your subset population is that much
17 different in risk than mine, which may not have
18 cancer, but may have other immuno compromising
19 diseases. So, what do we do with the hospital
20 that's high in AIDS? Do we say well, we're not
21 going --- we're going to stratify MRSA and C.
22 diff?

1 I actually don't like this. I'm very,
2 very uncomfortable. I think we all need a
3 national agenda to go after MRSA and C. diff. We
4 all need to recognize it. We all need to
5 understand what the measures mean when they come
6 out, but if we don't go after this world of
7 antimicrobials and how we use them and their
8 impact in the right way, the consequences are all
9 these super infections that are actually bringing
10 on a whole new burden to the health care system.
11 So, I wasn't supportive of the last measure, and
12 I'm not supportive of this one. I think everybody
13 needs an agenda on MRSA and C. diff, and I do not
14 buy what you're saying.

15 CO-CHAIR WALTERS: Shelley?

16 MS. FULD NASSO: Just a question. If
17 the motion is changed to conditional support,
18 what are the conditions now? I know the one about
19 the different --- the testing was resolved, so
20 what are the outstanding conditions?

21 DR. FIELDS: I think just --- the
22 condition was addressed about different testing

1 stratification, so it was just reporting them
2 separately. I don't understand how that would
3 work. Nancy gave us that information.

4 Additionally, Frank, we completely
5 agree that MRSA or MRSA and C. diff are
6 incredibly important infections in our
7 population, but we bring this --- this is the
8 collective request of the ADCC. So, that's --- I
9 bring it to this group for discussion.

10 CO-CHAIR WALTERS: Sean?

11 DR. MORRISON: I would just --- I would
12 expand on Frank's point. You know, our patients
13 need to take a lot of things into account when
14 they make decisions about where they get their
15 care. And if I'm debating between getting cancer
16 care, for example, at Memorial Sloan Kettering,
17 or across the street at New York Hospital, one of
18 the things that I really might like to know is
19 what are the MRSA rates between those two
20 hospitals, or in this case what are the rates of
21 C. diff, because that actually may be my life-
22 threatening event rather than my underlying

1 disease. And I do have a lot of trouble trying to
2 segment specific hospitals. Do we look at just
3 community hospitals, do we look at academic
4 medical centers?

5 Certainly, the data suggests that I
6 might get better cancer care in a designated
7 cancer center, for example. On the other hand, if
8 I'm going to die of C. diff, I might prefer to
9 get my cancer care elsewhere.

10 CO-CHAIR WALTERS: Okay. I think the
11 discussion has been very fruitful. Currently, the
12 measure, the C. diff measure sits on the support
13 list. Let's put the --- the motion is conditional
14 support. If the motion passes, it goes to
15 conditional support, if the motion fails it stays
16 on the support list.

17 MR. AMIN: And the condition is that
18 the measure be reported separately for this
19 patient population when publicly reported
20 specifically on Hospital Compare.

21 MS. IBRAGIMOVA: So, National Health
22 Care Safety Network facility-wide inpatient

1 hospital onset CDI outcome measure. Do you agree
2 with the motion to move from support to
3 conditional support? One, yes; two, no.

4 (Voting)

5 MS. IBRAGIMOVA: The results are 18
6 percent yes, and 82 percent no.

7 CO-CHAIR WALTERS: The motion stays on
8 the support list.

9 Measure seven is influenza
10 immunization, which has been proposed as
11 conditionally support. Karen, would you remind us
12 of the conditions?

13 DR. FIELDS: The two conditions for the
14 sake of discussion and brevity are to include
15 patients, or exclude patient --- add two
16 exclusions to the list, patients receiving anti-B
17 cell antibody therapy, such as rituximab, and
18 patients receiving intensive dose chemotherapy
19 for induction or consolidation of leukemia, as
20 both of these states have been found to be an
21 ineffective time to vaccinate patients. And those
22 are per the recommendations of the Infectious

1 Diseases Society of America. Otherwise, we fully
2 support influenza vaccinations in those patient
3 populations.

4 CO-CHAIR WALTERS: Other comments? Yes,
5 Woody?

6 DR. EISENBERG: It says here, "If
7 indicated," so given what you've told us about
8 what the Infectious Diseases Society is telling
9 us, does that mean that those people are not
10 indicated to get the vaccine? Then perhaps you
11 don't need to further modify this measure.

12 DR. FIELDS: They gave very specific
13 exclusion criteria, so we wanted to make sure
14 that those were included in the specific
15 exclusion criteria. Excluded solid organ, or
16 organ transplants, BMTs, other kinds of things,
17 so we felt strongly that we wanted to also
18 include another group of patients. I hear your
19 point, and that's an excellent observation.

