

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
HOSPITAL WORKGROUP

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TUESDAY
DECEMBER 11, 2018

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

WORKGROUP CHAIRS

CRISTIE UPSHAW TRAVIS, MSHHA

RONALD S. WALTERS, MD, MBA, MHA, MS

ORGANIZATIONAL REPRESENTATIVES

KEITH BELLOVICH, MD, Kidney Care Partners

ANNA LEGREID DOPP, PharmD, Pharmacy Quality Alliance

NANCY FOSTER, American Hospital Association

FRANK GHINASSI, PhD, ABPP, National Association of Psychiatric Health Systems

KIMBERLY GLASSMAN, PhD, RN, Nursing Alliance for Quality Care

MARYELLEN GUINAN, America's Essential Hospitals

MARTIN HATLIE, JD, Project Patient Care

GAYLE LEE, Association of American Medical Colleges

MARSHA MANNING, MLIR, BSN, RN, University of Michigan*

LISA MCGIFFERT, Mothers Against Medical Error

R. SEAN MORRISON, MD, National Coalition for Hospice and Palliative Care

SARAH NOLAN, Service Employees International Union

SHANNON PHILLIPS, MD, MPH, Intermountain
Healthcare
AISHA PITTMAN, MPH, Premier, Inc.
KAREN SHEHADE, MBA, Medtronic-Minimally Invasive
Therapy Group
SALLY TURBYVILLE, DrPH, MS, MA, Children's
Hospital Association
MARISA VALDES, RN, MSN, Baylor Scott & White
Health
DEBORAH WHEELER, Molina Healthcare

INDIVIDUAL SUBJECT MATTER EXPERTS

ANDREEA BALAN-COHEN, PhD
LEE FLEISHER, MD
JACK JORDAN
ANN MARIE SULLIVAN, MD
LINDSEY WISHAM, BA, MPA

FEDERAL GOVERNMENT LIAISONS

REENA DUSEJA, MD, Centers for Medicare &
Medicaid Services (CMS)
PAM OWENS, PhD, Agency for Healthcare Research
and Quality (AHRQ)*
DAN POLLOCK, MD, Centers for Disease Control and
Prevention (CDC)

NQF STAFF:

TAROON AMIN, MPH, PhD, Senior Director
AMEERA CHAUDHRY, Project Analyst
KAREN JOHNSON, MS, Senior Director, Performance
Measures
MADISON JUNG, Project Manager
MELISSA MARINELARENA, RN, MPA, CPHQ, Senior
Director, Quality Measurement
ELISA MUNTHALI, MPH, Senior Vice President,
Quality Measurement
DESMIRRA (DESI) QUINNONEZ, Project Analyst
ERIN O'ROURKE, Senior Director

ALSO PRESENT:

CORINNA ANDIEL, Alliance of Dedicated Cancer
Centers*

SUSANNAH BERNHEIM, MD, MHS, Yale CORE

KRISTEN McNIFF, MPH, Alliance of Dedicated
Cancer Centers

ROBERT MORGAN, Hospital IQR and VBP Programs,
CMS

IRA MOSCOVICE, PhD, MAP Rural Health Workgroup
Co-Chair*

GIGI RANEY, LCSW, Health Insurance Specialist,
CMS*

TOM ROSS, MS, PCHQR Program Lead, VIQR Outreach
and Education Support Contractor*

MICHELLE SCHREIBER, MD, QMVGIG Group Director,
CMS

*Present via telephone

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

9:01 a.m.

CHAIR WALTERS: Good morning. Thank you all for coming. I wanted to -- my name is Ron Walters. Cristie and I are the co-chairs. I'll let her speak in just a second. I wanted to say a couple of things first because we really do appreciate all of you coming to the meeting.

We know that the thought has probably crossed more than one mind around the room, why am I coming all this way, possibly through some bad weather, to talk about four measures? And for people who have been on this group for a while, we all remember the two-day marathons with, I don't remember where we peaked, but it was somewhere in the 40 measures.

This is, again, part of the patients over paperwork trend, part of trying to trim down to the ones that are most meaningful and worth the time and hassle to collect since many places cannot spit these out automatically, as automatically as they want to. It certainly

1 affects the hospital program tremendously, as
2 Nancy has pointed out since the very first
3 meeting. And we, of course, never really know
4 until December 1st or within 24 hours of that day
5 how many measures there are going to be, so when
6 they book everybody's appointments and everything
7 and travel and hotels, they're, at best, only a
8 feeling of, well, it's not going to be two dozen
9 measures or even one dozen measures and we never
10 know the exact number.

11 So congratulations to staff. There was
12 a lot of last -- the version you're seeing of the
13 agenda is probably about the fifth or sixth one,
14 as usual, and they have to also change the plan
15 as it goes along and they get exactly what we're
16 going to be doing on December 1st. So, again, a
17 big congratulations to staff and to everyone for
18 showing the dedication to come here in what could
19 have been really nasty travel. I know for some
20 of you it still was.

21 But we have to, we literally have to do
22 this. We commit to doing it as our

1 responsibility to give feedback to CMS about the
2 MUC list and about any other measure, actually,
3 existing measures or ideas for measures. And I
4 think, as Michelle will say later on, CMS really
5 does appreciate that feedback and taking into
6 consideration. This is an important meeting to
7 try to go to all odds to get to, and there was a
8 time where we thought those were going to be
9 considerable odds over the last few days and
10 still were for some people.

11 Cristie, do you want to say anything?

12 CO-CHAIR UPSHAW TRAVIS: Well, I will
13 just say ditto to all of that. And in our
14 efforts to be efficient, I won't repeat them.
15 But just to give my personal thanks to all the
16 work you have to do in advance, as well as the
17 work that we will be doing here today, so thank
18 you for being here. This is a big group of
19 people. I don't remember actually it being this
20 big in the past, so we're filling every seat.
21 This is wonderful. But thank you for all of
22 that, as well.

1 CHAIR WALTERS: Have we stalled long
2 enough that you're ready, or would you like a few
3 jokes or magic or something?

4 MS. MARINELARENA: We can do an
5 icebreaker, okay? Good morning, everyone. My
6 name is Melissa Marinelarena, and I'm the Senior
7 Director -- they're working on my badge outside -
8 - for those of you that don't me, but I think
9 mostly everybody does. I'd like to welcome you
10 to the MAP Hospital Workgroup, although we have a
11 small number of measures compared to the number
12 that we've had in the past. I think it will
13 still be an exciting and productive day, so thank
14 you very much.

15 CHAIR WALTERS: And I believe on the
16 phone do we have Marsha and Pam yet?

17 MEMBER MANNING: Marsha Manning is here.

18 CHAIR WALTERS: Thank you for calling
19 in. Pam?

20 MEMBER OWENS: This is Pam Owens from
21 AHRQ.

22 CHAIR WALTERS: Good. So I think

1 that's, we'll see, I think that's everybody
2 almost. Good. Remember that, as we work our way
3 through this, we're going to go over that the
4 process has changed just a little bit, but the
5 underlying process hasn't. Raise your tent cards
6 if you have something to say. Restrooms are in
7 the hallway. Please mute your cell phones and
8 speak directly into the microphone with it turned
9 on and then try to remember to promptly turn your
10 microphone off when you're done so that we don't
11 look around the room and see 20 people talking
12 when only one person does. And as we say every
13 year, your input is very important. We want you
14 to say what you need to say and give the input
15 that you came here for, but the co-chairs tried
16 to also make sure we get through the agenda and
17 we don't get terribly duplicative in our
18 conversations repeating what others have said.

19 So anything else? I think we're ready
20 to roll on to disclosures.

21 MS. MUNTHALI: Thank you, Ron and
22 Cristie and Melissa. Good morning, everyone. My

1 name is Elisa Munthali. I'm the Senior Vice
2 President of Quality Measurement at NQF, so I
3 would like to welcome you, as well, and to thank
4 you so much for serving on the Committee.

5 So what we'll do today is to combine
6 introductions with your disclosures of interest.
7 We're going to do it in two parts because there
8 are two types of committee workgroup members:
9 there are organizational representatives and
10 subject matter experts.

11 We're going to start with the
12 organizational representatives, and you'll
13 remember you received a form. It was an
14 abbreviated form. We just asked you about your
15 financial interest if it exceeded, it was \$10,000
16 or more. So what we're going to do is start with
17 the organizational representatives in the room
18 first. We're going to ask you to introduce
19 yourself, tell us who you're with, and let us
20 know if you have any disclosures. Once we do
21 that, then we'll go to the organizational reps on
22 the phone and then we'll go to our subject matter

1 experts in the room and those on the phone.

2 So I think we're starting with Frank,
3 who is to my left. Yes.

4 MEMBER GHINASSI: So good morning.
5 Frank Ghinassi. I'm at Rutgers University, and
6 I'm representing the National Association for
7 Behavioral Health. I have nothing to disclose.

8 MEMBER MCGIFFERT: Good morning. I'm
9 Lisa McGiffert. I am subbing for Helen Haskell
10 today for Mothers Against Medical Errors. I'm
11 also a patient advocate with the Patient Safety
12 Action Network, and I directed the Consumer
13 Reports Safe Patient Project for about 15 years,
14 and I also serve on the Patient Safety Committee
15 for NQF.

16 MEMBER GLASSMAN: Kim Glassman with the
17 National Nursing Alliance for Quality Care.
18 Nothing to disclose.

19 MEMBER MCGIFFERT: I don't have anything
20 to disclose. Sorry.

21 MEMBER VALDES: Good morning. Marisa
22 Valdes from Baylor Scott & White Health. Nothing

1 to disclose.

2 MEMBER SHEHADE: Hi. Karen Shehade with
3 Medtronic's Minimally Invasive Therapies group.
4 I'm a physician assistant and work in our health
5 economics and health policy and reimbursement,
6 and I do have disclosure of more than \$10,000 in
7 stock.

8 MEMBER BELLOVICH: I'm Keith Bellovich
9 representing Kidney Care Partners. I'm a
10 nephrologist from Detroit, Michigan. And my
11 disclosures, I'm a medical director with DaVita
12 Corporation and a joint venture partner.

13 MS. MUNTHALI: Thank you, Keith. I'm
14 just going to pause briefly. Just to remind
15 those who are on the phone if you could please
16 mute your lines if you're not speaking. Thank
17 you.

18 MEMBER HATLIE: I'm Marty Hatlie. Good
19 morning, everybody. I'm the CEO of Project
20 Patient Care. We're an improvement coalition in
21 Chicago, non-profit improvement coalition, and
22 it's nice to be here. And I have nothing to

1 disclose.

2 MEMBER MORRISON: Sean Morrison. NQF
3 has found me out. I am no longer a content
4 matter expert, but I'm now representing the
5 National Coalition of Hospice and Palliative
6 Care.

7 MS. MUNTHALI: Sean?

8 MEMBER MORRISON: I have to disclose no
9 disclosures.

10 MEMBER WHEELER: Debbie Wheeler. I'm
11 representing Molina Healthcare, and I have no
12 disclosures.

13 MEMBER GUINAN: Morning, everyone.
14 Maryellen Guinan with America's Essential
15 Hospitals, and I have nothing to disclose.

16 MS. MUNTHALI: So let me tell you who
17 the subject matter experts. So right now
18 everyone with the exception of Andreea, Lee,
19 Jack, Ann Marie and Lindsey.

20 MEMBER PHILLIPS: Good morning. My name
21 is Shannon Phillips. I am a pediatric
22 hospitalist. I'm the Chief Patient Experience

1 Officer at Intermountain Healthcare and I lead
2 safety, quality, and experience for our health
3 system. Have no disclosures. However, as
4 relevant to today's discussion, our organization
5 has participated in the pressure ulcer work with
6 Mathematica but, otherwise, nothing.

7 MEMBER LEE: I'm Gayle Lee. I'm with
8 the Association of American Medical Colleges.
9 I'm subbing today for Janis Orlowski, and I have
10 no disclosures.

11 MEMBER DOPP: Morning. I'm Anna Legreid
12 Dopp. I'm a pharmacist. I'm the Director of
13 Clinical Guidelines and Quality Improvement with
14 the American Society of Health System
15 Pharmacists. However, today we're representing
16 the Pharmacy Quality Alliance on the MAP, so I'm
17 really thankful to be here. I have nothing to
18 disclose.

19 MEMBER FOSTER: Good morning. I'm Nancy
20 Foster. I'm the Vice President for Quality and
21 Patient Safety Policy at the American Hospital
22 Association, and I have nothing to disclose.

1 MEMBER BALAN-COHEN: I'm Andreea Balan-
2 Cohen. I'm a research leader with the Center for
3 Health Solutions. I'm also the chair of the
4 Quality and Value Group at Academy Health, and I
5 have nothing to disclose.

6 MEMBER NOLAN: I'm Sarah Nolan from the
7 Service Employees International Union, SEIU.
8 Nothing to disclose.

9 MS. MUNTHALI: So thank you to everyone
10 in the room. Now we'll go to Marsha Manning from
11 the University of Michigan.

12 MEMBER MANNING: Good morning.

13 MS. MUNTHALI: Hello.

14 MEMBER MANNING: Good morning. This is
15 Marsha Manning, Manager of Medical Benefits from
16 the University of Michigan, and I have nothing to
17 disclose.

18 MS. MUNTHALI: Thank you very much. So
19 thank you to all of our organizational
20 representatives, and so now we'll do the
21 disclosures for the subject matter experts. And
22 for those of you that completed the form, you

1 know it was a lengthy form. We asked you about
2 your activities as they're related to the work in
3 front of us. A couple of reminders. We wanted
4 you to know that you sit on this committee as an
5 individual. You do not represent the interest of
6 your employer or anyone who may have nominated
7 you for the Committee. We're interested in
8 hearing any relevant work, not just that that is
9 paid but also unpaid. And I think this is a most
10 important reminder. Just because you disclose it
11 does not mean you have a conflict. We do this in
12 the interest of openness and transparency.

13 And so I'll start with your co-chairs.
14 Ron and Cristie are both subject matter experts.
15 I'll start with Ron and then go to Cristie, and
16 then we'll go to, I think Andreea, you did yours
17 already, we'll go to Lee, Jack, Ann Marie, and
18 Lindsey.

19 CHAIR WALTERS: Ron Walters. I'm a
20 medical oncologist at MD Anderson. I have two
21 affiliations. One is I'm on the board of NCCN,
22 which is the National Comprehensive Cancer

1 Network. They are not a measure developer. I'm
2 not sure what they're doing, but they're
3 definitely not developing measures. They use the
4 word endorse. They don't really know what that
5 means. And I'm also on the board of the TMF,
6 Texas Medical Foundation, QIN-QIO organization,
7 and it has about six states that it oversees and
8 numerous contacts with CMS. They are also not a
9 developer, they are an implementer of a lot of
10 things that go on.

11 When we get to later this afternoon, I'm
12 going to kind of recuse myself from the cancer
13 discussion, although I am not a part of that
14 measure development. You'll hear from the
15 measure developer for that. I was kind of the
16 idea generator, I guess.

17 CO-CHAIR UPSHAW TRAVIS: Good morning.
18 I'm Cristie Upshaw Travis, and I'm the CEO of the
19 Memphis Business Group on Health. I have just a
20 couple of disclosures. I do serve on the Board
21 of Directors as Vice Chair of the Leapfrog Group
22 which does put together measures related to

1 hospital quality and safety, and I do have stock
2 ownership in healthcare-related stock of more
3 than \$10,000.

4 MEMBER FLEISHER: I'm Lee Fleisher. I'm
5 the Chair of Anesthesiology at the University of
6 Pennsylvania. I do have grant funding from the
7 NIH with Jeff Silber on measure methodology. I
8 also chair the Leapfrog's Ambulatory Surgery
9 Group, as well as I am the affiliations with the
10 American Society of Anesthesiologists in the
11 AAMC. No other financial.

12 MEMBER JORDAN: I'm Jack Jordan. I'm
13 the Director of Quality at Henry Ford Hospital in
14 Detroit. I do also consult with Impact
15 International as a provider with CMS on the HINN
16 contract.

17 MS. MUNTHALI: Thank you.

18 MEMBER SULLIVAN: Hi. I'm Ann Sullivan.
19 I'm the Commissioner of the New York State Office
20 of Mental Health and on the faculty of the Mt.
21 Sinai School of Medicine and a psychiatrist.

22 MEMBER WISHAM: Good morning. I'm

1 Lindsey Wisham. I here as a health informatics
2 expert. I would like to disclose that my
3 employer, Telligen, does have contracts with CMS.
4 I'm also the patient representative for a macro
5 measure development and some DoD reviews.

6 MS. MUNTHALI: Thank you.

7 MEMBER FLEISHER: And just to add, I'm
8 a paid consultant to Yale CORE for the
9 development of some of the hospital mortality
10 measures.

11 MS. MUNTHALI: Thank you very much. So
12 that concludes our disclosures for the subject
13 matter experts. We also have federal liaisons
14 that are on the workgroup. They're non-voting
15 members of the workgroup, and I'd like them to
16 introduce themselves. We have colleagues from
17 CMS and Dan is here from CDC and I understand Pam
18 Owens is here from AHRQ on the phone. So we'll
19 start with Michelle and Reena and Dan and then go
20 to the phone to Pam.

21 DR. SCHREIBER: So good morning. I'm
22 Michelle Schreiber. I am one month into my new

1 role as the Director of QMVG, the Quality
2 Measures and Value-Based Incentives Group, and
3 you'll hear a little bit more from me later. I
4 have nothing to disclose.

5 MEMBER DUSEJA: Good morning. My name
6 is Reena Duseja. I'm the Chief Medical Officer
7 of QMVG. Looking forward to the discussion
8 today. Thanks. And nothing to disclose.

9 MEMBER POLLOCK: Dan Pollock. I'm a
10 medical epidemiologist at Centers for Disease
11 Control and Prevention. My day job there is to
12 provide oversight to the National Healthcare
13 Safety Network, which is a surveillance system
14 that's used widely for quality measure purposes.

15 MS. MUNTHALI: Thank you. Pam?

16 MEMBER OWENS: Good morning. My name is
17 Pam Owens. I'm an epidemiologist, and I co-lead
18 the AHRQ quality indicators. I'm with the Agency
19 for Healthcare, Research, and Quality, and I have
20 nothing to disclose.

21 MS. MUNTHALI: Thank you very much. Now
22 that you've heard all of the disclosures, I just

1 wanted to remind you if, at any time, you
2 remember you have a conflict, we want you to
3 speak up. You can do so in real-time, or you can
4 approach any one of us in the front and on the
5 side. These are our colleagues all over here and
6 the co-chairs. Likewise, if you believe that
7 anyone on the Committee is acting in a biased
8 way, we want you to speak up.

9 If you have any questions of me, please
10 do ask them. But thank you and have a good
11 meeting.

12 CO-CHAIR UPSHAW TRAVIS: So we do want
13 to be sure that we have an opportunity to
14 introduce our team from NQF that is supporting
15 our work. You've already met Melissa, and I'd
16 like to introduce Madison. And you can, if you
17 want to, say a few words and maybe introduce your
18 colleagues.

19 MS. JUNG: Sure. My name is Madison
20 Jung. I'm the Project Manager for this project.
21 You've probably received a lot of emails from me,
22 but thank you for joining us today.

1 MS. QUINNONEZ: And I'm Desmirra
2 Quinnonez, Desi. And I'm the project analyst on
3 this project, and I'm happy to work with this
4 workgroup.

5 CO-CHAIR UPSHAW TRAVIS: Okay.

6 MS. O'ROURKE: I'm Erin O'Rourke. I'm
7 one of the Senior Directors supporting the
8 Coordinating Committee.

9 DR. AMIN: Taroon Amin. I'm a
10 consultant to NQF supporting the MAP Coordinating
11 Committee, as well.

12 CO-CHAIR UPSHAW TRAVIS: Hi. Well, this
13 is the team behind the curtain, although they're
14 not very much behind the curtain, so thank you
15 all so much for all of your work today.

16 You see before you kind of an outline of
17 what our agenda is. We do have a mixture of some
18 updates and some reports, as well as working,
19 obviously, on the measures under consideration.
20 And so we are really respectful of the time that
21 we have here and we want to be sure that we are
22 using it to really further the work that we have

1 as a workgroup but also to provide CMS with some
2 comments along the way and our thoughts for their
3 use. So we do plan to be out of here no later
4 than 3:00 and, hopefully, that will be good for
5 all of your travel arrangements.

6 So if we want to go to the next.
7 Obviously, our meeting objectives are to review
8 and provide input on the measures under
9 consideration for the applicable federal hospital
10 quality programs that are under our purview and
11 also, as we do every year, to help identify gaps
12 in measures for these programs, really trying to
13 take a systematic view, if you will, of the
14 portfolio of the measures that are put together,
15 and our recommendations or at least thoughts to
16 CMS on what's missing and where we would like to
17 see those portfolios go.

18 Next slide. So it is my pleasure,
19 Michelle has already introduced herself, but I
20 would like to turn it over to Michelle so that
21 she could give us some opening remarks.

22 DR. SCHREIBER: Thank you, Cristie. I

1 appreciate it. As you heard, I'm Michelle
2 Schreiber, a grand total of one month into this
3 new job. But on behalf of CMS, I would truly
4 like to welcome you to the Hospital MAP and
5 sincerely thank you for your participation.
6 Welcome to all the hospital types represented.
7 It's actually very interesting. I've been on the
8 hospital side for a long time, but we have rural
9 hospitals, we have cancer hospitals, we have
10 inpatient psych hospitals, and so thank you for
11 that wide representation.

12 You know, your input really is extremely
13 valuable, as Ron eluded to before. In the short
14 time that I've been there, I have really
15 witnessed how CMS takes these comments to heart
16 and it does affect policy and it affects what
17 goes forward into the federal programs. So your
18 comments really are extremely appreciated and
19 helpful. Thank you also to NQF for convening
20 this work and as well as our CMS partners, our
21 contractors, who are here today to help support
22 us.

1 The Measure Application Partnership is
2 an important annual process, you all know this,
3 frankly probably better than I do, where NQF
4 really convenes multiple stakeholders. And my
5 computer doesn't want to work. That was not
6 good. But it convenes multiple stakeholders to
7 provide input on these measures that will go into
8 federal rulemaking that starts really almost as
9 soon as these meetings are over.

10 The Committee also helps provide
11 guidance on future direction and helps us
12 identify gaps in measure opportunities, as well.
13 There's also the important opportunity for public
14 comments, so we look forward to any comments from
15 the public either in person here or on the phone.

16 The Quality Measures and Value-Based
17 Incentives Group, QMVG, that we're representing
18 today is the group responsible for developing and
19 stewarding measures and for those programs that I
20 know you all love, including the hospital stars;
21 the hospital value-based programs; MIPS;
22 meaningful use, also known as promoting

1 interoperability; post-acute care programs;
2 inpatient psyche; ESRD. And so this really is
3 the whole host of programs, so that what you say
4 can affect not just hospitals but really all of
5 the programs that CMS has to offer.