20 CO-CHAIR WALTERS: Cristie?

21 MS. TRAVIS: I guess my thought,
22 though, is that it seems like there would be a

1 re-specification of this measure, which would
2 then mean that it would change, and that it would
3 need to go through NQF endorsement, which is why
4 I was curious about Woody's comment as to whether
5 or not these could be considered under as
6 indicated. Because it seems to me if we change
7 the exclusions, we would have --- it's a re-
8 specification of the measure.

9 CO-CHAIR WALTERS: Jack was next.

10 DR. FOWLER: I'm sure I'm going to be
11 in the minority on this one, but I have a
12 visceral response to having something that --
13 might offer me a very, very small benefit, or
14 given competing hazards might offer no benefit at
15 all to have it required, and something hospitals
16 feel they have to do. So, I would vote against
17 this totally, just on that basis.

18 CO-CHAIR WALTERS: Richard is next.

19 DR. BANKOWITZ: Yes. For all of these
20 evidence-based process of care measures they are
21 always clinical exceptions. You could get a
22 cardiologist and they're argue about aspirin on

1 arrival, and that there's that one case in a
2 thousand where you shouldn't use it. And for
3 those cases you just don't use it. And if you
4 get, you know, a checkmark in the negative
5 that's, you know, regrettable, but it's always
6 puzzled me as to why people can reach 100
7 percent, because there should be clinical
8 exceptions. So, no one is arguing with that, and
9 I would suppose this is no different. If there's
10 a clinical exception, go with your clinical
11 standard of care.

12 CO-CHAIR WALTERS: Nancy?

13 MS. FOSTER: So, Karen, I don't have
14 any idea how prevalent the population is you're
15 describing that you would like to see excluded,
16 so I'm curious about that. But I agree with
17 Richard for all of these measures, 100 percent is
18 usually not the right answer. On the other hand,
19 Dan is sitting just down the table from you, and
20 if you wanted to encourage CDC to consider
21 whether further exclusion should be made based on
22 what I understood to be, and excuse my lack of

1 clinical knowledge, specific drug therapies being
2 --- or specific therapies being rendered, that
3 would make the patient inappropriate for the flu
4 vacc, then maybe that's the message we should be
5 passing.

6 CO-CHAIR WALTERS: Sean.

7 DR. MORRISON: Quick question, Karen.
8 I think I agree with you, but just a clarifying
9 comment. I'm not an infectious disease doc, but I
10 am a primary care doc, and I do this a lot. It's
11 not dangerous to have the flu vaccine, it just
12 may not be effective in the setting of these
13 treatments. But that may be the case for anybody
14 who's immuno compromised, not just specific
15 therapies. So, I would say with Richard, you
16 know, we're not going to be 100 percent, and
17 there are some clinical indications where it's
18 not useful, but for the vast majority I think the
19 benefits far outweigh the harms, or lack of
20 efficacy here.

21 CO-CHAIR WALTERS: Okay, Karen?

22 DR. FIELDS: The percentage of patients

1 that might be in the hospital with acute leukemia
2 at an ADCC Center getting induction chemotherapy
3 consolidation can be as high as 30 percent
4 depending on the population at the center. And
5 likewise, a large percentage of the patients get
6 these therapies, We're going to see some new
7 immuno therapies coming down the pike, as well,
8 that render these vaccines ineffective.

9 So, if the issue is if there's a high
10 percentage of patients in your population that
11 aren't affected, it's not just a handful that you
12 would be excluding, it's a large percentage of
13 patients that won't be appropriate for the
14 vaccine.

15 CO-CHAIR WALTERS: Is there any more
16 discussion anybody needs to vote on this? Okay,
17 the motion on the table is for conditional
18 support. We'll set up the vote now.

19 MR. AMIN: And the condition is the
20 exclusion of the two patient populations,
21 patients receiving anti-B cell antibodies and
22 patients receiving intensive chemotherapy. Is

1 there a question?

2 CO-CHAIR WALTERS: Cristie, you had a
3 question?

4 MS. TRAVIS: I guess I'm just trying to
5 understand. So, if we vote that way then it
6 doesn't have to come back through NQF for
7 testing, validity, reliability, all the things,
8 or are we saying that it would need to come back
9 through NQF, or just that it could be changed?

10 MR. AMIN: The way this condition has
11 been written there's no --- it's that these
12 exclusions are added to the measure. That's the
13 condition. I would say that as these measures get
14 continuously updated, and there's an annual
15 update process ---

16 MS. TRAVIS: Okay.

17 MR. AMIN: --- minor exclusions in the
18 patient population wouldn't justify a full review
19 of the measure.

20 MS. TRAVIS: Okay, thank you.

21 MR. AMIN: I'm not suggesting that this
22 is a minor revision. We would need to look at how

1 many patients are ---

2 MS. TRAVIS: But those types of things

3 can ---

4 (Simultaneous speech)

5 MS. TRAVIS: --- annual update.

6 MR. AMIN: Right, and they get updated

7 ---

8 MS. TRAVIS: Thank you. That helps.

9 MR. AMIN: --- in relatively real
10 time. That is correct.

11 MS. SLOSBURG: We're looking at
12 influenza vaccination. Correct? It says
13 "Influenza immunization," which is number eight.
14 No, I'm talking about the screen. I'm sorry. We
15 were voting?

16 CO-CHAIR WALTERS: That's the name of
17 the measure.

18 MS. SLOSBURG: So, we're voting on
19 eight, or we're voting on seven?

20 CO-CHAIR WALTERS: Seven. We'll get to
21 eight here in just a second.

22 MS. SLOSBURG: Okay. Well, eight is

1 influenza immunization, and seven is influenza
2 vaccination. Sorry, it's just a technical point.
3 Did you all just look at number ---

4 MR. AMIN: Let me just make sure I'm
5 following this. There's seven right here on the
6 screen which is the discussion guide, which is
7 influenza immunization, and what we're voting on
8 up here is influenza immunization. It's still
9 seven.

10 CO-CHAIR WALTERS: And it's still about
11 the patients. The next measure is about the
12 health care workers.

13 MS. SLOSBURG: I apologize.

14 MR. AMIN: So, I just want to make sure
15 everybody is on the same page. I know it's
16 getting kind of late. I mean, we've been at this
17 for a while, so I appreciate it. So, seven on the
18 discussion guide here and that's the measure in
19 front of us, and the motion is to move to
20 conditional support on the exclusions that we've
21 discussed from support.

22 MS. KOPLEFF: I fully expect to get

1 overruled so we can move forward with the vote,
2 but I'm just sort of noting some inconsistency in
3 our application of conditions. With the other
4 programs, we didn't sort of pick apart measures,
5 we left that to the endorsement process. And
6 personally not feeling quite clear per the point
7 Woody brought up, you know, what are some of
8 these extra considerations around exclusions?
9 It's hard to judge how big are they, how small
10 are they? But I think we need to view the
11 measures as conditional upon NQF review or not.

12 CHAIR OPELKA: So, I'm just --- I'm not
13 sure I understand this. So, what I am reading
14 from the American Cancer Society is quoting from
15 the CDC which says that cancer patients receiving
16 chemotherapy are recommended to get a flu shot
17 because they're at higher risk, and they should
18 be treated, and there are at higher risk of
19 complications from this disease, and they should
20 receive a flu shot.

21 CO-CHAIR WALTERS: Wei?

22 DR. YING: I think I agree with Emma.

1 It feels to me we're getting into the measure
2 specification if we specifically say what the
3 exclusion should be. We can say there is concern
4 on the cancer patient, whether this measure can
5 be applicable to all of them. But as we discussed
6 earlier, there are other patients who don't have
7 cancer, but they also may not be appropriate ---
8 it may not be appropriate for them to have this
9 vaccination either.

10 I kind of feel if --- the condition
11 should be just like Emma stated, it should be
12 revisited for the exclusion qualification, but
13 not necessarily we put down what the exclusion
14 should be.

15 MR. AMIN: If it would be acceptable,
16 Ron, I would suggest something to be consistent
17 from our approach. And I think, Emma, thank you
18 for bringing that up. Potentially, we could re-
19 frame the condition to encourage --- the
20 condition would be encouraging the relevant NQF
21 endorsement committee to review the exclusions
22 specifically these that have been noted by Karen.

1 DR. FIELDS: I change my motion to
2 that.

3 CO-CHAIR WALTERS: Okay. Ready to vote?

4 MS. IBRAGIMOVA: Influenza
5 immunization. Do you agree with the motion to
6 move from support to conditional support? One,
7 yes; two, no.

8 MS. BAL: Could everyone just vote one
9 more time, just so we can make sure we're getting
10 everyone's votes. Thank you.

11 MR. AMIN: The motion is to have the
12 relevant NQF standing committee review the
13 exclusions, particularly those two that have been
14 mentioned by Karen. It's a conditional -Karen is
15 suggesting --- the motion is to move it to a
16 conditional support on the condition that the
17 exclusions are reviewed by the relevant standing
18 committee, in particular these two exclusions
19 that have been noted.