6 By way of background introduction,
7 actually it turns out I know you. I trained one
8 of you, surprisingly enough. I'm a primary --
9 it's hard to believe. I'm a primary care general
10 internist by background and training, and I've
11 worked both inpatient and outpatient. I've been
12 in the healthcare quality space really for many
13 years both in quality and as a practitioner,
14 mainly in Detroit but elsewhere. Most recently,
15 I was the Chief Quality Officer at the Henry Ford
16 Health Systems, so Jack and I do know each other
17 well. And I was the lead clinician for their
18 Epic implementation, so my particular interest is
19 actually the intersection of quality and
20 electronic medical records, and I have a
21 tremendous amount of experience in implementing
22 these systems.

1 I really chose to come to CMS to be on
2 the other side, to see the policy side and the
3 development of it, and it's been an amazing
4 transition filled really with wonderful people at
5 CMS who truly are committed to making it better,
6 and we all look forward really to working with
7 you today.

8 I know that you have heard presentations
9 on Meaningful Measures. CMS is an important
10 initiative around making sure that we have only
11 the most essential Meaningful Measures and to
12 reduce burden, as well. But let me just touch on
13 a few things for you to keep in mind as you
14 consider the measures before you today.

15 So Meaningful Measures was just launched
16 last year, and it was to improve outcomes for
17 patients and caregivers by empowering them with
18 information that's meaningful to them to make
19 decisions. But additionally, Meaningful Measures
20 is also about reducing burden to clinicians
21 because we recognize, and I've lived it, that
22 clinicians in healthcare organizations sometimes

1 find some of this work difficult and onerous, and
2 so CMS is actually committed to reducing that
3 burden and to promote patients over paperwork.

4 With this in mind, actually, we narrowed
5 down the initial 184 measures that were
6 originally the MUC list to a very parsimonious
7 list, so you're not seeing that many measures
8 come to you today. Part of that was intentional.

9 We recognize that really quality
10 measurements and reporting isn't a perfect
11 science. It hasn't been. I don't know that it
12 ever will be. But we're all trying to make it
13 better and that the programs have opportunity for
14 refinement.

15 As I said, I've lived for many years on
16 the receiving end of these programs, but, being
17 at CMS, there is ongoing and continued work for
18 improvement around both the programs and the
19 measures to provide better care for all patients.
20 And I think that's what we all have to keep in
21 mind that that's our primary goal.

22 As part of the effort to reduce burden,

1 last year Meaningful Measures removed 79 measures
2 from the various programs and saved over \$100
3 million in expense while continuing to align
4 measures across multiple programs so that we're
5 not duplicative. Meaningful Measures is a
6 commitment to infusing the principles of value,
7 innovation, and flexibility and following CMS's
8 quality strategy goals to remind us all making
9 care safer, strengthening the person and family
10 engagement, promoting effective care
11 communication and coordination, promoting
12 effective prevention and treatment of chronic
13 disease, working with communities to promote best
14 practices of healthy living, and, of course,
15 making care affordable.

16 Meaningful Measures is not just about
17 burden removal, however. The work also calls for
18 identifying and filling in gaps where there's a
19 lack of important measures, and we know that
20 there's many areas like that, and focusing more
21 on outcomes measures, although process measures
22 are still important, I want to be clear about

1 that, and patient-reported measures.

2 We'll also continue to align measures
3 across all programs and payers, and I'm really
4 particularly excited about the re-initiated work
5 that NQF, AHIP, America's Health Insurance Plans,
6 and CMS are jointly leading about the Core
7 Quality Measures Collaborative, in other words
8 trying to align measures not only across CMS but
9 across all payers in the United States as much as
10 we can so that we reduce burden with multiple
11 programs having multiple measures. So this is
12 really very exciting work, and we thank NQF for
13 that, as well.

14 Finally, we recognize that we must lower
15 the burden of measurement systems, including
16 making quality measures more real-time so that
17 they're more actionable. There's a great deal of
18 work going on with ongoing and multiple
19 registries and significant thought to electronic
20 quality measures.

21 So please think about these areas as you
22 make your recommendations today: One, are we

1 addressing high-impact areas? Do these make a
2 difference? Are they meaningful? Are the
3 measures meaningful to patients and caregivers
4 and include the patient voice? Is this an
5 outcome versus a process measure? Both have a
6 role. What's the burden of the measure? Are
7 there burdens or unintended consequences of
8 including the measure into a value-based program?
9 Is there a significant opportunity for
10 improvement or are these measures really just
11 topped out? And does the measure fit a
12 population-based payment or alternative payment
13 model and align with other programs and payers?

14 Finally, I would encourage everybody to
15 think about equity and to think about advancing
16 interoperability within electronic health
17 records.

18 So thank you all again for your time,
19 your dedication. And on behalf of CMS, thank you
20 for your participation. We all look forward to
21 working with you. Thank you.

22 CO-CHAIR UPSHAW TRAVIS: Thank you.

1 Thank you very much. I'm going to turn it over
2 to Ron, but, before I do, I do think we have a
3 couple of more disclosures that we probably need
4 to make. And just in case this is a disclosure I
5 should have made before, I do sit on the steering
6 committee for the Core Quality Measure
7 Collaborative, so thank you for bringing that up.

8 MS. MUNTHALI: Thanks, Cristie. And
9 Aisha and Sally just walked in, and so if you can
10 let us know, introduce yourself and let us know
11 who you're with and let us know if you have any
12 disclosures. Thanks.

13 MEMBER TURBYVILLE: Good morning. My
14 name is Sally Turbyville. I'm here representing
15 the Children's Hospital Association. I have no
16 conflicts of interest to disclose.

17 MEMBER PITTMAN: Hi, good morning.
18 Aisha Pittman with Premier. No conflicts or
19 disclosures.

20 CO-CHAIR UPSHAW TRAVIS: Sorry. We want
21 to just be sure we had all the disclosures out,
22 but thank you so much, Michelle, for your opening

1 remarks. It was very helpful to me. I wrote
2 them all down right at the end there about what
3 you were encouraging us to kind of keep in mind
4 as we go through our work.

5 We do have a few minutes if there are
6 some questions or discussion with Michelle before
7 we move on to our next agenda item. Well, it
8 says here, it says ask if the workgroup has any
9 questions.

10 CHAIR WALTERS: We're all friends here.

11 CO-CHAIR UPSHAW TRAVIS: And remember
12 this is her first time and we want her back. So
13 Nancy.

14 MEMBER FOSTER: Was that directed at me?
15 I actually want to thank CMS for its focus on the
16 Meaningful Measures initiative. The opportunity
17 to really hone down the list of measures to those
18 that are most meaningful to making a difference
19 for patients is really going to help drive
20 quality forward in ways that we all want to see
21 happen and kudos to you for making that happen,
22 to all of CMS for making that happen. It's

1 really an extraordinary opportunity because one
2 of the things you didn't mention, Michelle, but I
3 know you know from your previous experience is
4 that what that does is free up the time of the
5 quality improvement staff to really re-focus
6 their attention on making improvement happen,
7 rather than just measuring what's happening, and
8 that's truly important.

9 I don't know if this is the appropriate
10 time. Cristie, I'll leave that up to you. But I
11 am curious as to why the one psychiatric measure
12 that was initially listed has disappeared off the
13 list and if we can understand because CMS in its
14 rulemaking has said, has acknowledged that it
15 needs more good psychiatric measures. So just
16 curious about that.

17 DR. SCHREIBER: I actually am happy to
18 take that one. I have tremendous interest,
19 actually, in the psychiatric hospitals, having
20 worked with them through Henry Ford and other
21 places. We did a lot of deliberation around the
22 psychiatric measures. One had actually already

1 been passed through, and that's why you're not
2 seeing it, and the other one was on medication
3 reconciliation, which we actually thought was too
4 burdensome, had become much more of like a
5 checkbox-y thing than a meaningful measure, and
6 we pulled it.

7 CO-CHAIR UPSHAW TRAVIS: Thank you for
8 that, and I actually did mean to mention that
9 earlier. So thank you for bringing that up,
10 Nancy.

11 Can you show us your card? Sorry. It's
12 hard to tell. Shannon.

13 MEMBER PHILLIPS: In the spirit of if
14 you remember something say something, I am a
15 member, a senior fellow in the Society for
16 Hospital Medicine and I sit on the Public
17 Measures and Reporting Committee and we do
18 regular feedback to measures that come up as it
19 relates to hospitalists. So thank you for the
20 opportunity to add.

21 CO-CHAIR UPSHAW TRAVIS: Thank you. I
22 had my own opportunity, so thank you for that.

1 Are there other thoughts that we'd like to share
2 with Michelle or questions? All right. Well,
3 hearing none, we will move on to our next agenda
4 item, which is an overview of the MAP Rural
5 Health project. And Ameera, I'm going to let you
6 say your last name, will be walking us through
7 that. So thank you, Ameera.

8 MS. CHAUDRY: Thank you. Good morning,
9 everyone. My name is Ameera Chaudry. I'm the
10 project analyst on the MAP Rural Health project.
11 I'm joined by Karen Johnson. She's the senior
12 director on the project, as well as Ira
13 Moscovice. I believe he is on the phone. So,
14 Ira, if you're there, if you can just say hello.

15 DR. MOSCOVICE: Hello. I'm here.

16 MS. CHAUDRY: Hello. Good morning.
17 Thank you. So next slide, please. So just a
18 quick agenda here. I'm going to provide a brief
19 overview of previous NQF work followed by a
20 presentation by Dr. Moscovice on the 2018
21 recommendations made by the MAP Rural Health
22 Workgroup. And then, last, we'll discuss some of

1 the current work, next steps, followed by a short
2 discussion.

3 So in 2015, the Rural Health Project
4 identified four key issues faced by rural
5 providers and patients. Those four issues were
6 geographic isolation, small practice size,
7 heterogeneity, and low case volume. Based on
8 these issues, an overarching recommendation was
9 made to allow a phased approach towards mandatory
10 participation of rural providers in CMS quality
11 measurement and quality improvement programs.

12 Supporting recommendations addressed
13 guiding the selection of quality measures
14 relevant to rural providers, using a core set of
15 measures, and creating a MAP workgroup, a rural
16 workgroup, to advise CMS on the selection of
17 rural measures.

18 Next slide, please. So in 2017, the MAP
19 Rural Health Workgroup was assembled to ensure
20 that the rural providers selected was represented
21 on MAP. The workgroup is comprised -- clearly,
22 I'm a little nervous -- of 18 organizational

1 members, seven subject matter experts, and three
2 federal liaisons. Key activities of that
3 workgroup included identifying a core set of
4 rural relevant measures to address the needs of
5 the rural population, identifying rural relevant
6 gaps in measurement, and making recommendations
7 on access to care.

8 So with that, I'll turn it over to Ira
9 on the phone. He's the co-chair of the MAP Rural
10 Workgroup and the Director of the University of
11 Minnesota Rural Health Research Center.

12 DR. MOSCOVICE: Okay. Thank you. So
13 what I've done with the other workgroups is spend
14 about 15 minutes describing what we've been doing
15 in the MAP Rural Health Workgroup and that means
16 that I'll give an overview of the activities, but
17 we won't go into a lot --

18 MS. CHAUDRY: Ira?

19 DR. MOSCOVICE: Yes?

20 MS. CHAUDRY: Would you mind talking
21 either a little closer to the phone or a little
22 louder? It's just difficult to hear you in the

1 room.

2 DR. MOSCOVICE: Okay. Can you hear me
3 now?

4 MS. CHAUDRY: Better. Okay. Thank you.

5 DR. MOSCOVICE: Okay. So I have worked,
6 made this presentation with the other NQF
7 workgroups and it takes about 15 minutes, and
8 we're going to give a broad overview of what
9 we've done. I won't go into excruciating detail
10 on any of the specific measures, but I'd feel
11 free to answer any questions you might have about
12 them.

13 But, basically, in 2017 through '18, the
14 MAP Rural Health Workgroup had a couple of key
15 activities. The first was to identify a core set
16 with the best available rural relevant measures
17 and, you know, the motivation here is that many
18 of the measures that have been approved by NQF or
19 by other groups really aren't relevant in the
20 rural environment. It could be because of low
21 case volume, etcetera. And so the workgroup
22 really tried to figure out what kinds of measures

1 are particularly relevant for rural.

2 The second activity was to identify gaps
3 in measurement and provide recommendations on the
4 alignment and coordination of measurement
5 efforts, and the third was to make
6 recommendations regarding measuring and improving
7 access to care for the rural population. So
8 we'll talk a little bit about the work we did in
9 identifying gaps in measures and why we focused
10 on access to care.

11 And so if we look at the core set, we
12 had 20 measures in the core set that we
13 identified. Nine measures were for the hospital
14 setting at the facility level of analysis, and 11
15 measures were for the ambulatory setting at the
16 clinician level of analysis. And what we decided
17 up-front was to use four criteria to help with
18 identifying these measures.

19 The first is that they had to be
20 endorsed by NQF. The second is that they would
21 be cross-cutting measures ideally, i.e. not
22 simply focused on a specific diagnosis, and that

1 would help with the third criteria which is being
2 resistant to low case volume. So the notion was
3 if we could look at cross-cutting measures, when
4 possible, that would be helpful.

5 And then, finally, the fourth criteria
6 was to address transitions in care. And the
7 feeling here was that this whole issue of care
8 coordination and transitions from rural
9 environments to secondary and tertiary care
10 environments was a really important activity for
11 rural health professionals and something we
12 should look at.

13 And so, just briefly, the nine measures
14 for the hospital setting, two of them focused on
15 infection-related measures, one related to CAUTI,
16 and the other related to CDI. We had a measure
17 from HCAHPS because we really wanted, we felt it
18 was important to get the patient viewpoints here.
19 Another measure related to falls with injury, and
20 that was particularly relevant for the elderly
21 population. The emergency transfer communication
22 measure which tried to measure the

1 appropriateness of communication between patients
2 who were in emergency rooms in rural hospitals
3 and then get transferred out to secondary and
4 tertiary hospitals. A measure related to VTE,
5 prophylaxis, really felt it was very important
6 across all environments.

7 And then we had an interesting
8 discussion about including a measure, and this
9 was on cesarean birth rate. And although the
10 debate went, well, there are lots of smaller
11 rural hospitals that don't have, don't do
12 deliveries any longer, despite that, the overall
13 committee voted that it would be important to
14 include the cesarean birth rate in the measure
15 set because it's such an important issue for the
16 rural population.

17 A real interest in also including
18 measures that are related to substance abuse.
19 And for the hospital setting, the focus was on
20 alcohol use screening. And then, finally, self-
21 comparisons could be made with other hospitals
22 directly. We introduced a measure on hospital-

1 wide all-cause unplanned readmission measure. So
2 those are basically the nine measures for the
3 hospital setting.

4 The 11 measures for the ambulatory care
5 setting, once again, included a CAHPS clinician
6 and group surveys for adults and kids, so it was
7 getting input, once again, from patients. A
8 whole set of prevention and screening measures,
9 one related to tobacco use screening and
10 cessation intervention, one was related to
11 influenza immunization, and another is related to
12 screening for clinical depression and follow-up
13 plan. Another related to BMI screening follow-
14 up. And then, finally, another preventive care
15 screening measure related to unhealthy alcohol
16 use for screening and brief counseling.

17 In addition, there was a focus on
18 diabetes. Although we wanted cross-cutting
19 measures, diabetes has become such an important
20 issue, both in terms of obesity-related and other
21 kinds of comorbidities. As a result, we included
22 two measures. One was hemoglobin A1c poor

1 control and the other was optimal diabetes care.

2 Then a couple of the other measures in
3 the ambulatory care setting. One was for
4 medication reconciliation post discharge, which
5 was a big issue out in the rural hospitals. The
6 Committee felt strongly that we should include a
7 measure on advanced care planning, and we had an
8 interesting discussion on that. And then the
9 last ambulatory care setting measure was on
10 depression readmission six months and a strong
11 belief that we needed to have mental health
12 substance abuse measures in this overall set, and
13 we tried to do our best on that.

14 And then, finally, seven additional
15 measures were identified for the ambulatory
16 setting, but they're currently endorsed with NQF
17 for the health planning integrated delivery
18 system level analysis. And we went back and
19 forth on the committee and decided to identify
20 these measures but to say we would really like to
21 see them endorsed at the clinician level if we're
22 going to use them.

1 And those measures, several were for
2 cancer screening. There was a feeling we need
3 some cancer screening measures here. One was
4 cervical cancer screening. Another was
5 colorectal cancer screening, and the last was
6 breast cancer screening.

7 In addition to those measures of
8 controlling high blood pressure, a measure
9 related to weight assessment and counseling for
10 nutrition and physical activity for children and
11 adolescents, a measure on childhood immunization
12 status, and, finally a measure on contraceptive
13 care for the most and moderately effective
14 methods.

15 And so those were the measures that were
16 identified by the group. We believe they apply
17 to a majority of rural patients and providers
18 because of the criteria we used. They include
19 both process and outcome measures. They include
20 measures based on patient reporting, as we said,
21 and the majority are already used at quality
22 programs, which was important to us.

1 So that's a summary of the measure set.
2 In addition, the committee was charged with
3 looking at where are the measurement gaps for the
4 rural environment, and there were five areas we
5 discussed. One was access to care; the second
6 was transitions in care; third was the whole cost
7 arena; the fourth were specifically focused on
8 substance use measures, particularly with a focus
9 on alcohol and opioids; and then, finally,
10 outcome measures and particularly patient-
11 reported outcomes.

12 Because of the importance of access to
13 care in the rural environment, that's the one
14 area that we thought there was a gap in that we
15 did some work on, and we identified the facets of
16 access that are particularly relevant to rural
17 residents, documented the key challenges to
18 access to care measurement, identified ways to
19 try to address those challenges.

20 And we looked at this from three
21 perspectives in terms of access to care. The
22 first was availability, the second was

1 accessibility, and the third was affordability.
2 That really built on some of the previous NQF
3 work in this arena.

4 On the availability area, you know, key
5 items, we're focusing on specialty care,
6 appointment availability in terms of timeliness,
7 and we discussed strategies for addressing it in
8 terms of workforce policy, team-based care and
9 practicing the top of the license, use of
10 telehealth, improving referral relationships.

11 On the accessibility side, a key issue
12 that came up was the whole issue on
13 accessibility, both transportation, which
14 geography basically brings to the table key
15 issues in terms of transportation and the lack of
16 public transportation, etcetera, out in the rural
17 environments, but also accessibility to health
18 information, which relates to health literacy,
19 accessibility to language interpretations,
20 etcetera. And we discussed strategy to address
21 this via tele-access to interpreters, building
22 community partnerships, and use of remote

1 technology, and improving clinician-patient
2 communication.

3 And then a final dimension on the access
4 to care we looked at related to affordability.
5 Out-of-pocket costs, which are an issue, clearly,
6 for everybody but, clearly, play out in the rural
7 environment population. And delaying care due to
8 those out-of-pocket costs. And we talked here
9 about strategies in terms of policy insurance
10 expansion, strategies for protecting the safety
11 net, and the issue got raised here also the
12 notion of how important it is to appropriately
13 risk adjust any measures we're looking at in this
14 arena.

15 And key aspects of the discussion that
16 we had at the workgroup on the access issue is,
17 you know, we noted how difficult it is to
18 separate or de-link access and quality. We had a
19 vibrant discussion on this notion of what can we
20 expect clinicians to be accountable for and what
21 should we expect higher-level accountability for.
22 And where we came down on that in the end was,

1 yes, there are some variables that are out of the
2 individual clinician's control, but clinicians
3 can have a major impact in terms of decisions
4 their patients make and we felt it was important
5 to include these kinds of measures even if
6 clinicians don't have total control of all of the
7 levers, so to speak, in terms of improving access
8 to care.

9 And then, finally, you know, we
10 mentioned that telehealth can address several of
11 the barriers to access, but there still are
12 limitations to its use. We know the majority of
13 states now do have policies on reimbursing
14 telehealth services, but there still are about a
15 third of the states that don't. And so starting
16 with payment but there are other issues also that
17 need to be addressed if telehealth is going to be
18 more fully used.

19 And so that, I guess, will conclude my
20 comments on this end. I'll turn it back to my
21 colleague at NQF and then we can open up for
22 questions.

1 MS. CHAUDRY: All right. Thank you,
2 Ira. So I think the next slide, I believe, yes.
3 Go back. All right. So, yes, I guess the final
4 recommendation from the MAP Rural Health
5 Workgroup is listed here: that CMS should
6 continue to fund the workgroup's work, view the
7 current core set as a starter set, and, over
8 time, you know, being open to the opportunity to
9 refine that core set and involve the rural
10 perspective in various topics moving forward.

11 Next slide, please. Oh, yes?

12 MEMBER PHILLIPS: Shannon Phillips,
13 Intermountain. The use of the CAHPS survey in
14 the ambulatory setting for children, I think that
15 would be a first requirement, right? Is there
16 another program that requires child CAHPS? I
17 mean, I think that little piece is a big change
18 potentially, so a lot of children centers are
19 doing their own surveys. They have some
20 flexibility. So I want to call that out. If
21 this went in, that would be a major change, and
22 is that the intent?

1 And the interested in what the
2 discussion might have been around the fact that
3 the end sizes are tiny, right? So I did hear the
4 comment about risk adjustment, but in any rural
5 hospital the numbers of patients that would fall
6 into any one of these measures might be one or
7 none or a handful. And was there discussion
8 about how to approach that? Really important to
9 measure and we need to be careful if there's
10 transparency, if this is public, the end sizes
11 will be very small. The other thing is if you
12 set them up and say we're not going to show them
13 if they're less than X patients, there's going to
14 be a lot of blank slots around the country and so
15 just if there was discussion with the group on
16 that.

17 DR. MOSCOVICE: I'll take the first one
18 and try to deal with the second one and see if my
19 colleagues want to add to that. But, basically,
20 we really felt it was important to have input
21 both in terms of HCAHPS and CAHPS, and I'd be
22 interested in, I'm not a child health expert, but

1 the group felt that we did want to get input both
2 on the adult and the child side of things. And
3 one thing about using these surveys is that they
4 are cross-cutting, and so the experience has been
5 that some hospitals, some rural hospitals, are
6 able to provide enough surveys, others provide
7 more limited surveys, but we felt it was
8 important to include this and to try to, you
9 know, build the work in that area. But I am
10 interested, if there are child health experts in
11 the group, if they felt it was, it would be
12 useful and important from a policy perspective to
13 include that.

14 In terms of the overall volume issue, we
15 know some of the measures, we know we do have
16 enough sample size. Some we know right now we
17 don't. And the feeling was that we would
18 include, you can't come up with a rural health
19 core set of measures right now that have for sure
20 enough sample size for every hospital, every
21 rural hospital in the country. And what we tried
22 to do was to balance ones that we know we have,

1 and there are some where it's close. We ruled
2 out measures where we felt there wouldn't, you
3 know, be any volume whatsoever. And we need to
4 start some place, and the feeling is these
5 measures can both be used for internal quality
6 improvement, as well as external, for external
7 comparisons. And we played that back and forth
8 and got a variety of information in terms of the
9 volume related to many of these measures and took
10 some out, left some in, even though they're sort
11 of on the cusp, so to speak.