20 (Voting)

21 MS. IBRAGIMOVA: The results are 50
22 percent yes, and 50 percent no.

1 CO-CHAIR WALTERS: We're going to have
2 a re-vote. So, vote the same way you did the last
3 time, if you want.

4 (Off microphone comment)

5 CO-CHAIR WALTERS: Okay. We determined
6 that because a majority did not vote for the
7 motion it stays on the calendar as it is as
8 supported.

9 The next measure is measure eight,
10 which is influenza vaccination coverage. And this
11 is the one with regards to health care personnel.
12 Karen?

13 DR. FIELDS: NQF -- or, excuse me,
14 ADCC strongly supports this measure. We feel
15 that all health care personnel should have
16 vaccinations. Our discussion with this measure
17 is that it clearly defines who should get the
18 vaccination and why people shouldn't get the
19 vaccination, but it doesn't address how to get up
20 to 100 percent compliance by wearing masks or
21 other measures that decrease transmission in this
22 high-risk population.

1 So we might think about proposing the
2 same kind of proposal that we had, which is
3 support this measure conditionally, but request
4 that NQF add additional metrics to increase the
5 safety for our patients by including masks ----
6 or addressing the people that don't get
7 vaccinations, if I stated that so unclearly.

8 CO-CHAIR WALTERS: Nancy.

9 MS. FOSTER: So Karen, in that regard,
10 I think it is consistent with the way it is
11 applied across the entire hospital population
12 right now. And I understand your point that some
13 people, either for religious reasons or personal
14 health reasons or what have you, cannot or won't
15 take the vaccination, and therefore it may be
16 more accurate to show protection of the patient
17 population if you included both the vaccination
18 and the masking, et cetera.

19 But I don't know how you'd measure
20 masking 100 percent of the time, and it really
21 gets very complicated. So I guess in that
22 regard, while I support the sentiment, I think

1 this measure ought to stand as is.

2 CO-CHAIR WALTERS: Woody.

3 DR. EISENBERG: I have a question
4 about the data source. What does it mean that
5 the data source is the NHSN? I mean, given the
6 fact that health care workers can get their
7 vaccine at Walgreens or from their own personal
8 physicians or maybe in the hospital, how do you
9 figure this out?

10 DR. FIELDS: I think that's a question
11 for NQF --

12 DR. POLLOCK: So there are various
13 strategies for doing that, including requirements
14 that employees bring documentation of
15 occupational health, but it's -- sorry, sorry,
16 sorry. There are various strategies for
17 accomplishing that, including requiring employees
18 to bring documentation of influenza vaccination
19 elsewhere, or taking the word of employees. But
20 it is -- it's very important for occupational
21 health to have a complete accounting of who has
22 been vaccinated, who has not and reasons why not.

1 CO-CHAIR WALTERS: Andrea.

2 DR. BENIN: This is a classic dilemma
3 in vaccine coverage measurement, is this issue of
4 what do you do with these ones that are excluded,
5 and the fact of the matter is, they are not
6 vaccinated. So they count against the percent
7 vaccinated. Like, that's sort of like the way it
8 is in this world.

9 I will tell you that at our place
10 every year, we fire a few people over this. So
11 it's mandatory that you get vaccinated if you
12 want to walk into our place, and that includes
13 board members. It includes vendors, and we -- so
14 people bring in their paperwork.

15 CO-CHAIR WALTERS: Frank. Dan, your
16 card is down, right?

17 CHAIR OPELKA: So I am not sure I am
18 following our logic here. I understand the
19 measure as it's proposed, but I am not sure I
20 understand making conditions upon this measure to
21 a broader population.

22 I think that if there's others we need

1 to address, we ought to use another vehicle.
2 That this measure should just stand and then for
3 those who are not immunized, vaccinated for
4 influenza, if there's a need to put some other
5 measure in there, we'll put it in there. But
6 most places I know ---- and I am not sure I can
7 say this 100 percent, are pretty close to what
8 Andrea said: if you don't get immunized, you
9 don't work there. It's a requirement of
10 employment.

11 DR. FIELDS: I have no problem
12 changing this to support and not voting on it.

13 CO-CHAIR WALTERS: It's already on
14 support.

15 DR. FIELDS: Right --

16 CO-CHAIR WALTERS: You can withdraw
17 your --

18 DR. FIELDS: Changing --

19 CO-CHAIR WALTERS: -- motion.

20 DR. FIELDS: -- it. Withdrawing my
21 motion, but we did want to make a recommendation
22 that is a gap.

1 CO-CHAIR WALTERS: Okay. The motion
2 has been withdrawn.

3 So by my count, we'll do the calendar
4 voting next after public input --

5 MR. AMIN: Ron, can I just ask a quick
6 question --

7 CO-CHAIR WALTERS: Yes.

8 MR. AMIN: -- on this? Could you
9 repeat what the gap was, Karen? I just wanted to
10 make sure I have it for the notes.

11 DR. FIELDS: We need a measure that
12 addresses unvaccinated health care workers and a
13 policy that includes masks for all unvaccinated
14 health care workers.

15 MR. AMIN: Thank you.

16 CO-CHAIR WALTERS: Set up the consent
17 calendars. There is at least 6, 7, and 8 on the
18 support calendar, and 1 through 5, I think, on
19 the conditional support. Is there a public
20 comment?

21 THE OPERATOR: If you want to make a
22 comment, please press star, then the number 1.

1 CO-CHAIR WALTERS: Any in the room?

2 Hearing none, okay.

3 Nancy, you wanted to bring up some
4 gaps still?

5 MS. FOSTER: Thank you. Not
6 particularly for the cancer hospitals, but
7 because of the measure we dealt with. I think I
8 would encourage CMS to think about whether a
9 similar use of hospice/palliative care measure
10 could be developed for the COPD population, for
11 the congestive heart population, any others where
12 the -- where there is a prevalence of palliative
13 care being provided to patients with that
14 condition would be the gap I would note.

15 CO-CHAIR WALTERS: Okay. Given the
16 time, let's move on to voting for the consent
17 calendars. Calendar 1, which is support?

18 MS. IBRAGIMOVA: PCHQR Calender 1:
19 Support. National Healthcare Safety Network
20 Facility-wide Inpatient Hospital Onset CDI
21 Outcome Measure, influenza immunization, and
22 influenza vaccination coverage Among healthcare

1 personnel, HCP.

2 Do you agree with the support
3 calendar? One, yes. Two, no.

4 MR. HATLIE: We're wondering if C.
5 Diff. belongs in this calendar?

6 CO-CHAIR WALTERS: It does.

7 MR. AMIN: Yes, let's take a step
8 back. Let's go back to the measures, make sure
9 that we're all on the same page. If you don't
10 mind, Laura, can you take a step back?

11 CO-CHAIR WALTERS: Yes it was --
12 sorry. Measures 6, 7, and 8 ended up on the
13 support calendar one way or another.

14 Calendar 1 is the three measures that
15 you see there on the board, and I'll read them to
16 everybody. It's C. Diff., influenza
17 immunization, and influenza vaccination for
18 healthcare.

19 MS. IBRAGIMOVA: So do you agree with
20 the support calendar? One, yes. Two, no.

21 The results are 100 percent, yes, and
22 zero percent, no.

1 CO-CHAIR WALTERS: Okay. Now, just a
2 second before we do Calendar 2, because there is
3 some discussion about the encourage continued
4 development measure that could potentially land
5 it on Calendar 2 -- could. We are going to go to
6 Calendar 2 for a second and talk about the 30 Day
7 Unplanned Readmissions for Cancer Patients.

8 I am sorry, I meant the conditional
9 support calendar, which would be Calendar 2
10 except now there's three calendars.

11 DR. FIELDS: So this measure is an
12 exciting measure because it's the first measure
13 that we have proposed, as the PPS exempt cancer
14 centers, to report a metric specific for our
15 patients.

16 We strongly endorse this measure. It
17 was placed on the development -- under
18 development measure because indeed, it was under
19 development, but we've continued to move along
20 with some of the requirements for supporting it
21 and in the conditional status.

22 Our goal is that this -- the PPS

1 exempt cancer centers are excluded from the
2 hospital-wide reporting readmission metric, and
3 we feel that that's a metric that we should be
4 recording. So we are asking to do extra
5 reporting here today. We feel that readmission
6 is one of the facets of cancer care that can be
7 preventable. In the unplanned patients, it would
8 encourage us to get data concerning places to
9 improve symptom control and other kinds of
10 toxicities, and we feel that it's an important
11 measure to support.

12 Our goal is 30 Day Unplanned
13 Readmissions for Cancer Patients can help us
14 reduce costs and improve quality for our
15 patients. The few questions that remained were a
16 steward for the metric, and we have a steward,
17 which is preliminarily -- I am looking at Barb
18 because I never heard the final answer. So
19 Seattle is the steward -- no, MD Anderson is now
20 officially the steward of the measure. And we
21 also have aligned it with the CMS measure 1789,
22 which was another request.