12 So there's no easy answer to that.
13 What's happening now is NQF has a working panel
14 of statistical experts who are trying to address
15 this issue and come up with some recommendations
16 in terms of how the low volume issue can be
17 handled in general, and that should be done over
18 the next six months or so.

19 So no easy answer to that question, we
20 recognize it and try to put together a set that
21 would be as useful as possible.

22 MS. RANEY: This is Gigi Raney from the

1 Center for Medicare and Medicaid Services. I
2 work on the child core sets, and I think one of
3 your questions was about whether similar measures
4 are used in other spaces. So I just wanted to
5 let you know that we do have a CAHPS health plan
6 survey child version on the child core sets. I
7 know that if ours is collected at a state level,
8 our end is obviously very different from what
9 you're working at here, but we did have 40 states
10 that said that they reported using the child
11 CAHPS for FY17 reporting, just for a frame of
12 reference for other states that are using those
13 core sets.

14 CHAIR WALTERS: Who's actually chairing
15 this now? But Lisa, go ahead.

16 MEMBER MCGIFFERT: I'm wondering if you
17 discussed the idea of combining years of care,
18 looking at over time to address the small
19 numbers. As consumers, we're looking at old
20 information often, but if you, if you could
21 stretch it out and take a couple of years, two or
22 three years maybe at a time, did you have any

1 discussions about that? And I know there's, you
2 know, issues about the hospital changing, but I
3 think that there might be some way to address the
4 historical care that the hospital might give or
5 an ambulatory setting.

6 DR. MOSCOVICE: So the committee
7 discussed that very little, I would say. I can
8 say from my own work in this area previously
9 combining years of care does tend to help improve
10 obviously the volume consideration. But if
11 you're really going to try to make it relevant
12 from a policy perspective, particularly a payment
13 perspective, we haven't gotten a lot of positive
14 feedback in terms of let's use two or three
15 years' worth of claims to try to deal with, you
16 know, any kind of value-based payments or any
17 other kinds of programs like that.

18 So it's tricky. I think you're right.
19 On the one hand, we certainly can increase volume
20 by using more than one year. I think we need to
21 be considered from a policy, that's from a
22 statistically perspective but from a policy

1 perspective would be able to use that in terms of
2 payment updates for instance, etcetera, etcetera.
3 And I haven't heard any good evidence that that
4 would be helpful to CMS, to be honest.

5 CHAIR WALTERS: Nancy.

6 MEMBER FOSTER: Thanks, Ron. Hi, Ira.
7 Nancy Foster. As I look at this list of measures
8 and think about what the committee went through,
9 it seems to me that there is sort of an
10 interesting blend of measures that you've
11 recommended here. There are some, in fact the
12 ones that I'm looking at on the screen right now
13 where I would say clearly the action is the
14 hospitals and/or the hospital and its clinicians.
15 There are others that I think are absolutely
16 worth measuring in a rural setting but more
17 likely to be good fodder for discussions among
18 policymakers and others who care about rural
19 health in general and the huge transitions that
20 are going on in rural health right now, and so
21 even if CMS or others who might pick up this
22 rural health core set and try to implement it

1 decide that some of these aren't direct or
2 appropriate for hospitals or other sets of
3 providers, I guess I'm standing up in support of
4 measuring some of these things and thinking about
5 how they're best used, including holding
6 communities and insurers and others accountable
7 for making sure that we're working to achieve the
8 goal here, which is health in that rural
9 community.

10 So did your committee have discussions
11 about other potential uses of these measures?

12 DR. MOSCOVICE: Not that much. I don't
13 know if my NQF colleagues have anything to add on
14 that. But I agree with what you're saying,
15 Nancy, but we didn't really talk in detail about
16 that. What we raised is, the biggest discussion
17 we had is are we really going to hold clinicians
18 responsible for all of the ambulatory care
19 setting measures we laid out there, even though
20 they don't control, as I said, all of the
21 resources or levers to make sure that, you know,
22 patients follow recommendations, etcetera,

1 etcetera. And there was certainly a discussion
2 on both sides in terms of people who felt
3 strongly shouldn't all the clinicians be
4 accountable, but the majority felt that we should
5 but make it clear in the report that makes it
6 clear that we recognize they don't control, the
7 individual clinicians don't control all the
8 levers but they have such a potential for
9 impacting these decisions that we really need to
10 be involved.

11 So that was the discussion more so than
12 holding a higher level responsible, although we
13 did identify seven measures in the ambulatory
14 care setting that have been approved at the
15 health integrated delivery system level now, so
16 it related to that for sure in terms of the
17 cancer screening, controlling high blood
18 pressure.

19 So there was some discussion in that
20 vein, but not so much, I think, above and beyond
21 what you're suggesting. But I think it's a
22 relevant comment.

1 CHAIR WALTERS: Lee?

2 MEMBER FLEISHER: Thank you again. And
3 you just mentioned the health system level, and I
4 think about some of these measures and whether or
5 not patients really are willing to go outside of
6 the rural local community hospital and the
7 transfer issues. That's a really interesting
8 question about health systems. I wonder if
9 there's, you know, looking at whether these large
10 health systems, which have a tertiary care sort
11 of center and how that is affected by some of
12 these either readmission or emergency transfer
13 because I would think, in some ways, I'd hold
14 them to a higher standard because they're
15 supposed to be integrated or at least look at it
16 in that sort of manner than stratified by whether
17 or not they are a system or they're not a system
18 because that would give us information from a
19 policy perspective of whether it's useful to
20 allow some of these mergers or aggregations.

21 DR. MOSCOVICE: I definitely agree with
22 the sentiment of your comments. And we have a

1 couple of measures, as you pointed out, the
2 emergency transfer communication measure and the
3 cause on planned re-admissions, but, to be
4 honest, I was a little disappointed because up-
5 front we had everybody acknowledge that this
6 notion of transition through care and care
7 coordination is really important, but, in the
8 end, we came up with just one or two measures at
9 this point. As it was mentioned earlier, this is
10 going to be an ongoing effort that, you know,
11 this isn't the one and only. Certainly, things
12 change over time.

13 But I was a little bit disappointed that
14 we didn't get more there, but the committee as a
15 whole didn't come down to the final set to add
16 additional care coordination transition measures.
17 But I think the comments made are important ones.

18 CHAIR WALTERS: So this is a new
19 program, and this is the opportunity for the
20 members of this group to give feedback about what
21 they've heard. I'll ask the team in just a
22 little bit if they have felt they've gotten

1 enough feedback. I think common themes that we
2 talk about in every session were brought up. Is
3 there anybody else that would like to give the
4 rural health team some feedback?

5 CO-CHAIR UPSHAW TRAVIS: I just want to
6 echo what Lee was saying about, you know, about
7 systems. I think it's important to measure at
8 both the individual hospital where we can, but
9 the at the system level, as well.

10 The other aspect, which I think was
11 referred to but perhaps not said out loud is the
12 number of facilities that are closing. And so
13 although it certainly impacts access, geographic
14 access, I think we do need to be sensitive to the
15 fact that these systems, especially if they're
16 operating in systems, the infrastructure may be
17 there to actually get the telehealth and get the
18 other pieces of some of the core work that was
19 said here out into the different geographies.

20 And this is an impossible request, but
21 I'm going to make it anyway. There are several
22 other parts of the federal government that work

1 with rural health, and I think it is really
2 important to think about how rural health is
3 addressed across the federal continuum because
4 there are even probably some places where it's
5 not pushing for the same things and could be
6 sending contradictory messages down into rural
7 America. Tennessee is a major rural state. My
8 other heart is in Mississippi, which is another
9 rural state. So we're very sensitive to it, and
10 I think that sometimes the federal government is
11 not sending the same set of messages and wherever
12 that could be aligned I think would be helpful,
13 as well.

14 DR. MOSCOVICE: So I think that's an
15 important comment, and the creation of a federal
16 officer of rural health policy is a couple of
17 decades almost now, I think it was an important
18 step in that direction because I think different
19 parts of government were really considering or
20 not considering rural in many different ways.
21 And I think the federal officer of rural health
22 policy in its efforts have really helped improve

1 this whole issue of making sure that the notion
2 of is what we're doing relevant in a rural
3 environment, that that's really being considered
4 more and more in a variety of CMS programs and
5 CMS recently introduced, you know, their rural
6 health strategy and we need some more details as
7 time goes on now.

8 But I think more and more of
9 governmental entities and bodies really are
10 thinking, at least, as they develop new policies
11 and measures and you name it that, you know, is
12 this going to work out in the rural environment?
13 And, you know, going back to just the
14 implementation of DRGs many years ago, there
15 really wasn't much thought up-front about how
16 this was going to play out in a small volume
17 environment, and it continues as we go through
18 the pay-for-value environment and the comments
19 that were raised today in terms of are we going
20 to have enough sample size to look at things?

21 From my perspective, what's most
22 important is we need to get out of the ball game

1 of having asterisks in lots of tables, whether
2 it's measures or whatever else, and saying not
3 applicable or just not enough volume here because
4 when people see asterisks in the table related to
5 rural environments, they take that as a negative,
6 not just it wasn't applicable or they can't even
7 do it. And I think the efforts of our group and
8 the continuing efforts of CMS and other groups is
9 to really try to see: can we make sure that the
10 policies we're developing can really play out in
11 all environments? You know, we have a little
12 under 20 percent of the population living in
13 rural areas now. We need to make sure that they
14 are, whether it's through Medicare or other
15 public programs, that they are getting access to
16 as high quality of care as possible. And that's
17 why I think this effort is a starting point, not
18 an end point, and I think it's important because
19 of that because we need to really try to pay
20 attention, as has just been said, to make sure
21 that, A, we're doing something in this arena and
22 it's been coordinated across governmental

1 agencies and, hopefully, with the private sector
2 also.

3 CHAIR WALTERS: Thank you. Michelle
4 would like to respond and then Jack, and then
5 we'll go to some of the questions that Madison
6 has teed up on the screen.

7 DR. SCHREIBER: Thank you. I would like
8 to just really echo what was said on the phone
9 that the administrator, Seema Verma, this is of
10 particular interest to her, and that she's done a
11 tremendous amount of work and is bringing
12 agencies across CMS for focusing together on
13 rural health and I think is doing that for all
14 government agencies. So I think this really is
15 the beginning of a lot of new opportunities to
16 consider rural health and the health of rural
17 citizens together in a unified way.

18 MEMBER JORDAN: I think one comment to
19 make, too, is that sometimes we overly focus on
20 wanting to think about what we can do with the
21 data drilled down to its deepest point, but I
22 think, actually, with the rural health, just

1 filling in so many of the holes, you may get a
2 lot of insight into kind of regional or group
3 differences that may give you some actionable
4 things to move forward on this. Even when you
5 get down to a single hospital or a single
6 physician, you know, it's just too sparse. But I
7 think you'll see patterns in this, and I think
8 there's great, you know, gains to be made by kind
9 of filling in all the missing data spots so you
10 can kind of get some of those insights with this
11 and not get overly hung up on it has to be
12 something you can drill down to the individual
13 level to be your only actionables in place.

14 CHAIR WALTERS: Okay. Just hold a
15 second. Madison teed up some questions for
16 everybody just in case. You want to read them
17 off just in case not everybody can see them?

18 MS. JUNG: Sure. So on the screen, we
19 just have some questions addressing the topics
20 that we discussed related to core set gaps and
21 access to care. Specifically for core set, some
22 questions for the workgroup from the macro health

1 team is: do you agree with the overall topic
2 areas that were covered? Was there anything
3 missing? Do you have any particular concerns or
4 questions about any specific measures for gaps?
5 What are your initial thoughts on the identified
6 gaps for access to care? What did you think of
7 the approach? Do the three domains seem like the
8 right ones to focus on? Was there anything
9 particularly surprising or intriguing? And was
10 there anything missed?

11 So if there are any slides we want to
12 toggle back to, just let me know.

13 CHAIR WALTERS: Andreea?

14 MEMBER BALAN-COHEN: So I just wanted to
15 follow up on the comment about, like, the gaps in
16 the data and also the asterisks. And I think
17 that just to second that and say, like, how
18 important that is because a little bit of a
19 concern and, again, like, knowing the
20 difficulties about, like, the low volume, but
21 when I look at the sets of measures, like one of
22 the things that strikes me is that in the attempt

1 to try to make sure that we have all the right
2 information before we have all of these measures,
3 there's likely to be a lot less variation in
4 terms of, like, hospitals as a result of using
5 this specific set of measures, so they get a
6 little bit more diluted.

7 When I look at those measures, they are
8 probably only like one or two for which they are
9 likely to be, like, big meaningful differences in
10 terms of hospitals. Like, for some of the other
11 ones, they are likely to get, like, topped off,
12 like, relatively early. So that's why I just
13 wanted to second that it's important to try to
14 maybe get some of this information, even if it's
15 imperfect at first, and then, like, try to build
16 up on it and then try to get some meaningful
17 measures that can get to some of these, like,
18 true differences, even if there are for a
19 specific region, when you try to fill in some of
20 the gaps.

21 CHAIR WALTERS: Thank you.

22 DR. MOSCOVICE: Let me just offer one

1 comment in response. I think it's an important
2 issue. I'm never surprised at how much variation
3 exists out in the rural environment, and, in
4 general, if I had to generalize it, I'd say
5 there's more variation within rural environments,
6 across rural environments, as there is compared
7 to looking overall at rural providers versus
8 urban providers.

9 So there is substantial, in general
10 there's substantial variation in a lot of these
11 measures. That may be surprising, but that's the
12 reality. And that points out that you can do
13 well on many of these measures, and there's
14 really no excuse not to be doing well. And this
15 notion of best practices and finding out how
16 people are achieving some of these results
17 they're doing out in rural environments, that's
18 really important. There's been a variety of
19 technical assistance and health information
20 resources. RHIhub is one that has a lot of
21 information that is in this area. But it never
22 ceases to amaze me how much variation there is

1 across rural hospitals and small rural hospitals
2 in many of these measures.

3 CHAIR WALTERS: Okay. Lee.

4 MEMBER FLEISHER: Just a quick comment
5 to CMS in that, yes, volume does matter and low
6 volume we acknowledge in these hospitals, but
7 there's low volume and there's very, very low
8 volume. So I wonder if having more transparency
9 to say this hospital only does two a year, should
10 they be doing any, versus they do ten to twenty,
11 acknowledging that they can't get to fifty for
12 some procedures may be of some value to patients.
13 So just something to think about.

14 CHAIR WALTERS: Thank you. Do -- sorry.
15 Ira.

16 DR. MOSCOVICE: No, I was just going to
17 say I really agree with that notion and, you
18 know, one of the important decisions, I think,
19 from a hospital's perspective is to say: should
20 we be doing whatever the procedure is we're
21 talking about, or should we not be doing
22 something? And, you know, for some of the

1 measurers here in terms of screening, you know, I
2 think we want all facilities to be doing
3 screening for a variety of ambulatory care
4 settings, but I think all these smaller
5 facilities particularly need to really think
6 should they be doing something? If it's not an
7 emergency and they can't transport out quickly,
8 should they be doing very low volume as was just
9 pointed out. I think that's an excellent point.

10 CHAIR WALTERS: Frank.

11 MEMBER GHINASSI: There are three
12 measures on alcohol screening and use and one on
13 tobacco, and in the notes I think there's a
14 mention of other substances, as well. Is that
15 going to make it into this set, or will the focus
16 solely be on alcohol? I think you're missing a
17 large segment of the population who may be in
18 jeopardy of either with prescription medication
19 or illicit use of other substances, especially
20 given events of the last couple of years.

21 DR. MOSCOVICE: I think it's a valid
22 point. The set that we proposed is what you're

1 seeing and, as we said, in terms of the treatment
2 gaps, the measure gaps that were identified, the
3 use of opioids and other drugs is something that
4 we need further work on. The committee shared
5 your sentiment, but in the context of trying to
6 have a manageable number of items, decided on the
7 ones that are here right now.

8 CHAIR WALTERS: Nancy.

9 MEMBER FOSTER: So just a couple of
10 quick points. One is I think that there might be
11 use, it might be a good step forward in advancing
12 these measures if there were what I will refer to
13 as a collaborative organized where you collected
14 the data for a period, you brought people
15 together who were in those rural hospitals and
16 said, okay, here's what we're seeing from the
17 data, what does that mean to you? I've been
18 impressed over the years where I look at some of
19 the data we're publicly collecting and think, oh,
20 there's something wrong with the practice here at
21 that hospital, let me call them up and see, and I
22 learn that there's just something unique about

1 that hospital. And as we explore this territory
2 where we haven't measured a lot and haven't
3 played with the data a lot, there might be a real
4 value in thinking about bringing together that
5 kind of collaborative, either under Ira's
6 direction or some other, but really just learning
7 from the data first before deciding it's
8 appropriate for public accountability as a sort
9 of one-two phasing.

10 Secondly, Ira, I wanted to ask, I saw
11 the admission, re-admissions measures on there.
12 I know there was talk about the mortality
13 measures and so forth. Those measures are, I
14 would say, exquisitely sensitive to sample size
15 by the way they are constructed, and I was
16 curious as to whether the group thought about
17 that. They're important things to measure. I'm
18 sure the public would like to know about them,
19 but not sure the way the measure is constructed
20 will get people the information they actually
21 think they're getting.

22 And then, third, there was sort of this

1 casual mention of telehealth in the things that
2 you could look at in the set of measures that you
3 thought were worth CMS looking at further. To
4 me, telehealth is a great national experiment.
5 There are lots and lots of things that are going
6 on with telehealth, and lots and lots of plans
7 for more to go on with telehealth, and it helps
8 solve that access problem. But I think we don't
9 really understand yet: how is telehealth as it is
10 delivered comparable to the in-person, or what
11 are the bonuses for telehealth, what are the
12 deficits from telehealth in each kind of
13 encounter?

14 So I think measuring telehealth itself
15 and learning from that would be extremely helpful
16 as we move the nation forward on telehealth, not
17 just rural. But there you go.

18 DR. MOSCOVICE: Those are certainly good
19 comments. The notion of, I'm trying to remember,
20 you said the notion of the collaborative and
21 what's learned from the data before we start
22 using it publicly I think is a terrific comment,

1 and we'll see how NQF responds to that.

2 I can say, in terms of the last comment
3 on the re-admission measure, I was just looking
4 at our notes and it basically says, you know,
5 commenters noted that the majority of critical
6 access hospitals meet the threshold number of
7 cases for this measure. So we need to check that
8 if that's not the case.

9 And another part of this was that if a
10 hospital didn't have enough volume to report the
11 measure, then it would not be assessed with this
12 measure or otherwise penalized with inability to
13 report the measure.

14 So those are the two, just looking at
15 our notes, we had related to your comments. And
16 so there are some hospitals clearly that aren't
17 going to have enough sample size, but it's not
18 the numerator, remember, that we're concerned
19 about; it's the denominator obviously. And maybe
20 we can talk afterwards about this in terms of the
21 data you have in terms of how many smaller
22 hospitals would be involved.

1 Those are the two comments you had on
2 that. You had one other point raised. Oh, the
3 telehealth stuff. Hey, I agree with you. You
4 know, the federal health policy is funding a
5 telehealth research center down at the University
6 of Iowa is the lead on it, and Marcia Ward is on
7 that, and they are in right now developing new
8 measures trying to see how telehealth is being
9 used, trying to identify the pros and cons of it,
10 etcetera, etcetera.

11 So I agree with you. We're sort of in
12 an experimental stage, and we see new articles
13 every day. I just saw one this morning about
14 how, although it's much greater use of telehealth
15 than we've ever had, there's still the majority
16 of providers don't use telehealth at all or maybe
17 very little. So we had a lot of ways to go. And
18 they haven't been great measures in terms of
19 quality of telehealth care. And that field is
20 just starting really to be developed, so it's
21 going to take a little while.

22 CHAIR WALTERS: Okay. Let's go to Ann

1 and then Sally. And then I'm going to give our
2 members on the phone a chance if they want to say
3 anything and then public comments. So Ann.

4 MEMBER SULLIVAN: Yes, hi. Just in
5 terms of, you mentioned insurance coverage, and
6 I'm not sure if you're really going to be looking
7 into that or not. But if you should, I would
8 just emphasize that you think about parity for
9 mental health and substance abuse and to look at
10 that kind of specifically because that tends to
11 be a real access issue across the country.
12 Despite a lot of the parity legislation, that the
13 insurance is still not following on those rules.
14 So if you are going to look into insurance, I
15 would just keep parity on the list of what you
16 look at.

17 DR. MOSCOVICE: Okay.

18 CHAIR WALTERS: Sally.

19 MEMBER TURBYVILLE: Good morning. This
20 is Sally with the Children's Hospital
21 Association. Really great and important work and
22 lots of really great insights so far today.

1 You know, we share with Children's
2 Hospital something in common with rural health,
3 and that's real challenges with comparative
4 performance measurement, whether that's
5 comparative performance over time or to peer
6 groups. And I just wondered from those who
7 worked on this how much discussion was given to
8 alternative approaches to measurement. It's
9 become very clear in pediatrics that condition-by
10 condition measurement for children, especially
11 acute inpatient care but even ambulatory
12 specialty care, is very problematic and so been
13 pushing the envelope. At what point is the
14 perfect, the enemy in this case, not having the
15 perfect, you know, so looking at measures that
16 have worked very well in the adult healthcare
17 system condition by condition and any kind of
18 emerging new ways to measure, whether it's
19 through patient-reported outcomes, really
20 focusing on what matters to them or otherwise.
21 I'm just curious what you all learned in those
22 deliberations.

1 DR. MOSCOVICE: Yes, I think that
2 influenced the work of our group a lot. In fact,
3 you really only see one or two measures that are
4 diagnostic-specific just because of that. We
5 didn't have enough time or resources honestly to
6 start mapping out alternative strategies, so we
7 did start with the notion that any measure we
8 were going to look at had to be NQF endorsed, and
9 we had a thousand measures or so just within that
10 rubric. And so it was a pretty big framework to
11 start.

12 We didn't really spend a lot of time on
13 alternative strategies for measurement, and I
14 don't know if NQF has any thoughts about the
15 future work in that area. But I agree with your
16 comment there. On the one hand, it's hard to
17 compare, to make comparisons, as you said, just
18 the relevant peer groups, sample size, etcetera.
19 But if you use alternative strategies for
20 measurement, then the issue is how are they going
21 to get integrated into the existing measurement
22 world that's out there now. And I think that

1 shouldn't stop work on alternative strategies for
2 measurement, particularly low volume
3 environments. But we didn't, at least, have the
4 time in this workgroup to deal with that.

5 CHAIR WALTERS: Okay. Sometimes we do
6 remember that there is committee members on the
7 phone. Marsha, Pam, did you have anything you
8 want to say?

9 MEMBER MANNING: I do not. Thank you.
10 Other than I appreciate the comments about
11 thinking across the federal government when we
12 think about the rural issues. I think that's
13 absolutely true.

14 CHAIR WALTERS: Thank you very much.
15 And we didn't specifically have a time slot for
16 public comment, but I would like to open up the
17 lines if we can for any. Let's go to comments in
18 the room first. I see none in the room. Any
19 public comment?