1 We also have been doing all of the
2 final testing and risk adjustment in order to
3 report the data. Reporting will begin in
4 February of this year. So we would request that
5 it meets -- it should be moved from further
6 development to --

7 MR. AMIN: Conditional support.

8 DR. FIELDS: Conditional support,
9 depending on -- pending NQF endorsement.

10 MR. AMIN: Karen, can you just clarify
11 and just state for the record that this measure
12 is -- testing is complete? Reliability and
13 validity testing is complete and ready for
14 submission for NQF.

15 DR. FIELDS: I have someone in the
16 back, if you don't mind, that can give me that
17 final answer.

18 MR. AMIN: Can you come up to the
19 microphone and --

20 CO-CHAIR WALTERS: Identify yourself.

21 MR. AMIN: -- and identify yourself?

22 MS. TALLANT: Hi, this is Colleen

1 Tallant with the Alliance of Dedicated Cancer
2 Centers. So we're currently collecting data, and
3 that will be completed by January 1st. So we
4 have a submission date to CMS and NQF by February
5 1st.

6 CO-CHAIR WALTERS: I'd like to call on
7 Hayden for her comments, if you have any.

8 MS. HAYDEN: Oh, I am sorry, actually
9 I didn't -- did you want me to speak to the
10 measure? I didn't have any comments, thank you.

11 CO-CHAIR WALTERS: You spent some time
12 writing ---- wanted to give you a chance.

13 There's one other person in the crowd.
14 Barb, can I call you to -- ? Barb Jagels, yes.
15 Identify yourself?

16 MS. JAGELS: Hi, I am Barb Jagels. I
17 am from the Seattle Cancer Care Alliance, Fred
18 Hutchinson Cancer Research Center. I chair the
19 Quality Committee for the ADCC. Would you like
20 me to give my short speech, Ron?

21 CO-CHAIR WALTERS: Yes.

22 MS. JAGELS: Very good. So on behalf

1 of the Alliance of Dedicated Cancer Centers,
2 thank you for entertaining our measure. We are
3 very enthusiastically in support, obviously,
4 because we think that cancer readmissions in
5 particular have been characterized and over-
6 counted.

7 So we agree with you that foreseeable
8 and avoidable readmissions should be measured,
9 characterized, and prioritized for quality
10 improvement. In the cancer realm, we think
11 that's pain, we think it's chemotherapy and
12 nausea and vomiting, and we think it's febrile
13 neutropenia for high-intensity chemo.

14 So this measure is different because
15 when we readmit patients intentionally for
16 chemotherapy, radiation, or additional intensive
17 therapy, we think it shouldn't be counted against
18 us. Obviously we're planning around those
19 treatment elements, and instead what we'd like to
20 do is prioritize improvement related to things
21 that we should prevent, to give patients a better
22 outcome.

1 CO-CHAIR WALTERS: I think the
2 recurring question that has come up so far is
3 where is this in the endorsement process?
4 Because the motion on the table is to move it to
5 conditional support based on that condition.

6 DR. FIELDS: Can I make a comment?
7 Our concern is that if we continue to develop the
8 measure, and the measure will be developed by the
9 end of this month, then we'll have to wait
10 another year to bring it back to this Committee
11 for consideration.

12 So we propose that it go to NQF for
13 endorsement and then we adopt the measure at that
14 time. We don't want a delay in being able to
15 report this. We think it's a very important
16 measure.

17 MS. JAGELS: In support, we already
18 have a year's worth of data. We have data from
19 2011 and 2012. We're already using that data to
20 prioritize improvement among our centers. So our
21 goal is to put this in our measurement framework
22 for 2017, a year delay would take us out to 2018.

1 MR. AMIN: Just an administrative
2 clarification -- I mean, the only requirement for
3 moving from measures under development to the
4 fully developed pathway is that the testing is
5 complete, and it seems sufficient that the
6 testing is complete as long as the Chairs are
7 fine with that. So I mean the group can move
8 toward conditional support based on NQF
9 endorsement. So that seems reasonable to me, so
10 I think the group needs to discuss that.

11 CO-CHAIR WALTERS: Open for
12 discussion. Andrea?

13 DR. BENIN: I'm not sure what holds
14 the group back from doing what they want to do
15 with this measure, with or without the CMS level
16 of involvement, right? I mean, that's the part
17 I'm missing.

18 DR. FIELDS: Because it will be a
19 reportable outcome, that -- for the PPS-exempt
20 cancer centers. So this group needs to approve
21 that it's an appropriate reportable outcome, as
22 far as I understand the process. So we need this

1 group to support this as a reportable measure.

2 DR. BENIN: You're asking us to fast
3 track it, so ---- that we fast track it a little
4 bit. I am just --

5 DR. FIELDS: We're not necessarily
6 asking to fast track it. We are suggesting that
7 the data is done and that it should be
8 categorized in a different category than it was
9 categorized for this Committee.