20 OPERATOR: Okay. At this time, if you
21 would like to make a public comment, please press
22 star then the number one.

1 CHAIR WALTERS: Okay. I'll turn it back
2 over to Madison for some next steps, and then
3 we'll move on to the next agenda item.

4 MS. JUNG: Great. Thank you. Just
5 toggling back to our slides. So I'll be
6 reviewing the pre-rulemaking approach, and then
7 we'll be getting into some of the semantics and
8 logistics regarding the new updated voting
9 process.

10 CHAIR WALTERS: Oh, next steps on --
11 there's a slide there somewhere.

12 MS. JOHNSON: Go back two from the
13 discussion, and I'll just, Ira already noticed or
14 talked about these. Do one more. We have done
15 quite a bit of work with the work that came out
16 of the Rural Health Workgroup, including setting
17 up a Capitol Hill briefing that went very, very
18 well. Rural is very, it's a topic of interest to
19 our leadership in Congress, so that went well. A
20 couple of folks did a healthcare blog, so that
21 was a nice way to kind of publicize the work.

22 In terms of what the Rural Health Group

1 is doing right now and in the future, again,
2 sharing our recommendations to each of the three
3 MAP workgroups so you know what we're doing and
4 what we're thinking. Tomorrow, at the clinician
5 MAP workgroup meeting, Ira is actually going to
6 be here to give the rural perspective on the
7 clinician MUC list. So we had a call yesterday
8 and got some really interesting feedback from our
9 rural group on those measures, so we weren't able
10 to do that this time around with you guys to give
11 you the rural perspective, but we think that
12 might be coming, and it's a way to get the rural
13 perspective into this pre-rulemaking process. So
14 we're very excited about that.

15 And then, as Ira mentioned, we have
16 convened a five-person technical expert panel,
17 most of them Ph.D. statisticians, to help us
18 think through this low-case volume problem and
19 what do you do about it, and to go back to the
20 question about, you know, even doing, adding over
21 time. It's an idea, but there are very complex
22 statistical ways that you could approach doing

1 even more than that, and they're talking about
2 those things, but we're talking about future work
3 in measurement because it's so complicated. But
4 I think it's a really interesting little project,
5 and we will have a report out, if you're
6 interested, in mid-January going out for comment.
7 So if you're interested in seeing what our
8 statisticians think about this low-case volume
9 problem and what might be some of the next steps,
10 stay tuned for that. Thank you.

11 CHAIR WALTERS: Thank you all for your
12 feedback. I think the group got some very good
13 feedback. All right. Melissa and Madison,
14 moving forward into the pre-rulemaking process.

15 MS. JUNG: Okay. Now we will be going
16 over the rulemaking approach. So I'll just be
17 giving an overview of our process and some of the
18 updates and our approach for this meeting.

19 The approach for this meeting, as in
20 other years, is to provide, we'll start off by
21 providing a program overview, then reviewing the
22 current measure, and then evaluating the MUC for

1 what they should add to the program set. So
2 that's the lens through which we'll be looking
3 through things.

4 So the MAP workgroups must reach a
5 decision about every measure under consideration.
6 The decision categories are standardized for
7 consistency. We have had some updates to
8 decision categories this year, and we'll be
9 reviewing them on the next slides. But each
10 decision should be accompanied by one or more
11 statements of rationale that explains why each
12 decision was reached.

13 To facilitate the voting process, we
14 have conducted a preliminary analysis for you.
15 That was included in your meeting materials in
16 the discussion guide. The preliminary analysis
17 follows an algorithm that was based on the MAP
18 measure selection criteria. This measure
19 selection criteria was approved by the MAP
20 Coordinating Committee, and it's intended to
21 provide MAP members with a synced profile of each
22 measure and to serve as a starting point for MAP

1 discussions.

2 This is just a list of the MAP measure
3 selection criteria. I won't read these in
4 detail. And then these are the decision
5 categories for 2018 and 2019. Of note, we have
6 added the do not support for rulemaking with
7 potential for mitigation. This was added to --
8 excuse me. I dropped my notes. This was added
9 to preserve MAP's ability to show support for a
10 measure concept but clarify that MAP does not
11 think it's ready for implementation as it's
12 currently specified.

13 So to reiterate, the four decision
14 categories are support for rulemaking,
15 conditional support for rulemaking, do not
16 support for rulemaking with potential for
17 mitigation, and do not support for rulemaking.

18 I'll turn it over to Erin and Melissa to
19 add any maybe comments or coloring to that.

20 MS. O'ROURKE: Sure. I can start. Just
21 to add a bit on the do not support with potential
22 for mitigation, as Madison said, we used this to

1 replace the refine and resubmit because I think
2 last year we heard from everyone there was some
3 confusion about how to operationalize that and
4 where the line was between conditional support
5 and refine and resubmit, and the confusion that
6 the MAP process only really requires MAP to
7 review a measure once. So by having this
8 resubmit language, we were making an ask that's
9 not really within the scope of what MAP can
10 control.

11 So based on input from you all and other
12 MAP members, we are trying this new category this
13 year. And, again, we'd always welcome feedback
14 if this is an improvement, but hopefully this
15 makes it a little bit clearer where the dividing
16 line is with two categories essentially saying
17 you think the measure is ready for implementation
18 to saying it's not ready for implementation at
19 this time.

20 MS. JUNG: Did we have any questions
21 about the decision categories? Otherwise, we can
22 review the voting instructions. Okay.

1 MEMBER HATLIE: I'll just make a comment
2 that I think it is clearer. Having seen the
3 process get reinvented every year since I've been
4 on it, I think this is an improvement. We'll
5 see. I'm with Cristie. We'll see as it plays
6 out.

7 MS. MARINELARENA: So the voting process
8 has changed as well. The text in red is what is
9 different. They share from previous years.
10 Quorum is defined as 66 percent of the voting
11 members of the Committee that is present in
12 person or on the phone, so we establish that
13 before we actually start the voting.

14 And then we have also established a
15 consensus threshold of greater than or equal to
16 60 percent of voting participants voting
17 positively, and a minimum of 60 percent of the
18 quorum figure voting positively. And abstentions
19 do not count in the denominator.

20 And then different from other years,
21 we've had the consent calendar in the past. We
22 no longer have that. We also only have four

1 measures, so it's kind of a moot point. But
2 every measure will receive a decision from the
3 MAP, and, again, staff is going to, you know,
4 we're going to go over this process. And then
5 we'll provide some introductions from staff as to
6 how we reached a decision and then the lead
7 discussants will also provide their review of the
8 measure, and then we'll open up the discussion to
9 the group. And then you can provide clarifying
10 questions, we can respond as to the NQF part of
11 it, and then the lead discussants can provide the
12 additional information about the measure or any
13 clarifications before we move on.

14 And then, again, the preliminary staff
15 analysis is based off of the algorithm that has
16 been approved by the Coordinating Committee.

17 So the procedures are, so the staff,
18 again, did the preliminary analysis for each MUC
19 based off of the algorithm. We will present the
20 measures. The co-chairs will ask if there are
21 any clarifying questions, so, again, we've done
22 away with any motions this year. Everybody will

1 just have the opportunity to ask for any
2 clarifying questions, and then the developers
3 will also be able to respond to any clarifying
4 questions about the measure specification, so
5 they're either here in person or on the phone.
6 Staff will provide any clarifying questions about
7 the preliminary analysis itself, how we reached
8 it, or if there's any other information that may
9 be confusing to you that NQF can clarify. And
10 then the lead discussants will also dive into the
11 measure.

12 The voting is going to be, the first
13 vote will be based on the acceptance of the staff
14 preliminary analysis. That will be a yes/no
15 vote. If that doesn't pass, then the co-chairs
16 will be taking down any questions or any
17 clarifying issues. If the staff recommendation
18 doesn't pass, then we can either start with each
19 category or the co-chairs also have the
20 discretion to see, you know, if the group is
21 leaning towards one way or another. If we don't
22 need to go through all four categories, then we

1 can start there. But if there is any dissenting
2 opinion, then we can just go through all of them
3 so that everybody's voice is heard.

4 And, again, we need 60 percent or
5 greater for each of, for it to pass, for a
6 decision to pass. If none of them are reached,
7 none of the categories reached 60 percent or
8 greater, the default is the staff recommendation.
9 Correct? Yes.

10 MS. O'ROURKE: Correct. But at that
11 point, we would also like to pause and get some
12 input on why people feel so split so that we can
13 pass your reasoning, the results of the staff PA,
14 and then any comments and flag this all for the
15 Coordinating Committee to take a special look at
16 as a place where the group was having trouble
17 coming to a consensus.

18 MS. MARINELARENA: And, again, we'll be
19 capturing everyone's comments because I know in
20 the past CMS has really valued that, so we want
21 to capture all of your comments and your concerns
22 and recommendations as long as, in addition to

1 the votes.

2 So we talked about the discussion of
3 voting on the MUC. Ron and Cristie will be
4 leading that, and we've got it all ironed out, of
5 course, as we always do. And I think I already
6 went through all of this. You know, they'll
7 determine what decision category we're going to
8 start at, and they will put the vote forward.
9 And I went through this, right? Yes. And then
10 tally the vote.

11 Again, if no decision category archives
12 greater than 60 percent to overturn the
13 preliminary analysis, then the preliminary
14 analysis will stand, unless we, you know, can
15 come to another decision, but we can continue the
16 discussion. Again, we have four measures, so
17 feel free to discuss.

18 Commenting guidelines do not change.
19 Comments from the early public comment period
20 have been incorporated into the discussion, into
21 the discussion guide, so they were there. I know
22 that we updated the discussion guide so you've

1 had the opportunity to look at those. We will
2 also ask the public to provide any comments here
3 as well. We ask you to limit your comments to
4 two minutes.

5 And then the public comment on your
6 recommendations will run from the 21st through
7 January 10th. And then your recommendations will
8 go to the Coordinating Committee. And this is
9 just, you've seen this before, but it is an
10 overview of the time line.

11 And Desmirra is going to do a test vote.
12 Since we have new voting software, rather than
13 the clickers or the hands, so we're going to go
14 through that.

15 MS. QUINNONEZ: So this is exciting. I
16 just want to make sure that, at this time, I want
17 to make sure that everyone is logged in and has
18 had assistance or you've received your
19 instructions that were on the table of how to log
20 into Poll Everywhere. At this moment, if there's
21 anyone who has not logged in, if you could raise
22 your hand. Well, this should be great.

1 So we're going to read our first test
2 slide, and, as we do, usually we'll read through
3 the voting question just to make sure that we're
4 clear about what you're voting on. And you will
5 actually be able to enter your vote, and we will
6 be able to calculate those votes real-time.

7 So at this time, we're going to open
8 voting for our test voting, and please input yes
9 to cast your vote. So if you'll notice on the
10 right-hand side, you'll see the percentage.
11 You'll see at the bottom where you can toggle to
12 see the total results of how many people are
13 actually voting at this time. Right now, we have
14 a total of 25 results. Okay. And what I'll also
15 do is give you -- so we have 100 percent, which
16 is 25 people voting yes. So at this time, it
17 looks like everything is working wonderfully.

18 What I will ask that you do is refrain
19 from casting your vote until we open voting, so
20 that I don't have to lock the slides on you. But
21 we will vote after we finish the discussion.
22 We'll announce voting and then voting will

1 commence. Thank you.

2 Yes, they are voting online. Marsha,
3 Pam, have you all -- Pam is not voting. But
4 Marsha, have you been able to enter your vote?

5 MEMBER MANNING: Yes.

6 MS. QUINNONEZ: Awesome. Thanks so
7 much.

8 CHAIR WALTERS: It's going to be fine;
9 I know. I would like to echo again the process
10 which is, again, I agree that every year it's
11 changed a little bit. I think, as I was
12 reflecting on this, what becomes even more
13 important for, because Cristie and I are
14 listening for what to do with a second vote,
15 okay? If both the lead discussants and any other
16 people who enter in the discussion, we started
17 this actually at the beginning, but it's had some
18 improvements over the years, please state exactly
19 which of the four categories that you are in
20 support of. And what we can do is if, for any
21 reason, the staff recommendation is not the
22 consensus of the group, it gives us a numerical

1 way, I guess more than anything else, to try to
2 move to the appropriate one that we think
3 reflects the majority of the group, rather than
4 leaving it up to us and rather than just leaving
5 it up to our opinion of what we hear.

6 So that would help an awful lot, I
7 think. The default is, of course, as you heard
8 working our way right on down the list from
9 support to conditional support to do not support,
10 etcetera, the old refine and resubmit. We can do
11 that. It will just take a little more time to do
12 that.

13 But I hope, again, to try to give your
14 rationales and then a very specific which one of
15 the categories you support. I think that will
16 help us out.

17 CO-CHAIR UPSHAW TRAVIS: I'll just add
18 one other piece. Because we have four measures
19 and lots of people sitting around this table,
20 you'll notice that our lead discussant list is
21 very long. So, you know, I think what would be
22 helpful probably to the whole group is to build

1 on each other's comments versus feeling an
2 obligation to repeat them. You know, certainly,
3 if you have a differing opinion, please be sure
4 and articulate that so that we can all, you know,
5 understand. If it's consistent, you can
6 certainly say that, too, but maybe not feel like
7 you have to go into the same level of detail as
8 others that may have gone before you.

9 But we do appreciate the additional time
10 that each of you took on your measure that you
11 are a lead discussant, so we want to be sure to
12 capture what you wanted to say just as much as we
13 can be kind of efficient and build on it. It
14 will help us all, I think, be a little bit
15 clearer in our own minds as to where you are. So
16 thank you for that. Marty.

17 MEMBER HATLIE: I have a quick question.
18 I'm looking at our voting system, and it's got my
19 name on it, and I can't remember whether in the
20 past we have tracked who has voted how and
21 whether that becomes a part of the record. Was
22 it an anonymous voting process in the past, and

1 is it this year, or are we being tracked and
2 becoming part of the record.

3 CHAIR WALTERS: I think it's a fair
4 statement. It is not anonymous, but it is not
5 tracked. How is that?

6 MS. O'ROURKE: So it is tagged to your
7 name. We can't see how you voted. It's just to
8 make sure that the right people are voting and
9 that only the workgroup members are voting. In
10 the past, I know we just kind of assigned. In
11 the past, you had a clicker, so we didn't know
12 that Marty was clicker number 24. But when you -
13 - Desi doesn't have that information of who voted
14 yes, who voted no. It just, all we see is, like,
15 20 yes, 5 no.

16 MEMBER HATLIE: Right. Okay. Well, I
17 wouldn't be opposed to actually going on record
18 with our votes. So maybe we'll think about that
19 in the future, but thank you for the
20 clarification. I appreciate it.

21 CHAIR WALTERS: We're talking about --
22 yes?

1 MEMBER GUINAN: A quick question.
2 Maryellen here. Given that I don't have a math
3 background, so that's full disclosure, but I'm
4 wondering, I do appreciate that it will have a
5 further discussion because I could imagine that
6 if staff recommendation is to support and we have
7 50/50 in the two do not support categories, then
8 that's fairly meaningful. And so I think I hope
9 that doesn't occur but would welcome the
10 additional discussion.

11 CHAIR WALTERS: Oh, we all can remember
12 55 to 45. I wish I could promise you that wasn't
13 going to occur. So I think we're going to shift
14 the agenda up a little bit. Okay. And we talked
15 about this ahead of time. Since we went over the
16 voting process and the whole thing and then we
17 took a break to talk about pain, and you kind of
18 said why did they go through all that, we're
19 going to switch those up and Michelle is fine
20 with doing the pain management through quality
21 measurement after we do the IQR. And we're going
22 to take a ten-minute break first. So let's start

1 at 11. Is that okay?

2 CO-CHAIR UPSHAW TRAVIS: Great. Thank
3 you all.

4 CHAIR WALTERS: 11:00, and you get to
5 vote soon.

6 (Whereupon, the above-entitled matter
7 went off the record at 10:48 a.m. and resumed at
8 11:02 a.m.)

9 CHAIR WALTERS: So for those of you that
10 are here for the first time, the general order is
11 we go through the details of the program, and
12 then we see if there's any questions about that.

13 And then we work our way into the first
14 measure and work our way through the measures for
15 that program.

16 So who's going to do the over --
17 Melissa? Okay.

18 MS. JUNG: Just providing this slide as
19 a reminder of the programs that are considered by
20 the Hospital Work Group. We have nine programs
21 in total.

22 But, as this table displays, only two of

1 the programs have measures under consideration
2 today. It's the Hospital IQR Program, Inpatient
3 Quality Reporting Program, and Medicare and
4 Medicaid Promoting Interoperability Program for
5 Eligible Hospitals and Critical Access Hospitals.

6 So there are three measures in total
7 being considered today. And then the other
8 program is Prospective Payment System Exempt
9 Cancer Hospital Quality Reporting Program. And
10 we have one measure under consideration today.

11 MS. MARINELARENA: Okay. Before we get
12 started, I just want to do a quick overview of
13 the Hospital IQR Program.

14 Again, this is -- you've seen this
15 before, we went over it during the web meeting.
16 But this is a pay for reporting and public -- a
17 pay for reporting and public reporting program.
18 Hospitals that do not participate or meet the
19 program requirements receive a one-fourth
20 reduction in their Annual Payment Update.

21 And the goals of the Program are to
22 progress toward paying providers based on quality

1 rather than quantity of care that they give
2 patients, and interoperability between EHRs and
3 CMS data collection, and, again, to provide
4 consumers information about hospital quality so
5 they can make informed choices about their care.

6 We presented this on the webinar as
7 well. As Michelle discussed earlier about the
8 meaningful measures incentive at CMS, the updates
9 on the right include all of the measures that
10 have -- that were finalized for removal. And we
11 included the fiscal years.

12 So these are the updates that are going
13 to -- these are all the measures that are going
14 to be removed out of Hospital IQR.

15 We can -- you have that. And we're not
16 going to go through all of these. There were a
17 lot of them. Keep going, and there's more.

18 And then this is what is left after
19 those measures are removed. So the IQR Program
20 is quite smaller now. And then we have the NQF
21 status to the right. And you have seen this
22 before. And you have copies of this as well.

1 We talked about this on the webinar as
2 well, the high priority domains for Hospital IQR
3 that CMS identified, which included strengthening
4 person and family engagement as partners in their
5 care; promoting effective communication and
6 coordination of care; promoting effective
7 prevention and treatment of chronic disease; and
8 making care safer.

9 CHAIR WALTERS: The first thing we do
10 each -- kind of after we went through all the
11 measures in the program, we'll do at the start
12 now, is to open up the lines for public comment.
13 Let's do the -- anybody on the telephone first.
14 And then we'll do the people in the room.

15 So could we have the lines open for
16 public comment?

17 OPERATOR: Okay. At this time if you
18 would like to make a comment, please press star
19 then the number one.

20 There are no public comments from the
21 phone lines at this time.

22 CHAIR WALTERS: Thank you very much.

1 We'll open it up to the people in the room for
2 public -- for their comments about any of the
3 measures in the IQR MUC list.

4 Okay. Seeing none, we'll move ahead
5 with the -- these are the three measures that
6 we'll talk about. Hopefully they're in the same
7 order I have them. Yes, they are. That's always
8 good.

9 C-section birth first. Then the
10 hospital harm pressure injury. And then the
11 hospital harm hypoglycemia.

12 Lead discussants, this is a good time to
13 start getting ready. Okay. Starting with
14 Cesarean birth.

15 MS. MARINELARENA: Yes. So since the
16 staff is going to provide the introduction, I
17 think since we have a small amount of measures
18 and a lot of lead discussants, staff will
19 initially just go over the preliminary analysis
20 result and the summary of it.

21 And then we'll have the lead discussants
22 go over. And then we --

1 CHAIR WALTERS: Hold on just a second.
2 Nancy, do you want to say something?

3 MEMBER FOSTER: I just have a question.
4 We talked about this as the IQR Program. But
5 it's my impression at least, some of these
6 measures are for the Electronic Clinical Quality
7 Measures reporting program.

8 They do get publicly displayed or could
9 get publicly displayed, but are not yet for eCQM,
10 as I recall. But there's a penalty for not
11 reporting them. So I'm just -- I'm trying to
12 understand with clarity here, are these three
13 being proposed for IQR? For eCQM? For both?
14 What?

15 CHAIR WALTERS: Reena or Michelle? I
16 know that came up in my mind, too.

17 MR. MORGAN: This is Robert Morgan. I'm
18 the CMS measures lead for hospital -- oh, great.
19 Okay. Sorry.

20 So I'm the CMS measures lead for the
21 hospital inpatient quality reporting program and
22 the hospital value-based purchasing program.

1 With respect to these eQMs, yes, they're
2 included in the hospital IQR program and the PI
3 program.

4 Historically those two measure sets have
5 been aligned. Particularly with this last one --
6 where we removed the ED-3 measure from the PI
7 program hospital measure list.

8 And you are correct that for the
9 hospital IQR program, facility is allowed to
10 report one quarter of self-selected data for four
11 eQMs of their choosing among the broader eQOM
12 measure set.

13 And that would be true for these
14 measures as well if we maintain that requirement.

15 MS. MARINELARENA: Okay. The C-section
16 measure. The staff analysis was -- preliminary
17 analysis was do not support for rulemaking.

18 And the summary was -- this is because
19 -- this is a fully developed outcome measure. It
20 is the eQOM version of the existing chart-
21 abstracted version.

22 The chart-abstracted version is NQF

1 0471. The 0471 was supported by MAP for
2 inclusion in IQR back in 2014.

3 This is the first time you're seeing the
4 eCQM version of the measure. The eCQM version of
5 the measure was submitted to NQF in the fall of
6 2017 for endorsement.

7 It was reviewed by the new Scientific
8 Methods Panel for the scientific acceptability of
9 the measure, and they determined that it did not
10 demonstrate sufficient reliability and validity.

11 Therefore, it did not move forward for
12 the rest of the endorsement process. NQF, the
13 preliminary analysis summary recommendation is
14 that the eCQM should be resubmitted to NQF for
15 evaluation and endorsement.

16 So then I will turn it over to the lead
17 discussants.

18 CHAIR WALTERS: All right, Karen? Would
19 you like to say anything about that process?
20 Just briefly. Because this is going to come up.

21 This is the first time it has come up
22 before this Committee. And, you know, Melissa

1 explained how it was arrived at a do not support
2 rulemaking, but the Scientific Methods Panel
3 process leading to that is the first time they've
4 seen that.

5 MS. JOHNSON: Sure. I'd be happy to.
6 And Ron is one of our Scientific Methods
7 panelists. So I'm sure he could do a great job
8 on this just as much as I can.

9 We implemented our Scientific Methods
10 Panel just over a year ago. And the idea is that
11 the statistical questions about reliability and
12 validity is sometimes a little bit out of reach
13 of many of our standing committee members.

14 So we wanted to have experts who really
15 know what they're doing look at these measures.
16 And we don't have them look at all of the
17 measures, just a selected set of measures that we
18 call complex measures, usually outcome measures,
19 composite measures, measures based on
20 instruments. Those kinds of things.

21 When we first started the process, we
22 set it up in kind of like journal editors do,

1 where you have kind of blinded reviewers if you
2 will. And that worked fair. But we have
3 recently changed that. So now it's a little bit
4 -- we still have them do things in subgroups.

5 But we allow some discussion. We allow
6 more participation by the public and the
7 developers in being able to listen to the
8 conversations, that sort of thing. So that's one
9 of the things that's a little bit different about
10 this particular measure. This one was looked at
11 by the Methods Panel.

12 I believe it was in the first cycle that
13 we did. So that Panel was brand new then. And
14 we have changed the process then.

15 So we don't really have details that we
16 can share with you about what they saw with that
17 particular measure. Going forward we might be
18 able to provide those kinds of things.

19 I'm not sure if that got to what you
20 were thinking, Ron.

21 CHAIR WALTERS: That's exactly what I
22 wanted you to say, rather than me. That may

1 happen for -- as a measure comes up for
2 maintenance. It can also happen, and you'll see
3 a couple of examples again, where that happened
4 when a new measure was coming up for initial
5 endorsement.

6 And so the general theme is that if a
7 group of people who are experts in the assessment
8 of reliability and validity could not come to
9 consensus agreement about a measure that it
10 should not go to the panels. And I know that was
11 the subject of a lot of discussion. That's why
12 you'll see a do not support for rulemaking. I've
13 said that now.

14 I'll move into the lead discussant list.
15 And, again, please in a couple of minutes
16 summarize your -- your recommendations, and with
17 a specific opinion about which of the four
18 categories it should be in.

19 Anna? Or sorry --

20 MEMBER DOPP: Lisa was ahead of me.

21 CHAIR WALTERS: Lisa?

22 MEMBER MCGIFFERT: No, I had a question

1 about -- because I think I read that one of the
2 reasons that the Panel didn't recommend it was
3 that the data elements were not present in many
4 of the test sites, or whatever.

5 That hospitals didn't use the data
6 elements. That's what it sounded like, that it
7 was something that was missing in a lot of the
8 information.

9 Is that -- am I understanding that
10 correctly? And if so, my experience, which is
11 somewhat limited, but pretty broad in this area,
12 is that kind of, you know, if you require a
13 measure and put some validity to it, then the
14 data elements will follow.

15 And we saw that clearly happening when
16 infection reporting started. And unless, -- you
17 know, hospitals have a lot of things to do, and
18 unless they're required to submit certain data
19 elements, they're not probably going to do it.
20 So I want to clarify in my mind if that's the
21 issue.

22 CHAIR WALTERS: Well, that was certainly

1 the discussion in the early meetings of the
2 group, is that they had to go with the assessment
3 of reliability and validity for the data elements
4 that were built into the measure specs.

5 And if those data elements were not
6 present for whatever reason or unclear for the
7 group, they could not make an adequate
8 determination of the reliability and validity for
9 that measure.

10 Fair statement? Okay. Let's move on
11 now to Anna.

12 MEMBER DOPP: So I'm listed first in the
13 list of lead discussants. I'm a pharmacist. I
14 mentioned that earlier. So this is -- the topic
15 is a little out of scope, quite a bit out of
16 scope for my background.

17 But our group did meet by email on
18 Friday night. And we -- some of us were able to
19 meet yesterday. And so I think we have a good
20 understanding of what the thoughts are with this
21 measure.

22 So I have a question, and then I'll

1 defer to the rest of the group. Because I -- it
2 was very valuable discussion over email and over
3 our meeting yesterday, brief meeting yesterday.
4 So they have good information to share.

5 But under the voting procedures there
6 was a step that was going to allow for the
7 measure developer to respond. Is anyone from
8 Joint Commission present to react to the staff
9 analysis? Or -- or not.

10 MS. O'ROURKE: Correct me if I'm wrong,
11 but I don't think we have anyone from the Joint
12 Commission who was able to join us.

13 MR. MORGAN: Well, this is Robert. I
14 can speak on their behalf as I have spoken with
15 them about this measure. This is a Joint
16 Commission measure. And -- CMS is no longer
17 maintaining this under one of our contracts.

18 What I will say is that through their
19 testing, they did find that, I believe,
20 approximately 68 percent of the data elements
21 currently are captured in discrete fields.

22 And in the near future, within two

1 years, approximately 90 percent. But with that
2 said, you know, CMS we agree with the need to
3 resubmit this measure for NQF endorsement.

4 And we have implored the agency to do
5 so. So we're looking forward to that.

6 MEMBER DOPP: Thank you. I'll defer to
7 the rest of the group.

8 CHAIR WALTERS: And I wasn't explicit,
9 but, again, your recommendation can be any of the
10 four categories that you want to recommend. And
11 that is worthwhile information back to CMS also.

12 The Scientific Methods Panel process is
13 a process related to this process, but this is a
14 separate process, so please feel free to give
15 your recommendations. Okay. Nancy?

16 MEMBER FOSTER: So thanks, Ron. In the
17 spirit that you and Cristie outlined where we're
18 going to build on each other's comments, I'm
19 going to focus on the sort of a conceptual issue
20 around the measure first. Which is -- and let my
21 colleagues talk about some of the specifics of
22 the measure, the specifications and so forth.

1 The conceptual issue I have right now
2 is, as you would think about including this
3 measure in a program, there are two main issues
4 that I'm aware of that hospitals are working on
5 very hard.

6 One is to eliminate early elective
7 deliveries. And we've made great progress in
8 that regard. But we're not where we need to be.
9 And the second is more -- has come to attention
10 more recently, and that's maternal mortality.

11 To the extent this measure would be
12 related to maternal mortality, it might be
13 important to include. But as I understand the
14 issues around maternal mortality, this is not the
15 first issue that would be addressed.

16 And so in my mind one of the issues that
17 wouldn't have been addressed by the Scientific
18 Methods Panel is that we really want to stay
19 focused on those two critical issues right now as
20 we move things forward.

21 And I worry that adding this measure any
22 time soon, even if it were scientifically

1 superior, would distract from the need to focus
2 on getting those two things right as we work
3 towards better reliability in healthcare.

4 CHAIR WALTERS: And I think you -- yeah?

5 MEMBER FOSTER: I was just going to say,
6 and I support the staff recommendation.

7 CHAIR WALTERS: I think you pointed out
8 one of the -- many -- criteria. So there are
9 other criteria other than reliability and
10 validity, and your comment was very pertinent.
11 Gail?

12 MEMBER LEE: Thanks. So I think that as
13 well, I support the staff recommendation of do
14 not support at this time for a couple reasons. I
15 think -- I was hoping to find out a little bit
16 more information about what the Scientific
17 Methods Panel had discussed.

18 And so we tried to find that report.
19 But we couldn't, I guess. But, looking at it, I
20 think that there were a lot of questions that
21 were raised about the variability of the rates of
22 C-sections.

1 And that, I think, raised for me
2 questions about risk adjustment and whether
3 there's adequate -- it says there's no risk
4 adjustment for this measure at this time.

5 And so I think that's something that NQF
6 needs to really take a closer look at. Also
7 questions about just the overlap that this
8 measure has with the elective delivery measure
9 that already exists in the denominator piece.

10 And also the last point is whether there
11 are -- would be any unintended consequences
12 associated with this measure due to some of the
13 pressure that may occur in the delivery room to
14 meet certain criteria or certain ratios.

15 And so, you know, there's a lot at risk
16 when you're dealing with -- both the mother and
17 the baby. And so that was also a concern and I
18 think something that needs to be looked at more
19 closely.

20 CHAIR WALTERS: Thank you. And I think,
21 again, as this continues, it is helpful to hear
22 some of the other criteria that fail. And you

1 brought redundancy into play. And you brought
2 unintended consequences into play.

3 So -- the whole criteria set's
4 important. Okay. All right. Sally?

5 MEMBER TURBYVILLE: Thank you. I agree
6 with my fellow lead discussants. Only to add
7 that I also am inclined, as Nancy is, to question
8 whether this is the right focus at the right
9 time.

10 I do -- I'm probably a little bit more
11 open in thinking that the high performance
12 variability found might actually be real.

13 But that maternal outcomes is a real
14 issue we know. As well as the outcomes of the
15 infant, being from the Children's Hospital
16 Association, is of great importance.

17 And the impact of the delivery, care
18 delivery. So not much else to add other than
19 agreement.

20 CHAIR WALTERS: Okay. Thank you. Lisa?

21 MEMBER MCGIFFERT: I do not agree with
22 my fellow discussants. I think that this measure

1 should move forward.

2 C-sections are one of the most common
3 procedures in the hospital, and there is
4 substantial overuse in this procedure, and I
5 personally, as a consumer advocate, have been
6 involved in trying to get public reporting on
7 this for decades, beginning in Texas.

8 It does create a significant risk for
9 adverse outcomes for mothers like infections,
10 blood clots, length of stay, and maternal
11 mortality is probably one of those issues, and
12 for babies, respiratory problems and the
13 likelihood of some chronic childhood conditions.

14 The cost is about 50 percent higher to
15 Medicaid and Medicare. It triggers subsequent C-
16 sections nine and ten, despite best evidence that
17 this is not appropriate way to provide care.

18 Professional societies support it. It
19 is -- and I think that generally this population
20 is highly attuned to getting information about
21 quality.

22 This measure is, my understanding, is an

1 electronic medical record measure. Which I
2 understand is the way we want to go.

3 The chart review measure has been
4 endorsed. It's been out there. A lot of
5 hospitals are using it. It is not publicly
6 reported. I think there are some states that
7 publicly report it. But it's spotty. You know,
8 it's not all over the country.

9 And I -- as I expressed before, not
10 knowing exact -- I understand the reliability
11 could not be established. But I think this is
12 one of those situations where you have to get out
13 there and do it.

14 And I'm kind of, you know, if there are
15 some states that have been publishing this
16 information, then we could start with them and
17 try to see what kind of electronic health records
18 they have.

19 But I personally believe we have to
20 really push hospitals to get on board with
21 electronic measurements so that we can reduce the
22 paperwork and focus on the patients. So I would

1 recommend that this go forward.

2 Another comment about risk adjustment,
3 from my reading, it is my understanding that risk
4 adjustment for age was removed from the chart
5 review version of this.

6 And I don't exactly know why, but I'm
7 assuming it's because this population is well
8 defined as, you know, women who are giving their
9 first birth, and so it's a -- and not high risk.

10 So it's a narrow enough population for
11 us to look at on this measure. And I believe
12 that this is an extremely important measure for
13 us to move forward after so many decades of
14 talking about it.

15 CHAIR WALTERS: So your recommendation
16 would be support or conditional support?

17 MEMBER MCGIFFERT: Support.

18 CHAIR WALTERS: Okay. Deborah?

19 MEMBER WHEELER: I agree with the
20 majority of the lead discussants, where I do not
21 support the measure due to the lack of validity
22 and reliability.

1 Many of us -- we've had many comments so
2 far related to the measure. But one that I want
3 to bring up is related to the comparability of
4 data collection processes, whether it's this
5 measure or measures related to chart review.

6 Has there been, or can there be work to
7 focus on, you know, if a hospital collects data
8 in one system using the same specifications, is
9 that process comparable to another hospital that
10 looks at the measure?

11 So I think there should be more work in
12 that area.

13 CHAIR WALTERS: Okay. As we continue to
14 work with the new -- thank you very much. That
15 gives us very explicit direction exactly how the
16 lead discussants feel.

17 So now we're going to turn it over to
18 the measure stewards and have them comment --
19 comment and/or reply to some of the consideration
20 they heard from the lead discussants.

21 Then we'll go back to open it up to the
22 entire committee. Then if we need to, we'll go

1 back to the lead discussants to respond to the
2 entire committee points.

3 And then we'll have a vote. So, yes,
4 sir?

5 MR. MORGAN: So this is Ronald Morgan
6 again. I'll say one, with respect to risk
7 adjustment that was brought up earlier, age was
8 previously included in the chart version but was
9 removed prior to -- submission of the measure for
10 NQF endorsement. And it was subsequently
11 endorsed, and that's because the correlation
12 between age and body mass index cancelled out the
13 defect, and BMI isn't regularly captured, so it
14 couldn't be included.

15 And so therefore, the lack of risk
16 adjustment in this electronically specified
17 version of the measure is in fact to align with
18 the chart version of the measure, which was NQF
19 endorsed.

20 I also note that in terms of, you know,
21 the PC-01 was brought up quite a bit. And early
22 in the slides, you had listed the various

1 removals for the hospital IQR program.

2 Among them was the electronically
3 specified version of PC-01, the early elective
4 delivery measure. Which, to get at someone's
5 earlier point, does capture a different
6 population then PC-02.

7 That same measure is also moved from the
8 hospital value-based purchasing program, but was
9 retained in chart form in the hospital IQR
10 program. And for those who rated close to the FY
11 2019 VS rule, you'll note that that reason was
12 really because we recognize the importance of
13 capturing maternal health in the program in some
14 way or form.

15 And that was the only measure through
16 which we can get at that at this point in time.
17 However, that measure is of course -- the
18 performance of the measure is topped out.

19 So that's a measure we're looking very
20 closely at and monitoring in the future to see
21 whether or not that topped out performance
22 continues.

1 So in bringing this measure before the
2 MAP, what we're really looking for, really trying
3 to convey is our intent to look at more
4 meaningful measures related to maternal health.

5 Although it may not directly get a
6 maternal mortality, which we agree is an
7 important issue. This is more related to
8 surgical complications if you think about the
9 ultimate outcome.

10 So to that end, that's really what we're
11 looking at. But we do welcome, if you have any
12 sort of feedback related to what risk adjustment
13 variables we might need to incorporate for CMS
14 consideration and for feedback to TJC since they
15 support this measure.

16 And also where you see this measure and
17 the IQR program relative to PC-01. Because this
18 is a measure where you do see variation in
19 performance, unlike the PC-01 measure, which is
20 topped out.

21 CO-CHAIR UPSHAW TRAVIS: I'm going to
22 ask you to tell -- remind me what PC-01 is.

1 MR. MORGAN: I believe it's early
2 elective delivery prior to 37 weeks gestation, or
3 39 weeks. One of the two.

4 CO-CHAIR UPSHAW TRAVIS: Thank you. I
5 just am probably not as familiar with the numbers
6 and letters that get associated with things. So,
7 thank you.

8 CHAIR WALTERS: I'll open it now to
9 everybody else on the committee and their
10 comments. And that was a hard thing to see.
11 Lee?

12 MEMBER FLEISHER: With regard to risk
13 adjustment, I'm just wondering in the way it's
14 constructed, eclampsia or preeclampsia, which is
15 one of the major risk factors for increased
16 maternal mortality, is or is not included?

17 And if it's not, then we're -- and
18 having a C-section addresses eclampsia. Then we
19 have unintended consequences of this measure.

20 Do you know the answer?

21 MR. MORGAN: So in terms of measure
22 exclusions, abnormal presentations are excluded.

1 But there is no risk adjustment for the measure.

2 MEMBER FLEISHER: So -- but you don't
3 exclude patients with eclampsia or preeclampsia?

4 MR. MORGAN: I don't believe so, no.

5 MEMBER FLEISHER: So getting to Nancy's
6 comment, you know, I can -- I understand from a
7 consumer perspective, we want to do the right
8 thing.

9 But this actually goes against
10 potentially optimal treatment of a patient with -
11 - who is at increased risk for maternal
12 mortality.

13 So I think before I would be willing to
14 endorse it, I'd have to see that adjustment.

15 CHAIR WALTERS: Lindsey?

16 MEMBER WISHAM: Yeah. I don't know at
17 this point that I have an additional suggestion
18 to the status.

19 However, I do have a question. I think
20 it's interesting, this was the measure that we
21 received additional information on.

22 And the testing results that we received

1 indicate May and June of 2018. Yet the
2 Scientific Review Panel addressed this measure in
3 2017.

4 So I'm curious to know if this measure
5 has been updated to address any of those
6 concerns? Or if that was additional testing?

7 Because this current status still reads
8 as in field testing.

9 MR. MORGAN: Yes. So this measure is
10 now fully tested. And so that's why, you know,
11 CMS is looking forward to TJC resubmitting the
12 measure for NQF endorsement.

13 We feel pretty positively about with
14 this additional data, its ability to obtain NQF
15 endorsement.

16 MEMBER WISHAM: Thank you.

17 CHAIR WALTERS: Jack?

18 MEMBER JORDAN: I think one of the
19 things to remember though is that CMS putting
20 something out there can fix documentation. You
21 know, we saw that when we first had, you know,
22 beta blocker kind of issues.

1 And the documenting that there was a
2 contraindication was terrible. And that was all
3 the misses. And within a year or two, we got
4 reliable at documenting the contraindications.
5 And the same kind of thing here.

6 I don't think we should be held back on
7 a measure because we have some, you know, missing
8 documentation things. Because if you're missing
9 BMI, and that's important in the severity
10 adjustment here, you turn this on, that will get
11 fixed incredibly quickly.

12 And that's one of the things that I
13 think CMS can be a forcing function. And the
14 other comment with this is I don't know how many
15 states are like my own. But the private insurers
16 are -- we're going to do this.

17 So in some sense it's not going to go
18 away. I mean, does Medicaid, you know, care
19 around this? But the private insurers do. It's
20 going to be there. Hospitals are going to deal
21 with it if CMS does or doesn't.

22 So, I think, you know, being on there to

1 help with it be as good as it can be, is probably
2 better for us then to cause kind of the challenge
3 of, you know, not endorsing it might.

4 CHAIR WALTERS: Marty?

5 MEMBER HATLIE: I looked at the comments
6 for this measure, and there was a really striking
7 comment from Lamaze International about how this
8 fills a data gap.

9 And I think Lisa spoke to it. And I
10 think Jack just spoke to it as well. If support
11 for this would help -- and Lamaze's comment was
12 it would fill a data gap for both consumers and
13 for perinatal professionals, people who are
14 working in this field. And it sounds like we do
15 have a data gap and that this measure could
16 perhaps help us close it.

17 I'm liking what I just heard Jack say in
18 terms of using this as a way to drive better data
19 reporting. And I'm also wondering, Lisa, you
20 mentioned professional groups supporting it.

21 I don't know if there's anyone besides
22 Lamaze. I was surprised that there were only

1 three comments on this measure.

2 Are there other groups, Lisa, that you
3 know of that you could tell us about?

4 MEMBER MCGIFFERT: Well, I think A -- I
5 want to say ACOG has supported this measure for a
6 long time.

7 I did hear back from several people who
8 really weren't aware that this was coming up.
9 There's a group in California that's been working
10 on these issues.

11 And I've talked to some of those people.
12 And they're very supportive. Let me see if I can
13 find -- give me a second if there are other
14 comments, and I'll find the list because I think
15 I have it.

16 MEMBER HATLIE: Thank you.

17 CHAIR WALTERS: Are there other comments
18 and feedback you'd like to give to the --- to
19 CMS? Cristie, sorry.

20 CO-CHAIR UPSHAW TRAVIS: That's all
21 right.

22 CHAIR WALTERS: It's hard to see

1 sideways.

2 CO-CHAIR UPSHAW TRAVIS: I know.

3 MEMBER McGIFFERT: Okay. I just found
4 the list and, you know, it's -- like the Leapfrog
5 Group has it as voluntary measure.

6 It's part of the Medicaid Child Core
7 Set. It's the Joint Commission, of course the
8 National Quality Forum, multiple state level
9 perinatal quality collaborative use this.

10 Over 100 hospitals in California are
11 participating. Healthy People 2020 included this
12 as an indicator of a national goal.

13 And then mention of NQF measures. Which
14 we already know.

15 CO-CHAIR UPSHAW TRAVIS: Well thank you.
16 I probably don't have any way to really add to
17 that long list.

18 You know --

19 MEMBER McGIFFERT: Oops, I found a few
20 more.

21 CO-CHAIR UPSHAW TRAVIS: Oh. Go on.

22 MEMBER McGIFFERT: The Alliance for

1 Innovation of Maternal Health is a multi-
2 professional group. ACOG and SMFM, which I'm not
3 sure what that is. And the American College of
4 Nurse Midwives.

5 The -- okay, I think that's it.

6 CO-CHAIR UPSHAW TRAVIS: Thank you.
7 Just a couple of comments as -- I'm taking off my
8 co-chair hat and putting on my other hat.

9 I certainly would agree with Nancy
10 around maternal mortality being a significant
11 issue. But this has been an issue, Caesarian
12 birth has been an issue that we have been trying
13 to address across the country in many ways.

14 And Lisa's list, I think, really shows
15 it. Personally, if you're having surgery and you
16 don't really -- shouldn't really be getting
17 surgery that is a harm to a patient. To go
18 through surgery when they really should not
19 appropriately have been getting it.

20 I do think the cost is an important
21 criteria as well because when we allocate money
22 in that direction, we don't have it to allocate

1 in other pieces.

2 And I know just in looking at the
3 Leapfrog data, which I'm glad you mentioned. And
4 just to remind you, I serve on the Leapfrog
5 board. There is -- there's significant variation
6 in this across the country.

7 And trying to think about how we could
8 make this part of maternal health, an important
9 improvement I think is valid. All that said, I
10 think we need to be really looking at maternal
11 mortality and how we can advance it.

12 This is probably one piece of the
13 solution. I think the elective early deliveries
14 is another piece.

15 But I don't think that by putting this
16 in it means that we're not going to continue to
17 look at the bigger picture for maternal health.

18 CHAIR WALTERS: Okay. Andreea?

19 MEMBER BALAN-COHEN: Just adding to some
20 of the comments to say that this is definitely an
21 area where there's been some experimentation.

22 And there is definitely a lot of

1 evidence like coming from California and from
2 Massachusetts that reporting on this issue can
3 have significant and relatively rapid
4 consequences in the sense that the declines like
5 in C-sections have been rapid after some of this
6 reporting has been implemented.

7 So that's something to keep in mind. So
8 even though this might not be, and again, it's
9 just like a smaller component of the larger issue
10 regarding maternal mortality. But it could be
11 one first important step. And we all probably
12 have to start somewhere.

13 And the other point is that I like the
14 fact that it has a little bit like the cost
15 component like implicitly built up on it. And
16 then there is also the relationship with some of
17 the efforts potentially around like maternity
18 bundles, and there are like some other
19 considerations as well.

20 So I think it could be an important step
21 like by filling the data gap from that point of
22 view as well.

1 CHAIR WALTERS: Okay. Nancy?

2 MEMBER FOSTER: Thanks. I just wanted
3 to provide a point of clarification, which is
4 this measure is not NQF endorsed. This measure
5 is not on the NQF list.

6 Its predecessor, the chart abstracted
7 measure is. Or was. I don't know if it still
8 is.

9 But part of what you're seeing here,
10 part of what you're seeing in the Scientific
11 Methods Panel comments is that people are
12 struggling to find the data in an electronic
13 capture. Right?

14 And it's -- I can tell you how
15 vehemently our members have said we want to be
16 able to measure most of this electronically and
17 accurately.

18 And we've tried valiantly on a number of
19 measures. We haven't gotten to accurate yet. So
20 what you're seeing here is them saying this is --
21 you can get some information. It will not be
22 accurate.