10 CO-CHAIR WALTERS: Nancy.

11 MS. FOSTER: So some clarity from NQF
12 around if this were -- if this were to be brought
13 in for NQF endorsement in January, do we have any
14 idea when it would have completed that
15 endorsement process?

16 MR. AMIN: Yes, I am not sure I can
17 answer the question because that would be
18 determined on when we have an upcoming either
19 readmissions or cancer project where this measure
20 would be able to come into.

21 The requirement that we've used up to
22 this point -- again, I am not sure that I am

1 answering your question now, is that the Measures
2 Under Consideration List has to indicate that the
3 measure testing is completed --

4 MS. FOSTER: Right.

5 MR. AMIN: We don't actually look at
6 the completed testing until the relevant
7 committee is ready to review it. So in this
8 case, I think that the measure steward is making
9 an update to the Measure Under Consideration List
10 in realtime. So it is a little unusual, but in
11 that sense they are ----

12 MS. FOSTER: I guess, to Karen's
13 point, the idea here is that this will somehow
14 expedite moving this into use, but my guess, is
15 it actually won't have any impact --

16 MR. AMIN: I can't speak to that. I
17 certainly can't -- I can't speak to when this
18 measure will be even reviewed by the NQF
19 endorsement process.

20 MS. FOSTER: Right.

21 MR. AMIN: That is dependent on the
22 review cycle and funding from CMS to do so.

1 MS. FOSTER: Right.

2 MR. AMIN: So I can't speak to that.

3 MS. FOSTER: I mean this is a very
4 different -- as I hear what the measure is,
5 because I have not seen anything about it yet.
6 As I hear what the measure is, it's a very
7 different framework for thinking about
8 readmissions. Maybe one I absolutely love
9 compared to the current framework we currently
10 have, but you know, it's hard for me to say, yes,
11 let's move this. Without understanding fully the
12 implications both here and for further -- for the
13 other readmission measures, if there are any.

14 So I'm a little bit in the -- and
15 because I don't actually think that saying we
16 fully support this notion. Let's continue to
17 develop it, continue to use it in the cancer care
18 hospitals. I don't think that actually delays
19 anything because you are going to take probably
20 near to a year, if not more, to get the NQF
21 endorsement. So it gives us a little bit of time
22 to come back next year when more of us have an

1 understanding of what's in the box that we're
2 trying to vote on.

3 CO-CHAIR WALTERS: Emma.

4 MS. KOPLEFF: But as I understand it,
5 we need a motion to vote on something and that
6 voting on it under continued development doesn't
7 really make sense, since it's fully developed.
8 So my question for the group and to Nancy, to
9 your comments, is if you have a motion that's
10 different than conditional support recognizing
11 the measure will go through the NQF process, then
12 we should discuss that but otherwise we could
13 probably vote on it.

14 CO-CHAIR WALTERS: So again, the
15 motion on the table is to move it to conditional
16 support. If that passes, it goes to conditional
17 support and the condition is NQF endorsement. If
18 it does not pass, then it is on the in-process
19 type plan.

20 MS. KOPLEFF: Well what I'm saying
21 though is, again, just to be consistent. Earlier
22 today -- and Andrea made this point. Earlier

1 today, when we had measures that were previously
2 noted as under development, upon receiving an
3 update about the status of those measures, we
4 moved it to the conditional support category, and
5 that wasn't a motion, it was just there.

6 So I am suggesting we should follow
7 suit and the same process should apply. So a
8 motion needs to be made to something other than
9 the true state of the measures which appears to
10 be fully developed.

11 MS. FOSTER: Well -- and to your
12 point, Emma, I have to say I was a little
13 uncomfortable with moving the measures
14 previously. I mean, it just seems odd that
15 things can change while you're being expected to
16 review them. There should be sort of a stop
17 process. Let's go for the MAP review deadline,
18 and it seems to me that's December 1 by law.

19 MR. AMIN: So that is fair, Nancy, and
20 we will take that under consideration as we go
21 forward.

22 Our approach has been to try to be as

1 responsive to CMS and any of the measure
2 developers that have submitted measures into the
3 Measures Under Consideration List, recognizing
4 the time it takes to go through the clearance
5 process and that things may change by the time it
6 gets to this Committee.

7 Obviously between day one and day two
8 of the Committee meeting, may be a little bit too
9 responsive and not recognizing -- or at the
10 meeting itself, may be a little too responsive.
11 So we will take that into account as we go
12 forward into the future.

13 And I would suggest, Ron, that Emma
14 does make a valid point in terms of how the
15 measure developers -- the testing was updated
16 overnight yesterday as it relates to the two
17 measures, and that's pretty similar to what we're
18 seeing here. So -- .