1 And they said the differences that they
2 could see, as I understand it, were related to
3 the patient population rather than to actual
4 performance when they looked at the data.

5 So it's a struggle here. It's not --
6 please understand me, I'm not saying this a bad
7 concept. I have prioritization issues. But it's
8 not that the concept is bad. It is that the
9 execution is not where you need it to be to
10 provide useful information.

11 And to date, the history has been that
12 wishing we could capture things electronically
13 has not resulted in actual accuracy.

14 CHAIR WALTERS: I'm trying to get all of
15 them to respond to. Marty?

16 MEMBER HATLIE: I want to mention one
17 thing that hasn't been mentioned yet, and that is
18 the importance of information like this.

19 So this is kind of conceptual, Nancy,
20 but it's information like this to share decision-
21 making.

22 I mean, this is an area where, I mean,

1 the core to the CMS policy on quality and the PFE
2 component of it is this focus on shared decision-
3 making. And this is the kind of information that
4 I think really, really advances that dialog
5 between potential mother and provider.

6 So conceptually I'm for it. And then,
7 Nancy, where I always kind of feel like I part
8 ways with you, even though I like you so very
9 much and we go way back, is, you know, we have to
10 drive data and to make it better. So I think I'm
11 agreeing with Jack here.

12 Sometimes setting -- if the data is
13 crappy and we've been waiting for a long time,
14 how do we drive it to make it better?

15 And if -- and sometimes putting out a
16 requirement that forces whoever is in charge to
17 kind of make the data better, needs to be done.

18 And that's kind of where I fall here.
19 It's not like I'm comfortable waiting for the
20 data to get better. I want to drive something
21 that makes the data get better.

22 And I'm not a measurement person. So I

1 know that was a pretty sloppy thing. But I am an
2 advocate, and that's what I'm really looking for
3 here is just ways to drive the -- I'm so tired of
4 hearing about how we have systems full of bad
5 data.

6 We've got to figure out a way to create
7 the drivers and make that data better. Thank
8 you.

9 CHAIR WALTERS: So I think I have Sean,
10 and then Ann. And then I think it was Lindsey.

11 And then it was over here to Sarah and
12 -- so anyway, Sean?

13 MEMBER MORRISON: Yeah. Thanks Ron.
14 You know, I'm hearing this, and this happens
15 almost every year, the tension between what we
16 think needs to happen, and the way to make it
17 happen.

18 And I completely agree that this is a
19 very important issue. And yet lousy data, Marty,
20 are lousy data.

21 And we shouldn't be putting people or
22 trying to drive quality by saying well, we should

1 just go out and measure it. Because we don't
2 know what we're measuring.

3 And we could easily be measuring rates
4 from hospitals which bear no resemblance to
5 reality. And that's not fair to our patients.
6 It's not fair to our families. And it's not fair
7 to our hospitals.

8 So yes, it is important, you're right,
9 we should be driving data collection. But
10 driving it through this particular process is --
11 is not the way to do it.

12 There are other ways of approaching
13 this. And I'd like to see this come back when
14 it's NQF endorsed and when I can see that what's
15 being reported is truly, A, valid, which is we
16 are reporting what's actually happening, and, B,
17 reliable, that if we continue to report it, we're
18 getting the same results every single time.

19 That is what we owe our patients and our
20 families. We owe them that degree of
21 responsibility in my opinion. And so I
22 completely agree with the staff's recommendation

1 not to move this forward yet.

2 CHAIR WALTERS: Ann?

3 MEMBER SULLIVAN: Yes. I just need
4 clarification. When we say this long list of
5 groups that have endorsed it, have they endorsed
6 this electronic measure or did they endorse the
7 older measure?

8 MEMBER McGIFFERT: The other measure --

9 MEMBER SULLIVAN: The other measure.

10 MEMBER McGIFFERT: That this is based
11 on.

12 MEMBER SULLIVAN: So I think that makes
13 perfect sense that there's a kind of a consensus
14 that this is an important thing to measure.

15 I think the question is kind of what
16 we're here for, is how you measure it. And I
17 tend to agree with the previous speaker that you
18 have to be cautious about the data that you put
19 out there from hospitals and from this.

20 And I'm not saying at all that it's not
21 a good measure. And agreeing with all the people
22 who endorsed the chart review.

1 I assume we want to go to electronic
2 because it will make it easier. And we'll get
3 more people to do it.

4 But, if we're not ready yet to really do
5 it that way, then I would have serious concerns
6 about going forward with this measure.

7 CHAIR WALTERS: Lindsey?

8 Turn on your mic.

9 MEMBER WISHAM: -- that the measure that
10 the Scientific Panel probably reviewed in 2017
11 was not a measure that was specified using the
12 clinical quality language.

13 The clinical quality language is the new
14 expression model used for eQMs. Which did allow
15 for a -- for much more expressivity in the
16 measures, including in the description of
17 gestational age.

18 So knowing that that's an element in
19 this measure, I know the Joint Commission is here
20 to speak to the details of it, but the measure
21 has changed.

22 The measure specifications that we were

1 provided is specified using the clinical quality
2 language. Which would have been a different
3 version than what the Scientific Panel had
4 reviewed.

5 And so I do think it is, as stated
6 before, that the measure would be coming back
7 through NQF for additional review for
8 endorsement.

9 But I do think it's worth note that
10 again, the reliability of how that data is
11 captured electronically, very much has changed as
12 the expression model has been updated.

13 CHAIR WALTERS: Dan?

14 MEMBER POLLOCK: Yeah, another comment
15 about the use of quality measures to drive
16 changes in documentation. The flip side is, is
17 that quality measures can have unintended
18 consequences with respect to documentation.

19 Which actually can deteriorate the
20 record keeping rather than improve it. And I
21 think we all have to be very cognizant of that
22 and not let data quality improvement be a

1 principal driver of quality measurement.

2 CHAIR WALTERS: Sally?

3 MEMBER TURBYVILLE: It's really more of
4 a question, and it might not be answerable given
5 that the Joint Commission is not here.

6 But given that it is a Joint Commission
7 measure, which is a well-known measure steward
8 who has their own products, do we know if they
9 plan to continue to gain more experience with
10 this measure and bring it back to NQF for
11 endorsement?

12 And so that there's -- this is not the
13 one and done kind of killing of the measure's
14 prospect?

15 Did they --

16 CHAIR WALTERS: Sure.

17 MEMBER TURBYVILLE: Do we have any sense
18 of --

19 MS. MUNTHALI: We haven't -- this is
20 NQF, Elisa. We haven't heard anything from the
21 Joint Commission directly. But perhaps from CMS?

22 MR. MORGAN: So this is Robert again.

1 From what I've heard, they are considering that.
2 But they haven't made a decision yet on that
3 point.

4 I'll also add that we agree that the
5 industry is in a state of transition. Right,
6 that's something we've heard. That's something
7 we've seen in the data.

8 And that's really partly why we have the
9 fairly lenient program requirements that we
10 have. Where you can voluntarily report the data
11 and that data will not be publicly reported.

12 And really the primary driving reason
13 for that is, you know, one we're still -- we
14 still have some improvement to go in terms of
15 data quality for all of our extant measures.

16 But, two, we want to give hospitals and
17 implementers an opportunity to become accustomed
18 with submitting EHR-based data, and not be
19 punished for that.

20 CHAIR WALTERS: Aisha and then Marsha on
21 the phone. Aisha?

22 MEMBER PITTMAN: So my point is

1 following along that. In that we know that just
2 adding a measure doesn't actually improve the
3 data.

4 So there have been lots of eQMs that
5 have taken them out of the programs because they
6 don't continue to work. So just adding it isn't
7 going to help drive the data.

8 We know that's not the issues. There's
9 far more far reaching issues with trying to get
10 to the electronic capture. So just putting it in
11 a program doesn't necessarily help.

12 CHAIR WALTERS: Okay. Marsha, you're on
13 the phone.

14 MEMBER MANNING: Thank you. I just
15 perhaps a question related to clarification after
16 listening to this, you know, very robust
17 discussion.

18 When I look at the decision definitions,
19 I'm actually just a little bit confused as to how
20 the preliminary analysis came to the do not
21 support for rulemaking decision.

22 I believe this is a very important

1 concept for a measure. And I've heard that from
2 several other committee members.

3 When I look at the criteria that's used
4 for -- for the decision categories, I guess my
5 point of confusion is Item Number Three, which is
6 does the measure address a quality challenge?

7 The answer to this question from the
8 preliminary analysis is no. But what I'm hearing
9 is, is that it's -- that our -- that data issues
10 are driving this analysis, and not the importance
11 of the measure to address a quality challenge,
12 perhaps conceptually.

13 So I'm just a little bit confused about
14 that. And if anybody can provide some clarity, I
15 would really appreciate it.

16 Because it does -- I'm hearing and my
17 perspective on this is that addressing --
18 providing data related to Caesarian rates does
19 address a quality challenge.

20 And there may be another decision
21 category that's more appropriate if we're really
22 looking at significant data issues. So if

1 there's any clarity that can be shared, I would
2 appreciate that.

3 CHAIR WALTERS: I'll try to get that.
4 Anna and then Lee, and then Shannon. And then
5 Reena.

6 MEMBER DOPP: I'm thinking about how
7 much this discussion reminds me of last year when
8 we had the ORARE measure, the opioid-induced
9 adverse respiratory event. And everyone in the
10 room felt like it was compelling and met an
11 important need.

12 And then -- and we went against our
13 purview, I think, and said to refine and
14 resubmit.

15 But that's -- that's how I view this.
16 It's just not ready. And it seems to go against
17 the real intention from CMS to -- with the
18 meaningful measures and reducing burden to people
19 to show they're not going to just put a measure
20 out there that's not ready to be met.

21 CHAIR WALTERS: Okay. Lee?

22 MEMBER FLEISHER: Yeah. In listening

1 and trying to read the materials, and this is a
2 common both for CMS and NQF, it's interesting
3 that this is an endorsed measure in the old
4 world.

5 Do we have data, and I don't have it in
6 my packet and maybe I'm not finding it, on how
7 that old measure had done?

8 Because -- both from unintended
9 consequences and achieving its goal. Because
10 we're actually arguing around conversion to an e-
11 measure and the scientific acceptability or the
12 methodology without actually asking the question
13 of did the original measure achieve its goal?

14 Even if not nationally, we're looking at
15 Utah where we're seeing that C-section rates came
16 down. A few years later, maternal mortality is
17 going up.

18 So my question is, give us more data to
19 judge both issues, scientific acceptability and
20 relevancy if you have a previous measure.

21 CHAIR WALTERS: Shannon?

22 MEMBER PHILLIPS: I'm not far off of

1 that. I guess I would say part of what would be
2 compelling is to look at the, I think somebody
3 said 40, but many states that are using this
4 measure, ours included.

5 And let's see what that's shown. Right?
6 So why wouldn't, you know, so really echoing what
7 Lee said.

8 But that data would be impactful to
9 understand if the burden of the measure is worth
10 it. Or is it really an issue of risk adjustment?
11 Right?

12 So to the point of eclampsia and other
13 things, maybe it is completely a great measure.
14 But not -- it would explain why infant -- or
15 maternal mortality is going up.

16 And it's an interesting measure to
17 potentially place next to an outcome measure of
18 interest. So if this process measure may be risk
19 adjusted, we do see helps.

20 Put it next to infant mortality or
21 maternal mortality so that we can see the process
22 and the outcome together. Because that speaks to

1 clinicians, and I would think would speak to
2 patients powerfully as well.

3 CHAIR WALTERS: Reena?

4 MEMBER DUSEJA: So first I just want to
5 thank everyone for their comments. I mean, as
6 always it is so delightful to be here and to hear
7 the variety of comments, particularly with this
8 measure.

9 I just wanted to just have some framing
10 comments from CMS's perspective as we think about
11 this as it relates to meaningful measures. And I
12 heard a comment, well this doesn't really
13 translate to meaningful measures.

14 And I want to first point out is, we do
15 believe -- we wouldn't bring this to the MAP if
16 we didn't feel like it was meeting a gap. We do
17 feel like this is addressing an area of variation
18 in care.

19 We have data to at least point that
20 there has been variation in rates in terms of C-
21 sections from 20 to 50 percent. And so we do
22 think that there is room to improve.

1 We also think there is a link if we
2 measure this measure in terms of improving
3 morbidity for mothers as well as for children.
4 So I just wanted to specifically say that in
5 terms of that link.

6 Now as far as this measure being put
7 into a program, just to remind the work group,
8 this is voluntary. So hospitals can report on
9 this measure.

10 I think one of the advantages,
11 especially with some of these concerns about the
12 data science, and are we there in being able to
13 report this?

14 Is if you allow it to be voluntary,
15 perhaps we can actually get those hospitals that
16 are at the forefront in being able to report on
17 this. And other hospitals can learn from them.
18 Right?

19 So, and how they're able to successfully
20 capture this data. So we have to start
21 somewhere. We -- I think that from our
22 perspective, at least from our group, we believe

1 that you know, measures can drive some of this
2 data collection.

3 So those are some of our thoughts from
4 bringing this for the discussion today. But if
5 there's anything else you would like to add,
6 okay. That's it.

7 CHAIR WALTERS: Lisa and then Aisha.
8 And then I think we'll be about ready.

9 MEMBER MCGIFFERT: Just real quickly,
10 kind of to follow up on those comments, is I
11 don't know why the chart review has not been put
12 through this process since it's endorsed by so
13 many groups and has been around for so long, and
14 lots of states are using it.

15 But set that aside, from the consumer
16 perspective, we really need public reporting. We
17 do not have public reporting on this measure.

18 And it, again, I mean, this was like the
19 first thing I did on quality back in 1989 or '93,
20 or somewhere around there. And we still weren't
21 -- we still are not getting public reporting on
22 this across the board.

1 And so I think that is a compelling
2 argument to move this forward, that the public
3 deserves to see these results.

4 And again, I don't know why the chart
5 review has never been put forward to the IQR.
6 Maybe that's a good question.

7 MS. MARINELARENA: This is Melissa. So
8 just some clarification. The chart-abstracted
9 version has been through MAP. MAP did recommend
10 it, I believe, with some conditions back in 2014.
11 Now I don't know if it was -- ever went through
12 rule or not. But it did come through MAP.

13 CHAIR WALTERS: Aisha. And then I think
14 we're going to move into voting.

15 MEMBER PITTMAN: I guess just to Reena's
16 point about it being voluntary. So, yeah, while
17 eCQMs are voluntary, CMS could change that policy
18 at any time and say, all eCQMs are mandatory,
19 which was the case.

20 And they've switched going back and
21 forth with how many measures are voluntary. So I
22 think that's just a point for the group to be

1 aware of.

2 If it goes into the program, it can be
3 mandatory at any time, and that decision doesn't
4 come back to the MAP.

5 CHAIR WALTERS: Okay. I'm going to have
6 staff review the four categories again and make
7 sure everybody's clear on the criteria. And to
8 remind everybody that first we'll vote on the
9 staff recommendation.

10 MS. MARINELARENA: Okay. So as a
11 reminder, support for rulemaking, you absolutely
12 support it with no conditions.

13 Conditional support for rulemaking, you
14 would include any conditions that you want to add
15 to this measure. Some common conditions are NQF
16 endorsement.

17 Do not support for rulemaking with
18 potential mitigation, it's kind of the opposite
19 of that, you don't support it because there's
20 some things that are wrong with it, usually the
21 specifications so we would include that as well.

22 And then do not support for rulemaking,

1 which is the staff recommendation, was you just
2 don't support it at all for inclusion in the
3 program.

4 MEMBER MCGIFFERT: So are we voting on
5 the staff recommendation?

6 CHAIR WALTERS: That's the first thing
7 we vote on. That's correct.

8 MS. MARINELARENA: The first thing. So
9 it will be --

10 MEMBER MCGIFFERT: And that's what we
11 mean by the work group recommendation?

12 MS. O'ROURKE: So the first vote would
13 be if you -- sorry. If you want the staff
14 recommendation to become the work group
15 recommendation.

16 If -- yes. And just a caveat. If you
17 want to keep discussing, vote no here, even if
18 you think you may eventually agree with the staff
19 recommendation.

20 If you think there's a need for further
21 discussion, vote no. Because that would be the
22 end of voting if that reaches 60 percent.

1 CHAIR WALTERS: You want to tee up the
2 voting? So the staff recommendation, again, was
3 do not support for rulemaking.

4 MS. QUINNONEZ: Okay. We are now voting
5 for MUC2018-52. And the question reads, do you
6 vote to support the preliminary analysis as the
7 work group recommendation.

8 So that's do you accept what the staff's
9 recommendation is? Option one is yes. Option
10 two is no.

11 Can you refresh your browser? It should
12 be unlocked now. Sorry.

13 (Laughter.)

14 MS. QUINNONEZ: You're not in trouble.
15 I promise.

16 (Laughter.)

17 CHAIR WALTERS: No, but showing the
18 results while we're voting. But, none of the --
19 it's a different MAP.

20 So we talked about the days of when we
21 could hit close votes. And -- we're waiting for
22 one vote to come in, right?

1 MS. O'ROURKE: We -- yes, most of the
2 numbers work out to a percentage point. So we
3 rounded, I believe, always up to count for the
4 next whole person.

5 MS. QUINNONEZ: I'll read it. You want
6 me to read it out loud?

7 CHAIR WALTERS: Yes.

8 MS. QUINNONEZ: Okay. So the results of
9 the voting were 14 individuals who voted yes, and
10 that is 11 individuals who voted no.

11 Which that actually puts us, we do not
12 move forward. So this goes down at this point.
13 So we'll have to vote on the sections after this
14 individually.

15 CHAIR WALTERS: Now this is where we
16 kind of jot around, and Cristie and I have been
17 talking.

18 We think we heard, if not the staff
19 recommendation, the next category that got a lot
20 of discussion was something in the realm of
21 conditional support.

22 Is that correct? And that condition

1 almost certainly was NQF endorsement. Is that
2 assessment correct or not?

3 Is there anybody in the room who would
4 like to say that they do not believe conditional
5 support was the next thing to vote for?

6 We certainly could vote for support if
7 you wanted to although I think we're going to run
8 into some problems there with endorsement.

9 So speak up. Yes, Lee?

10 MEMBER FLEISHER: I would propose do not
11 support for rulemaking with potential for
12 mitigation is the next thing if there was -- if
13 we were very close to the -- I think there is
14 uniform interest in this measure and getting it
15 right.

16 And what I heard was that it may be a
17 little further from getting it right. Or more
18 data to get it right.

19 So I would propose we vote on that next.

20 CO-CHAIR UPSHAW TRAVIS: Could staff
21 once again kind of give us your suggestion on how
22 to differentiate between conditional support and

1 do not support with potential for mitigation?

2 MS. MARINELARENA: Sure. So the do not
3 support with potential for mitigation would mean
4 that the measure -- there needs to be changes to
5 the specifications.

6 You know, and the Methods Panel, based
7 on what they looked at, said there were issues
8 with the measure. Right? There were issues with
9 the data.

10 If that's the way you want to go, you
11 could provide some recommendations as to what
12 issues you have. Is it risk adjustments?

13 Are there other issues with the measure
14 specifications? And then of course, you can
15 include the NQF endorsement.

16 The difference with conditional support
17 for rulemaking could be that the measure as
18 specified is fine, it just has to go through NQF
19 endorsement.

20 CO-CHAIR UPSHAW TRAVIS: But I hate to
21 muddy up the waters, but you know, personally I
22 don't know that I have enough information to say

1 whether the specifications are right or wrong.

2 So if I have to make a decision, which
3 I do, between those two categories, if you're
4 unclear about the need for it to be re-specified,
5 what do you do? And I'm not telling -- I'm not
6 asking you to tell me how to vote. I'll make
7 that clear.

8 But I'm just trying to weigh it.
9 Because I don't really know, you know, since it -
10 - and I don't know whether, you know, I'm
11 thinking of Lindsey's comments.

12 It may already have been done. But it
13 hasn't been reviewed by the Methods Panel under
14 its current, you know, specifications even if
15 they have changed.

16 So, I'm just -- and does it really -- I
17 mean, I hate to ask it this way, but, is -- tell
18 us the implications of conditional.

19 Because in the past conditional meant
20 that if the -- if the condition is met, it can
21 automatically be put into the program. I mean,
22 our recommendation is that it would

1 automatically.

2 Does that still work?

3 MS. O'ROURKE: Sure. Do you want me to
4 try to take some of that?

5 CO-CHAIR UPSHAW TRAVIS: Yes. Please.

6 MS. O'ROURKE: So I think first to start
7 with your last point. I would emphasize that MAP
8 is an advisory body to CMS.

9 So nothing would automatically go into
10 the program. That's --

11 CO-CHAIR UPSHAW TRAVIS: Right. Okay.

12 MS. O'ROURKE: Again, I think what we
13 were trying to do with these changes, were say
14 that the conditional support, you're ready for
15 the measure to go forward with some changes.

16 The do not support is, as you see it
17 currently specified, you're not comfortable with
18 it being implemented.

19 And again, we know there's a lot of gray
20 in between there. So it's probably, you know, to
21 everyone to vote how they feel it's best.

22 We did use it yesterday in the PAC to

1 capture some concerns about coding, risk
2 adjustment exclusion, those types of issues. But
3 in the past we have also used conditional support
4 to capture those.

5 And we do pass this feedback on to CMS,
6 to the measure developers, to the Standing
7 Committees that will review the measure for
8 endorsement. We don't necessarily need to come
9 up with the full list of change specifications
10 today.

11 But I think just getting a broad flavor
12 of the concerns. And just to make sure that
13 people know we passed that all along and it goes
14 in the report.

15 And we have channels to make sure that
16 it's acted upon.

17 CHAIR WALTERS: So we have two choices
18 for voting realistically. Conditional support
19 for rulemaking, and do not support for rulemaking
20 with potential for mitigation.

21 The steward is on the phone, but we're
22 deep in the process now.

1 One way to handle this is to march down
2 the list. You can decide which of the two
3 categories you want.

4 If you're not in favor of conditional
5 support for rulemaking, then I would certainly
6 suggest a no for that. And then we'll vote for
7 do not support for rulemaking with potential for
8 mitigation after that.

9 If you are in support of conditional
10 support for rulemaking, vote yes. And if 60
11 percent of the people support that, then we will
12 not vote on do not support for rulemaking with
13 potential for mitigation.

14 So just as we said, in your minds you
15 have to decide which of those -- since we've
16 eliminated two of the categories, there's only
17 two.

18 Choose which one you like the most. And
19 what we'll do first is vote for the conditional
20 support for rulemaking, just because it's higher
21 up in the list. No special reason on that.

22 MS. QUINNONEZ: Okay. We are going to

1 vote for MUC2018-52. The question reads, do you
2 vote conditional support? And this is for
3 MUC2018-52. Do you vote conditional support?

4 Option A is yes. Option B is no. Okay.

5 CHAIR WALTERS: Results?

6 MS. QUINNONEZ: So it looks like -- give
7 me one second. So nine individuals voted yes,
8 and 16 individuals voted no.

9 So for percentages, we are at 36 percent
10 voted yes, and 64 percent voted no.

11 CHAIR WALTERS: So now we move on to the
12 next on the list, which is do not support for
13 rulemaking with potential for mitigation.

14 And please don't make me sorry we did
15 this.

16 MS. QUINNONEZ: Okay. We're now voting
17 for MUC2018-52. The question reads, do you vote
18 -- is your vote do not support for rulemaking
19 with potential for mitigation?

20 Option A is yes. Option B is no. I'll
21 give you a couple more moments to enter your
22 votes. Okay.

1 Ten seconds and I'm going to lock the
2 vote so no one changes. Okay. It looks like all
3 the votes are in. Voting is closed.

4 So for -- it looks like 88 percent voted
5 yes, and 12 percent voted no, and those specific
6 counts are we have 22 individuals who voted yes
7 and three individuals who voted no.

8 CHAIR WALTERS: So for those of you that
9 have been on the committee for a while, remember
10 when we used to vote on all four measures at
11 once? And we've been through all various
12 permutations of this I think you can possibly
13 have.

14 Let us know how you thought, not only
15 for this, but for the rest of the day, how this
16 process worked. But the sequential voting on
17 category by category according to the feel of the
18 group is we thought would simplify and shorten
19 the process.

20 Break?

21 CO-CHAIR UPSHAW TRAVIS: Yeah. Oh --

22 MS. O'ROURKE: Before I just want to

1 make sure that we've captured the mitigating
2 factors correctly.

3 So from what I was hearing, it sounds
4 like first and foremost making sure the EHR
5 measure can be operationalized and it's feasible.
6 And then asking the measure to be resubmitted for
7 NQF endorsement.

8 And passing along to the Standing
9 Committee to pay close attention to the potential
10 need for risk adjustment or additional exclusions
11 to address some of the concerns that MAP raised.

12 MEMBER MCGIFFERT: I'd add to that the
13 issue of eclampsia and preeclampsia that was
14 brought up.

15 MS. O'ROURKE: Yes. We can highlight
16 with a particular attention to how to handle
17 eclampsia and preeclampsia.

18 MEMBER MCGIFFERT: And what about
19 getting the Science Panel to review the current
20 data?

21 CHAIR WALTERS: Sure.

22 MEMBER PHILLIPS: And I was going to

1 say, can we add looking at the data that exists
2 today from all the states that are doing this?

3 CHAIR WALTERS: Sure.

4 MEMBER NOLAN: And I would say not only
5 the states, but Medicaid as well. I mean, that's
6 more than half the burden in the country. And
7 they do have some kind of measure.

8 CHAIR WALTERS: Nancy?

9 MEMBER FOSTER: So just to expand on the
10 preeclampsia. I mean, the data Lee was quoting
11 were not about preeclampsia although his point
12 was about preeclampsia.

13 But the unintended consequences, I'd
14 never before heard that data. The unintended
15 consequences of the increasing maternal mortality
16 are concerning. I would like to make sure they
17 look at that in the available data as well.

18 CHAIR WALTERS: Anna then --

19 MEMBER DOPP: One of the other comments,
20 or it was from Shay, didn't believe that this
21 fell under the healthcare associated infections.
22 I don't know if that is a point of consideration

1 to make either.

2 MS. O'ROURKE: We can certainly
3 highlight it that it might be closer related to
4 other meaningful measure areas than infections.

5 CHAIR WALTERS: Okay. Let's take a
6 lunch break. And thank you all for helping us
7 pilot --

8 MS. MARINELARENA: Let me just confirm
9 really quickly.

10 CHAIR WALTERS: -- the voting process.

11 MS. MARINELARENA: So you want -- you
12 want the measure developer to provide data from
13 the chart abstracted version of the measure? To
14 compare?

15 MEMBER FOSTER: I'm sorry, I'm not sure
16 that it's the measure developer. We were asking
17 for organizations currently collecting the chart
18 abstracted measure to be asked to provide that
19 data.

20 Right? Because Joint Commission may or
21 may not have that.

22 MEMBER PHILLIPS: So -- in Utah we're

1 required to report this to the state. There are
2 other states that do that. Medicaid, great
3 point.

4 We should look at that data to inform.
5 And have a balancing measure of maternal
6 mortality, infant mortality to make sure that
7 we're assessing that there's not an unintended
8 consequence to the measure.

9 MS. MARINELARENA: Okay. I know the
10 chart-abstracted version is going to be up for
11 review within a year or so. I'm looking at Kate.

12 So we can make that recommendation for
13 that measure. And then we can make the
14 recommendation from the MAP for both different
15 measures as they go through the committee, that
16 you have talked about balancing measures as well,
17 including maternal mortality.

18 Does that satisfy?

19 MEMBER FLEISHER: Well, I think there's
20 a lot of support for a measure that works
21 correctly to reduce C-section rates. So to wait
22 for a year for the review, I mean, it would be

1 great if CMS comes back within the next year with
2 this data.

3 So that we can get a robust measure for
4 public reporting that reduces C-section rates in
5 the right population that doesn't increase
6 maternal mortality. That's what I would like.

7 And I'm hearing at least people
8 surrounding me say that would be an ideal thing.
9 And if we can do it in an electronic measure
10 that's fantastic.

11 CHAIR WALTERS: Okay. Okay, go --

12 MEMBER BALAN-COHEN: And just one quick
13 comment about like the maternal mortality. So
14 just making sure that the maternal mortality
15 though is for the right population.

16 I mean, there are so many other drivers
17 of maternal mortality. I mean, like maternal
18 mortality has been increasing like independently.

19 So just like just putting the data side
20 by side, like an increase in C-section and an
21 increase in maternal mortality, I mean, just
22 making sure that we're looking at the right data.

1 All right?

2 So if you're looking at like decreasing
3 C-sections and then like maternal mortality for
4 that specific population, where we've examined
5 the C-section rates.

6 CHAIR WALTERS: Okay. We've got three
7 more measures and lunch. I mean, and the
8 presentation after lunch. So --

9 MS. O'ROURKE: Lunch is ready, yeah. Do
10 you want to let people take a lunch? Would
11 people maybe be okay with a working lunch?

12 CHAIR WALTERS: Okay.

13 MS. O'ROURKE: And with the -- you know,
14 maybe we could take 15 minutes. Get our lunch.
15 Take a little --

16 CHAIR WALTERS: Start a working lunch
17 kind of at about 12:30?

18 MS. O'ROURKE: Stretch your legs and
19 then take a little bit of a working lunch.

20 CHAIR WALTERS: Okay. Thank you.

21 (Whereupon, the above-entitled matter
22 went off the record at 12:14 p.m. and resumed at

1 12:30 p.m.)

2 CHAIR WALTERS: So you now have
3 experience with the new process and the new
4 categories. The feedback was absolutely
5 fabulous. And again, the job of the committee is
6 to give appropriate feedback back to CMS. That's
7 the job. And you know I'm not the judge of
8 whether that occurs; the people sitting in this
9 corner over here are. And we just try to make
10 sure the process works.

11 So the next -- I lost all my staff.

12 Now that you've been through it once,
13 again, there are two more measures in the IQR and
14 there's one in the cancer program. So we'll go
15 ahead and move along with the 2018-107 Hospital
16 Harm for Pressure Injury.

17 MS. MARINELARENA: Just one moment,
18 while we're queuing everything up.

19 CHAIR WALTERS: Yes, so I think what
20 this first one did was to try to get you thinking
21 in terms of what category you feel the strongest
22 about relatively early on and then aligning your

1 vote, whether it's with a first vote or
2 sequential votes to get to that category and yet,
3 make all the points you want to in support of
4 your recommendation.

5 Let's see who our lead discussants are
6 okay. Want to go over pressure injury?

7 MS. MARINELARENA: Okay, the next
8 measure up for discussion is the pressure injury
9 electronic measure.

10 The staff's preliminary analysis result
11 was conditional support for rulemaking. And the
12 reason for that is this measure is not fully --
13 our recommendations are that this measure is not
14 fully tested and it should be submitted to NQF
15 for review and endorsement once testing is
16 complete.

17 The difference between this one and the
18 C-section measure in the recommendations is
19 because NQF has not seen the testing results. We
20 don't know if there's any issues with it at all.
21 Again, just looking at how it fits in the program
22 the recommendation was conditional report and,

1 again, that it gets submitted to NQF. So that's
2 the difference between the two recommendations.

3 So I will turn it over to Ron.

4 CHAIR WALTERS: So we'll go through the
5 lead discussants and then, as I did on the last
6 measure, then we'll turn it over to the measure
7 stewards to respond to -- public comment -- I'm
8 sorry, we'll go to public comment, then we'll
9 turn it over to the measure developers to respond
10 to any concerns the lead discussants had, then
11 we'll open it up to the committee to express
12 their feedback, and then we'll go back to the
13 stewards and/or CMS in this circumstance to kind
14 of wrap everything up as best we can.

15 So the first thing -- we did public
16 comment for the IQR at the beginning of the IQR
17 session for all measures.

18 Kimberly.

19 MEMBER GLASSMAN: Okay, I'm very excited
20 that after three years I finally get a measure I
21 know something about.

22 (Laughter.)

1 MEMBER GLASSMAN: So that's exciting.
2 So this measure for hospital-acquired pressure
3 injury is being proposed for an eMeasure. The
4 reporting of a hospital-acquired pressure injury
5 currently exists, I believe, in the HAC program.
6 So these are already being reported stage 3,
7 stage 4, primarily.

8 This now adds stage 2, along with deep
9 tissue pressure injury and unstageable. So, it
10 has the full range of the five descriptors of how
11 we would note someone with a pressure injury.

12 It continues the theme that we would
13 need to note this for all patients who are
14 admitted to the hospital and we have a 24-hour
15 period to identify a pressure injury for a
16 patient that is coming from another setting, so
17 either being admitted from home or a nursing
18 home. We have to do careful assessment and note
19 if the patient is coming in with something and if
20 we don't do that, then we own it.

21 It's an outcome measure. It's an
22 important measure for patients and the staff

1 recommendation was, as Melissa said, conditional
2 support.

3 I am inclined to support the staff's
4 recommendation with a comment and that is, deep
5 tissue pressure injury sometimes can take longer
6 than 24 hours to develop. It can appear as a
7 bruise. The bruise could be small visually and
8 have potentially injury to the tissue down below.
9 So many of the comments on this measure noted
10 that the ability to have a wider window of time
11 with which to see if this deep tissue injury is,
12 in fact, real and is going to progress or if it's
13 going to go away might be something to be
14 considered.

15 So because this has not gone through
16 testing, as was noted, I guess I have a question,
17 if I'm allowed to ask a question, which is can
18 the testing also include the ability to look more
19 closely at that one particular stage. Two,
20 three, four, and unstageable are quite clear in
21 the definitions. This is the one that there is
22 just a little bit of question around.

1 CHAIR WALTERS: So as I understand it,
2 the question your asking is is that a substantive
3 change.

4 MEMBER GLASSMAN: Yes, I'm asking if
5 under conditional approval, where the condition
6 is this has to go through more testing, can we
7 also add something to be looked at in testing.

8 CHAIR WALTERS: Got it. Okay, well-
9 understood.

10 Marty.

11 MEMBER HATLIE: I support the staff
12 recommendation for many of the comments that were
13 just made. The only thing I guess I would add is
14 that there were several comments made. I think
15 there were nine in total and there was just broad
16 support from a wide variety of organizations for
17 this measure.

18 CHAIR WALTERS: Jack.

19 MEMBER JORDAN: I also have a fair
20 amount of experience with this in building an
21 internal ECQM on it. So I have three things,
22 actually, to add to the list for them to be

1 looking at as well.

2 One of the things we found in validating
3 our measure was that you could not rely on the
4 nurse checking the box present on admission and
5 we actually used did they start documenting on
6 the injury within 24 hours was a much more
7 reliable thing when we were validating it. And
8 at least in the definition you gave us, we
9 couldn't really see that level of discernment in
10 detail.

11 The other one is I have mixed feelings
12 on the stage 2 in that should it actually be
13 separated as a separate measure. I think there's
14 wide variation across the country about
15 incontinence-associated dermatitis being
16 documented versus stage 2 and I think you get
17 into some issues with inter rater reliability
18 kind of challenges there that go away if you
19 either carve out stage 2 as its own thing or
20 exclude it from the measure altogether. And I
21 think looking at that topic is important.

22 And then the other one that happened

1 with the billing measure that they have now in
2 the HAC penalty is guidance was given to billers,
3 I don't know about 18 months ago, that if a
4 patient came in with an unstageable, there was
5 debridement, and then it's a three or a four,
6 their guidance in the billing was to put that as
7 a three or a four not present on admission when,
8 in reality, it was present on admission in
9 different from and that actually caused a huge
10 jump in the HAC kind of thing.

11 I think it's important here that, and I
12 know I'm thinking in my own electronic record,
13 these are a flowsheet row that that injury should
14 probably be defined as the final stage in its
15 course for the thing versus having that whole
16 issue of it changed.

17 And I know at one time they had a
18 measure, it's been dropped now, that was looking
19 at pressure ulcers that did progress and that is
20 extremely difficult to do with an ECQM and I see
21 it's dropped. And the reason is if you put the
22 staging as a flowsheet row, then the nurses have

1 variability in what they document and that drives
2 you nuts. And if you put it as a header row,
3 then it's very difficult to find that change in
4 staging because you don't have kind of a time
5 stamp of it changing. So I know there's some
6 real challenges with this.

7 But that said, I'm wholeheartedly in
8 agreement we need an ECQM on this. I think it's
9 an important thing to do. And so I want to
10 endorse that we move forward with it but make
11 sure that we're really trying to fix some of
12 these things and you may have some tweaks in the
13 definition that really can do that. But with
14 that said, I wholly support going about it.

15 CHAIR WALTERS: The developers will get
16 to respond in just a little bit.

17 Sean.

18 MEMBER MORRISON: Just I support the
19 staff and nothing to add that hasn't already been
20 said, Ron.

21 CHAIR WALTERS: Thank you.

22 And Lindsey.

1 MEMBER WISHAM: So I also agree with
2 staff's recommendation and obviously have wise
3 lead discussants -- or fellow lead discussants.
4 So I won't cover what they've covered. I do
5 agree that this is best suited for ECQM due to
6 the large population.

7 CHAIR WALTERS: Okay, I'm going to turn
8 this over to either CMS or the Yale people in the
9 room to respond to some of the measure spec
10 changes that might be considered.

11 DR. BERNHEIM: Hi, this is Susannah
12 Bernheim from the Yale CORE. I see some future
13 TEP members in our room.

14 (Laughter.)

15 DR. BERNHEIM: So thank you for the good
16 comments. I'm going to be very brief.

17 I just want to actually update this
18 committee to let you know that we are now just
19 completing two rounds of testing of these
20 measures. So I'm going to consult my notes so I
21 get it right.

22 We do enhanced alpha testing, which is

1 to say that we do an early stage testing, where
2 we have a clinical adjudication to ensure that
3 the harms that are identified are confirmed by
4 clinicians looking at the chart and then we do
5 second round of that. For this pressure injury
6 measure, we've now done that in three health
7 systems with different EHRs at a total of 25
8 hospitals and we are finding, as we'd hoped, that
9 they are quite feasible, that people are finding
10 them, except for the issue exactly as you
11 identified, of being sure that we could track
12 from one location, the same location, the
13 worsening issue, which as you know that we
14 dropped because the testing confirmed exactly
15 what we noted, but that, otherwise, we're finding
16 high degree of positive predictive value for what
17 we're finding in the EHR compared to a chart.

18 And we did look at some high-risk
19 patients to ensure that we weren't missing and
20 also found that that was extremely rare.

21 So the measure testing is supporting
22 what you're saying and there's some great things

1 for us to go back and look in a little more
2 detail at here.

3 CHAIR WALTERS: Okay, other committee
4 comments? Time to raise your cards.

5 MEMBER PHILLIPS: So I had disclosed at
6 the beginning that we are one of the
7 participating organizations in this and when I
8 asked our team about that, just a couple of
9 comments had come up.

10 One, patients can have multiple skin
11 issues, each with varying stages, which I think
12 makes a flowsheet pull or an eMeasure quite
13 challenging.

14 And the measure, I guess some of the
15 technical specification is difficult because the
16 documentation requirements or the specs say every
17 time something is charted by nursing about the
18 ulcer that matters and it is, they thought very
19 cumbersome.

20 So an incredibly important topic in
21 hospital care and their sense was technically not
22 ready for prime time yet for entirely the reason

1 we're all doing this but thought it was very hard
2 to do.

3 CHAIR WALTERS: What is your
4 recommendation for a category?

5 MEMBER PHILLIPS: Oh, sorry. I would
6 support the staff recommendation.

7 CHAIR WALTERS: And did you have your
8 card up?

9 MEMBER GUINAN: Thanks. So a couple of
10 comments just on the risk adjustment aspect of
11 the measure. I fully support this being an
12 important issue to track. I think speaking from
13 the essential hospitals or safety-net providers
14 in terms of the complexity of the patients that
15 they see, both clinically and socially, just
16 things to consider in terms of a lot of our
17 members are academic medical centers and have a
18 lot of folks in the ICU. There is a lot of
19 complex clinical issues that they're dealing with
20 that may want to look at whether this measure,
21 when you're looking between teaching status/non-
22 teaching status has any unintended consequences,

1 just based on the number of patients that are in
2 that condition.

3 The social aspect may be not as direct
4 but frailty comes into play when talking about
5 pressure injury. Also nutrition comes into play,
6 so very aware of food and security being an issue
7 for a lot of our members in terms of how the
8 patient comes to the hospital.

9 And so I just wanted to put that out
10 there in terms of the risk adjustment
11 conversation.

12 So my vote would be to not support with
13 potential for mitigating.

14 CHAIR WALTERS: Nancy.

15 MEMBER FOSTER: I'd actually like to ask
16 Jack a question, since you've built your own
17 electronic version of this. It's not the exact
18 same measure, I assume, but very close.

19 One of the benefits that has been
20 supposed about the capture of this information in
21 that rapid format is that it will foster greater
22 opportunities for quality improvement and I would

1 like to know if that's been your experience sort
2 of really addressing issues that appear in the
3 moment.

4 MEMBER JORDAN: Yes, it has been. You
5 know we did have kind of an unreliable process,
6 as you know, filling out an incident report you
7 know when you had a thing. And yes, we find them
8 all now. There's never a miss from that.

9 A number of us in our hospital, we get
10 an email every day with any of these 22 --
11 they're running you know. So you know yesterday
12 someone documented in a flowsheet a new pressure
13 ulcer and so our wound ostomy nurses can use that
14 every day so that they're on it very quickly.
15 They actually have a report they can run inside
16 the record as well for that but they tend to much
17 prefer having the ding, go look at these kind of
18 process.

19 So it has been very helpful in tying up
20 the -- in making things very fast. And then
21 also, you never have any issues of oh, well that
22 was two weeks ago. This got billed and I don't

1 remember the patient. You know they are there
2 right then and there so you know they're still
3 present. So it has been I think very helpful to
4 really close the loop on those things.

5 CHAIR WALTERS: Is there anybody else
6 that would like to comment? Maybe we should have
7 all the measures after lunch.

8 Gayle.

9 MEMBER LEE: I just wanted to ask a
10 question for clarification between the
11 categories. So we have the same concerns about
12 the time frame, the 24-hour window and the fact
13 that a pressure ulcer might not immediately show
14 up.

15 So if we were to vote conditional
16 support, would that be something that would be
17 addressed or does it have to be the do not
18 support with the -- you know the other category,
19 I guess.

20 CHAIR WALTERS: Yes and that's why I
21 brought up the substantive change things. It
22 depends on what data they submit and how it's

1 analyzed.

2 So if the measure is rewritten and then
3 analytics is supported to substantiate those
4 changes, it could fall in either category but it
5 might be possible to get by as conditional
6 support.

7 I can't tell you because those are
8 decisions made actually at a sub-regulatory
9 level.

10 MS. O'ROURKE: And I obviously can't
11 speak for CMS but when we were designing this
12 category, we tried to align with the CDP around
13 the language for substantive change. But again,
14 the categories aren't meant to be binding and the
15 group has the freedom to vote the way you think
16 it is if you think it's a significant change or
17 if it's something that you'd be okay having it
18 addressed and the measure move forward.

19 Again, it's not always clear and it's to
20 your discretion of what you like the better.

21 DR. BERNHEIM: -- the way the measure is
22 set up -- this is just a brief clarification so

1 that I'm sure people are understanding the way
2 the measure is designed.

3 Because we're not using claims, we're
4 using the electronic record, we are not counting
5 something as a new pressure injury unless the
6 first time that it's documented is after 24
7 hours. So I wasn't sure if there -- I mean there
8 was a lot of discussion with our TEP and in
9 public comment about what the window should be
10 but the general sense was that any pressure
11 injury that is present on admission should be
12 documented within the first 24 hours and so that
13 then it will only kind of be things that show up
14 for the first time after that, you should be
15 largely capturing things that are new.

16 MEMBER FOSTER: So just for
17 clarification, and since you're here, Susannah,
18 did you think about the issues of the academic
19 medical centers that may have more patients who
20 either can't be moved or there is an extreme
21 danger in moving them, those kind of patients who
22 would be perhaps more susceptible to pressure

1 ulcers but reasonably so?

2 DR. BERNHEIM: Yes, this was a
3 discussion with our technical expert panel as
4 well, and a thoughtful discussion. We spent some
5 time thinking about it. The general sense was
6 that most pressure injuries can and should be
7 avoided and that the measure was simpler to
8 implement, which is part of what we're trying to
9 balance here bringing forth these measures and
10 would be supporting the right kind of
11 improvements to not complicate it with trying to
12 risk adjust, given the sense from our Technical
13 Expert Panel that these greater stage pressure
14 injuries should be avoided in inpatient
15 hospitals.

16 CHAIR WALTERS: Jack.

17 MEMBER JORDAN: You did bring up a
18 recommended exclusion that made me think of this,
19 Nancy, and that would be ECMO patients are an
20 order of magnitude at more risk. And if you do
21 want to compare hospitals that have some penalty
22 program on it, it would be an unfair disadvantage

1 to hospitals if you didn't have an exclusion for
2 ECMO.

3 If you're just looking for improvement,
4 it's one thing. If you're going to actually do
5 comparison, the ECMO is a whole other animal.

6 CO-CHAIR UPSHAW TRAUS: I hate to ask
7 this but what is ECMO?

8 MEMBER JORDAN: Extracorporeal membrane
9 oxygenation.

10 CO-CHAIR UPSHAW TRAUS: I knew I would
11 regret that.

12 (Laughter.)

13 CHAIR WALTERS: Nancy.

14 MEMBER JORDAN: Yes, it's expanding more
15 and more the uses for it but it's essentially
16 getting oxygen to put back into your blood, other
17 than your lungs. Is that an okay --

18 CHAIR WALTERS: TEP is never big enough,
19 is it?

20 Maryellen.

21 MEMBER GUINAN: I have question more on
22 process in terms of the mitigating category.

1 Last year I know we spoke about sending a measure
2 back through the Disparities Committee for review
3 as part of kind of the risk adjustment
4 conversation. Would that then come under the
5 purview of do not support with potential
6 mitigating factors?