19 CO-CHAIR WALTERS: First, let's vote,
20 then -- you've heard the considerations. Let's
21 vote on whether or not to -- again, the measure,
22 the proposed measure right now is in encourage

1 continued development. The motion is to move it
2 to conditional support, and we'll take that vote
3 first.

4 MS. IBRAGIMOVA: 30 Day Unplanned
5 Readmissions for Cancer Patients. Do you agree
6 with the motion to move from encourage for
7 further development to conditional support
8 pending NQF review and endorsement? One, yes.
9 Two, no.

10 The results are 63 percent, yes, and
11 38 percent, no.

12 CO-CHAIR WALTERS: Okay, so the motion
13 passed to move it to conditional support.

14 MR. AMIN: Conditional support pending
15 --

16 CO-CHAIR WALTERS: Pending NQF
17 endorsement. Which is why -- now to go back
18 about 20 minutes, which is why I wanted to see
19 how this turned out before we then put for vote
20 the conditional support calendar.

21 MS. IBRAGIMOVA: PCHQR calendar,
22 conditional support. At least 12 regional lymph

1 nodes are removed and pathologically examined for
2 resected colon cancer, post breast conservation
3 surgery irradiation, needle biopsy to establish
4 diagnosis of cancer precedes surgical
5 excision/resection, Hospice and Palliative Care:
6 Treatment Preferences, National Healthcare Safety
7 Network Facility-wide Inpatient Hospital-onset
8 MRSA Bacteremia Outcome Measure, and 30 Day
9 Unplanned Readmissions for Cancer Patients.

10 Do you agree with the conditional
11 support calendar? One, yes. Two, no.

12 The results are 82 percent, yes, and
13 18 percent, no.

14 CO-CHAIR WALTERS: Again, I'd like to
15 thank everybody for their participation and
16 tolerance of a new process. I'll turn this over
17 to Frank right now.

18 CHAIR OPELKA: Well, first of all, I
19 want to thank all of you for your time. You've
20 stayed past the hour, so -- and all as
21 volunteers. I really appreciate that, and I'm
22 sure CMS and the NQF does. It has been a really

1 great two days.

2 Putting out a new process is always a
3 challenge, and you were the guinea pigs, and you
4 vetted it and you moved it. So I want to thank
5 all of you for doing that. I think we've learned
6 a lot. There's another one of these in a week,
7 and I think the team is going to take a lot of
8 lessons learned into that process from all of you
9 today, so I can't thank you enough for that.

10 I also want to thank the staff who
11 did, I think, an incredible job teeing this up
12 for us.

13 CO-CHAIR WALTERS: And except for the
14 nursing ones, did a good job at reclassifying --

15 CHAIR OPELKA: So we have, you know,
16 we're -- we tried to catch more of your gaps
17 today than we did yesterday, so I don't think we
18 have time, and we're after the hour, to go around
19 again and catch any more gaps. But if you have
20 gaps in any one of these areas, if you'd mail
21 those thoughts into staff, I think that's
22 probably the most prudent way to do it at this

1 point in time.

2 And this will then go into a report
3 that we'll put together and have to bring forward
4 to the Coordinating Committee. So will that
5 report come back out to this group en route to
6 the Coordinating Committee?

7 MS. O'ROURKE: We won't have time to
8 get it to you before public comment opens, but we
9 would welcome any public comments members of this
10 group would like to make on the draft report and
11 the draft table that will have all of the
12 workgroup's initial recommendations to the
13 Coordinating Committee.

14 CHAIR OPELKA: So that's not our
15 normal process at the NQF, but the timelines are
16 so tight that it all gets compressed. So please
17 accept apologies on that, but you're just going
18 to have to help us work with that tight timeline
19 in getting your comments in.

20 So once again, I want to thank all of
21 you. I hope you have safe travels home and a
22 very happy holiday season.

1 MS. O'ROURKE: And I just wanted to
2 add a note to thank -- also, thank all of you for
3 attending, and to thank Frank for his three years
4 of service as our Chair and leader.

5 And to Ron, for surviving his first
6 effort as our Vice-Chair.

7 CO-CHAIR WALTERS: The Chair is only
8 as good as the Committee members are, and the
9 Committee is fabulous.

10 MS. IBRAGIMOVA: For those of you who
11 signed the cab share to go to the airport, you
12 could all just huddle outside and figure out who
13 is going with whom.

14 (Whereupon, the meeting went off the
15 record at 4:13 p.m.)
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In the matter of: Measure Application Partnership

Before: NQF

Date: 12-10-14

Place: Washington, DC

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