7 MS. O'ROURKE: I think that's one you
8 could make that a condition or you could make it
9 a mitigating factor, depending on your comfort
10 with what's in front of you. Yes, it's another
11 one that you could use that type of a caveat
12 either way.

13 MEMBER GUINAN: Okay. I'm sorry,
14 follow-up.

15 So, in that case, then if I made it a
16 condition, then it would be a support with the
17 condition of going back to the Disparities
18 Committee but then that could be taken up by CMS
19 as-is, regardless of the decision. Whereas, if
20 it's a do not support with the mitigating
21 component of going through the Disparities
22 Committee, then it's not to CMS.

1 MS. O'ROURKE: That's a good way to put
2 it, yes.

3 You know, at least what we're trying to
4 say from the MAP point of view is that you would
5 not want CMS to use the measure as-is without
6 doing that. Again, just to emphasize that the
7 input is advisory and not binding in any way but
8 that is the -- you know it's to try to clarify
9 what the recommendations are saying from the MAP
10 perspective.

11 CHAIR WALTERS: Nancy.

12 MEMBER FOSTER: Thank you, Maryellen,
13 because you reminded me of my question, which was
14 if we were to recommend that it be conditional
15 support -- if we recommended a condition that was
16 CMS look at whether there is an unfair and an
17 inappropriate kind of publication to the public
18 about performance for hospitals that have a lot
19 of ECMO or other patients of that nature, do we
20 -- is that a mitigate? Is that -- where are we
21 on that?

22 MS. O'ROURKE: Again, I think you could

1 probably do it either way. Again, this came up
2 in PAC a little bit, so just to give you the
3 history of yesterday, so it's not a great sample
4 but they -- when they looked at some of the
5 transfer of health information to the patient,
6 the group had some input for CMS which was a
7 little bit maybe broader than a strict condition
8 of how that list would look, and what information
9 would be useful to patients, how you would
10 communicate it. And it was some guidance on
11 being very clear about how information gets
12 reported out that I think would be in the domain
13 of what MAP could talk about under the
14 conditional support.

15 CHAIR WALTERS: Shannon.

16 MEMBER PHILLIPS: Really questions for
17 nursing colleagues. I think of two things and I
18 think it was touched on a little bit but the
19 expertise for trying to stage pressure ulcers is
20 significant and I wonder about bias in that
21 against hospitals who are not part of large
22 health systems or don't physically have on-the-

1 ground people who really have certification and
2 expertise in this and was there any look at that.

3 And then the second is the opportunity,
4 which I, again, have learned about over time,
5 that one notices skin issues and it ends up
6 ultimately being maybe a vascular issue rather
7 than a deep tissue injury. And does this measure
8 take into account the fact that this -- what you
9 see from one day to the next or one week to the
10 next may give you a better sense of what the
11 underlying cause was and to have that, again, not
12 get in the way.

13 But my nursing colleagues probably could
14 speak to this better but curious about that as it
15 relates to measuring performance in hospitals.

16 CHAIR WALTERS: Yes. So reliability
17 comes up in every Scientific Methods Panel
18 discussion about exactly issues like that and it
19 would be noticed.

20 When humans report things, how do you
21 know that humans are reporting things
22 consistently?

1 Okay, I'm going to turn it over to
2 measure developer to see if there's any other
3 comments they want to make in response to this.

4 Lee, did you flip yours up?

5 MEMBER FLEISHER: I'm just wondering as
6 we talk about it, because in working with the
7 Yale CORE, one of the nice things is they were
8 able to get albumin in some of the data sets.
9 Kaisers were working on some of the measures.
10 And some of the future risk adjustments, and
11 that's really the robustness of ECQMs is how do
12 we sort of give advice, which may be by me
13 stating this now, that it would be great for you
14 to start looking in subsets of data, where we
15 could even more robustly risk adjust these and,
16 therefore, it would be an even better measure.

17 MS. O'ROURKE: Ron, could I make one
18 process concern that --

19 CHAIR WALTERS: Yes.

20 MS. O'ROURKE: Or, not concern, but that
21 Lee's question just triggered. I did want to
22 highlight to everyone that the spreadsheet of

1 decisions is only one deliverable we report out
2 from the MAP conversations. There is also a
3 whole written report that has all of -- a summary
4 of this whole conversation and all of the context
5 that goes along with the group's discussion and
6 how they came to that decision.

7 So to highlight that you have the
8 opportunity to make comments like that that might
9 go outside of the strict recommendation
10 categories, and that we capture that, and we pass
11 it along to CMS and to the field broadly.

12 CHAIR WALTERS: Yes. Any last comments?

13 In one form or fashion, then, whether it
14 be with conditions that we're not sure whether
15 they'll go through or not but at least listen to,
16 or through conditions that should be added, the
17 staff recommendation, the preliminary analysis
18 recommendation was conditional support for
19 rulemaking. Cristie and I heard that that was
20 generally there were some questions about what
21 conditions could and could not be but, generally,
22 the discussion flavor that we had with outside

1 chance that if that -- or I shouldn't say that --
2 with the chance that if that does not go through,
3 it might be the category below that, the do not
4 support with potential for mitigation.

5 So I believe we'll take a vote on the
6 preliminary analysis of conditional support
7 first.

8 MS. QUINNONEZ: Yes, thank you.

9 Voting is now open for MUC2018-107 and
10 the question reads: Do you vote support the
11 preliminary analysis as the workgroup
12 recommendation?

13 And this is for conditional support for
14 rulemaking for MUC2018-107. Option A is yes;
15 option B is no.

16 It looks like a couple more votes are
17 coming through. Do you need to reconnect to the
18 WI-FI?

19 Just waiting for one more vote.

20 CHAIR WALTERS: Okay, Marty votes yes.

21 MS. QUINNONEZ: Okay, we're going to
22 close the vote.

1 On the screen you'll see 87 percent of
2 individuals voted yes so this will be a little
3 higher, and 13 percent of individuals voted no
4 but we will add Marty's vote in there and get our
5 total count.

6 And our count for this measure is 20
7 individuals -- actually 21 individuals, with
8 Marty's vote, voted yes and three individuals
9 voted no.

10 CHAIR WALTERS: Thank you very much.
11 That was very good feedback given to the measure
12 developer and thank you for your participation.

13 All right, having tested the process,
14 now I'm going to turn it over to Cristie for
15 hypoglycemia.

16 DR. SCHREIBER: Do we have clarity on
17 what the conditions are?

18 CHAIR WALTERS: Tabulate the list there.

19 MS. O'ROURKE: So the one that staff put
20 forward was NQF endorsement. Also hearing some
21 particular concerns that perhaps the Disparities
22 Committee could take a look at this measure.

1 CHAIR WALTERS: ECMO patients.

2 MS. O'ROURKE: ECMO patients.

3 CHAIR WALTERS: The timing of the
4 sequential assessments.

5 MS. O'ROURKE: Sequential assessments.
6 For the record, that's multiple ulcers at the
7 same time and how that's handled.

8 MEMBER GLASSMAN: I thought this was
9 tissue injury.

10 MS. O'ROURKE: And a focus on deep
11 tissue injury.

12 CHAIR WALTERS: There was something in
13 there also about competence assessment but I
14 think that might be a whole different measure,
15 actually. I don't know. It's going to come up
16 in our other committee, I know that.

17 Michelle.

18 DR. SCHREIBER: May I just ask the group
19 another point of clarity because Jack raised this
20 as an issue? Is everybody comfortable with it
21 including stage 2 pressure ulcers? It's a big
22 change from prior pressure ulcer measures.

1 CHAIR WALTERS: That was the first thing
2 that was brought up.

3 Sally.

4 MEMBER TURBYVILLE: I just wanted to --
5 I voted no because I was going to go for the
6 mitigation but mainly because there were so many
7 conditions that were uncovered that some of them
8 may imply specification changes and further field
9 testing and that regardless, supporting the
10 group's decision and deferring to the majority,
11 that it's not just about NQF endorsement, that
12 it's actually looking at these conditions and
13 whether or not the measure currently meets them
14 and if not, what changes would have to happen
15 regardless of that kind of committee's decision
16 that reviews it for endorsement? They're just
17 too important, the conditions being listed by my
18 colleagues.

19 CHAIR WALTERS: Keith.

20 MEMBER BELLOVICH: I just wanted to
21 offer another additional diagnostic group, being
22 the ESRD with calciphylaxis as another group with

1 horrible skin conditions that sometimes are
2 misinterpreted as decubitus ulceration and is
3 not.

4 CHAIR WALTERS: I believe you could
5 stratify this by a whole bunch of things. Have
6 fun.

7 CO-CHAIR UPSHAW TRAUS: Okay, well thank
8 you all.

9 Our next measure is MUC2018-109,
10 Hospital Harm for Hypoglycemia.

11 MS. JUNG: This is Madison, for those on
12 the phone. I will be giving the overview.

13 So for this measure, the staff's
14 preliminary analysis result was conditional
15 support for rulemaking with the rationale that
16 while this measure addresses a gap, it does not
17 address the concerns of the previous MAP
18 Workgroup. This measure was submitted to the MAP
19 Workgroup back in 2013. The previous workgroup
20 had expressed concerns that electronically-
21 specified measures -- that this measure is only
22 electronically specified. The concern was

1 because many hospitals still face significant
2 barriers in reporting eQMs and using them to
3 drive quality improvement.

4 Of note, this measure is based on NQF
5 2363, which is endorsed but this measure here has
6 been re-specified. The re-specified measure is
7 not fully tested and should be submitted to NQF
8 for review and endorsement once testing is
9 completed. And I believe it is due for
10 maintenance in 2019.

11 CO-CHAIR UPSHAW TRAUS: Okay, just one
12 clarification because I know it may impact our
13 thinking on this. I assume the eMeasure with its
14 re-specifications would go through separately
15 from the other measure that is up for
16 maintenance. Is that correct? Okay, so it gets
17 its own independent review. Okay, wonderful.

18 All right, well let's go to our lead
19 discussants and we can start with Keith.

20 MEMBER BELLOVICH: Thank you for pulling
21 this fish out of dialysate waters and putting me
22 into hypoglycemia. I'm not sure how that

1 happened but my sympathies to those that have
2 been in the same situation before.

3 With regard to our initial analysis, it
4 certainly is an important issue about helping
5 patients and avoiding harm to patients that are
6 hospitalized with hypoglycemia. They certainly
7 do happen frequently. It's the most common drug
8 event in the hospital in the range of 2.3 percent
9 to 5 percent among hospitalized patients is a
10 real consideration and almost 2 percent of these
11 patient in the ICU.

12 But there's three steps in this process
13 that give us cause for concern. One is the
14 patient must receive a hypoglycemic agent within
15 a 24-hour period to be considered as part of the
16 numerator, a low blood glucose of less than 40,
17 and then a second lab measurement within five
18 minutes of the discovery of that low blood sugar.
19 There seems to be some disparities in terms of
20 that previous presentation back in 2014 as part
21 of the endocrine project in that basically a
22 difference between including hypoglycemic

1 episodes versus one patient over that entire
2 hospitalization.

3 So it seems to be that there is a little
4 disparity between what was initially approved by
5 NQF and what is now in this MAP measure. We just
6 need clarification as to making sure that it is
7 one patient per hospitalization but out of
8 concern would be the concept that one patient
9 could have multiple episodes and, in fact, they
10 are at higher risk of having adverse events
11 mainly by having one hypoglycemic episode.

12 Secondly, the actual value of less than
13 40 is a concern. In fact, the American Diabetes
14 Association has even made recommendations that
15 hypoglycemia as low as 50 or even less than 70 is
16 concerning. So even the 40 we're curious as to
17 why we went so low and there's probably some
18 adverse events that are happening that aren't
19 being discovered as well.

20 And then lastly, this second lab
21 measurement within five minutes, I don't know
22 about you around the table, but that seems to be

1 a very complicated process to identify a second
2 measurement while you're supposed to be first
3 addressing the needs of your patient initially.

4 So for these reasons that overall our
5 impressions were to not support this measure.

6 CO-CHAIR UPSHAW TRAUS: Thank you.

7 Richard Knight. He's not here. I
8 didn't think so.

9 Maryellen.

10 MEMBER GUINAN: Great. Full disclosure,
11 I'm an attorney by trade so I'm really out of
12 water here but we'll just go with this.

13 A few things in terms of the measure.
14 One just general comment in terms of eCQMs and
15 resource allocation I think is a concern for a
16 lot of our members because they do operate on low
17 margins. And so kind of where we're signaling to
18 the medical community where to dedicate those
19 resources in terms of having that kind of boost
20 in infrastructure that's really needed for eCQMs
21 is something to kind of take into consideration
22 in terms of this measure specifically.

1 Also just the range of folks' adoption
2 of eCQMs and their ability to work with vendors
3 and being varied nationally.

4 The other issue was, to your point,
5 Keith, in terms of the kind of multi-step, it was
6 interesting to see the glucometer is usually the
7 point of care kind of diagnostic use. And so the
8 switch to then include lab testing seemed to go
9 or run counter to what is currently probably the
10 more cost-effective avenue and actually at the
11 point of care and not adding that what could be
12 burdensome or more complicated in terms of the
13 measure itself.

14 So and I do also caution in terms of --
15 and again, out of my wheelhouse here, but the
16 standard of care being that there could be an
17 unintended consequence that we're causing
18 hyperglycemia by trying to control for
19 hypoglycemia. So just those kind of adverse
20 effects I think we should think more carefully in
21 terms of the mitigating side.

22 And so ultimately, that led me to a not

1 support with potential for mitigation for those
2 conditions.

3 CO-CHAIR UPSHAW TRAUS: Thank you very
4 much.

5 Shannon.

6 MEMBER PHILLIPS: I absolutely won't
7 repeat but it clinically happens to me regularly.
8 So I guess different from my colleagues, I do see
9 this. You know narcotics, anticoagulants, and
10 antihyperglycemics are the most risky drugs we
11 prescribe in hospitals and so I appreciate the
12 fact that there is attention to figuring this
13 out.

14 Forty feels comfortable to me because 70
15 would have a lot of noise. Maybe 50 would be
16 different but what we have to be careful about is
17 if we measure people on something we need to be
18 really sure it's abnormal. And so I appreciate
19 that.

20 As was stated, five minutes after
21 identifying it, you should be tending to a
22 patient and repeat tests might be done to verify

1 that it is low but you're not stopping to do
2 that. You're actually taking care of the patient
3 and so the timing on this measure feels very off.

4 And in fact, if we really want to
5 understand the burden of this risk in healthcare,
6 simply saying one event and one admission per
7 patient completely misses the boat on looking at
8 safety around these drugs in healthcare.

9 So all that said, I would not support it
10 and I think there are mitigating factors. I
11 think it's important to do this. It's just not
12 ready yet.

13 CO-CHAIR UPSHAW TRAUS: So just to be
14 sure I write it down right, do not support with
15 potential for mitigation. Okay, thank you.

16 Aisha.

17 MEMBER PITTMAN: I'll be quick. I think
18 I'm aligned with the other lead discussants of
19 not supporting it with mitigating factors.

20 It just wasn't clear to me if it was
21 intended to just solely be lab tests or was
22 including glucometer readings. It says lab tests

1 but not seeing the full specifications. So can
2 the measure developers comment on that?

3 CO-CHAIR UPSHAW TRAUS: Let's finish up
4 with our last lead discussant and then we'll go
5 to the developers.

6 Ann Marie.

7 MEMBER SULLIVAN: I basically agree with
8 everything that's been said. And I think what
9 was most troublesome was the five minutes I think
10 that even timing that becomes a little bit crazy.
11 So I think that that kind of requirement on
12 staff, when you have that, that's particularly
13 difficult. And I agree with everything else
14 that's been said.

15 So basically with the mitigation.

16 CO-CHAIR UPSHAW TRAUS: Thank you.

17 Okay, we'll kind of look to the
18 developers to maybe address some of these issues
19 and I wrote down a few but if you don't address
20 them I'll remind you what they were. So you can
21 go.

22 DR. BERNHEIM: Prefect, thank you. I

1 wrote them down but I appreciate you keeping me
2 online.

3 Thank you for the comments. I will say
4 just two -- a few brief things about the status
5 of this measure and some of the concerns. I hope
6 that in better explaining the measure we may be
7 mitigating some of your concerns already.

8 So again, this measure was selected
9 because our Technical Expert Panel and patient
10 group felt that it was both important and
11 meaningful for patients and that it would be
12 feasible. And our aim is always not to add
13 anything to clinical workflow. So I'm going to
14 start with that five-minute piece because I think
15 it was misinterpreted and I want to be really
16 clear.

17 What this measure does is it looks at
18 among patients who have been given
19 antihyperglycemic medications, or dealing with a
20 group of patients who are risk of hypoglycemia
21 based on our actions in the hospital, it
22 identifies whether a patient's blood sugar goes

1 below 40.

2 And you're exactly right, the reason we
3 choose a lower number than some of the guidelines
4 is to make sure that we're really identifying
5 serious hypoglycemia and not spurious events.

6 And the issue of spurious events is
7 where that five minutes come in. This measure
8 does not require you to recheck blood sugar. It
9 simply says if we see in your lab values that you
10 rechecked it in five minutes and it was over 80,
11 then we believe that 40 was spurious. So it's
12 just to prevent us from counting something as
13 serious hypoglycemia when it was not but there's
14 no requirement of a recheck at all.

15 It does bring in both lab values and
16 point of care values. Many of these are done at
17 point of care. So both of those are read.

18 And what we're learning is that this is
19 -- these labs -- I mean now I'm using the term
20 lab value which I think is confusing you -- these
21 blood test results, whether they are done at the
22 point of care or from the lab are the things that

1 are among the most feasible for hospitals to
2 extract, including timestamps. The timestamps
3 seem to be pretty good.

4 So it is not -- there is no work for
5 that five minutes. There is only an opportunity
6 to prevent us from counting something as having
7 been hypoglycemic when it wasn't. So I think
8 those are the most important clarifications.

9 Stay tuned on the concern of a balancing
10 measure. We'll see you next year.

11 (Laughter.)

12 DR. BERNHEIM: And then the one other
13 thing is that this is, at this point, specified
14 as a one event per patient, either the event
15 occurred or not. And I hear -- and we thought
16 about it and we tried to balance the question of
17 sort of do you look for multiple events. The
18 advantage of a single event, if you think that
19 this something that we should try to avoid in all
20 cases, is that there's less data to be extracted
21 once you see that there has been a severe
22 hypoglycemic event and there was not an immediate

1 improvement based on suggesting a spurious lab
2 value, you found that event. In some of these
3 measures, we look for numbers of events and I
4 think you could argue either way but we did that
5 to keep it as simple as possible.

6 Did I get them all, Cristie?

7 CO-CHAIR UPSHAW TRAUS: You got the ones
8 I wrote down.

9 DR. BERNHEIM: I will say, like the
10 other measure, this is now done with two rounds
11 of testing with very high positive predicted
12 value and good reliability in those results and
13 it will be going to NQF in January.

14 CO-CHAIR UPSHAW TRAUS: So just to
15 remind everybody, the staff's recommendation was
16 conditional support for rulemaking.

17 What we heard from the vast majority of
18 our lead discussants was to not support with
19 mitigating factors and a couple of do not support
20 at all.

21 So hopefully this clarification at least
22 gets us on a common foundation in terms of what

1 this measure is and what it is not.

2 Are there any additional questions or
3 clarifications? And I probably should have
4 started looking earlier but I'm just going to
5 start with Jack and then go around the room this
6 way. So, Jack.

7 MEMBER JORDAN: Thank you.

8 A couple things. Opposite of the others
9 here, I think the five minutes is actually too
10 short. Well one, I know my hospital policy is
11 ten but also if you think the glucometer
12 something is wrong with it so you're going to go
13 find another one and come back, you'll flag over
14 the five. Though I can tell you looking at over
15 three million glucose readings in my lifetime
16 kind of things with that, that rarely really
17 happens where you get the false positive there.

18 But that said, the other thing with this
19 that can make this a lot easier to build, and
20 anytime you are using drug class kind of things,
21 to avoid making the definition be a list of a
22 bazillion RxNorm codes and instead to say

1 contains drug class or sub-drug class. That's
2 ten times easier for someone to build the rule
3 and it doesn't have to be maintained every year
4 that you build a new list every year for your
5 definition of the new list of RxNorm codes.

6 So that's just something whenever you're
7 doing one of these eQMs with drugs, it makes the
8 world a lot easier to implement for that.

9 And then I agree on kind of switching to
10 the multiple incidents kind of thing. Our rule,
11 we use 15 minutes and if you have a second one,
12 more than 15 minutes apart, then we count it as a
13 second event.

14 And I think we have actually done some
15 things where we've had resident kind of studies
16 and such where they look at the recidivist
17 patients and see are there things different there
18 and such. So I think they are kind of something
19 interesting to look at multiples.

20 CO-CHAIR UPSHAW TRAUS: So do you mind
21 sharing with us what you're leaning towards in
22 terms of the decision categories?

1 MEMBER JORDAN: I guess the challenge is
2 always you know what is kind of agree with it and
3 these kind of things or tweaks that don't count,
4 which I would be fine with saying that or saying
5 go back and kind of fix the things.

6 To me, if you changed it from five to
7 ten minutes, I don't think that's a substantive
8 change that's like saying you have to go back.

9 The drug class kind of thing, again,
10 that's probably a big deal in one way but, in
11 reality, it's kind of a trivial change to it. So
12 I would say I would agree to move forward with it
13 but I think those things could be done but I
14 think of them as minor changes.

15 CO-CHAIR UPSHAW TRAUS: Okay, so
16 conditional support?

17 MEMBER JORDAN: Conditional support.

18 CO-CHAIR UPSHAW TRAUS: Okay, that
19 sounds great. Thank you, Jack.

20 Keith.

21 MEMBER BELLOVICH: I just wanted a point
22 of clarification. Was there any thought -- I

1 don't want to step on the toes of future MAPs --
2 but the concept of unintentional hyperglycemia as
3 a result of erring on the side of no therapy?

4 CO-CHAIR UPSHAW TRAUS: Was that your
5 balancing measure or --

6 DR. BERNHEIM: I can't speak to CMS'
7 future intentions but yes, a lot of thought about
8 that. We felt like hypoglycemia was -- a single
9 instance of hypoglycemia is a much more serious
10 event for patients associated with all kinds of
11 morbidity. And so that was our first focus but
12 there is a lot of thought about the importance of
13 balancing measures.

14 CO-CHAIR UPSHAW TRAUS: And I'm sure our
15 comments can incorporate that as well, Keith.

16 Lee.

17 MEMBER FLEISHER: I guess I'll take up
18 my role from the methodology standpoint. So we
19 actually did get funded by the NIH to do a study
20 of the SCIP measures and glucose levels.
21 Unfortunately, it's never been published because
22 CMS did not renew our data use agreement.

1 (Laughter.)

2 MEMBER FLEISHER: Yes and we called

3 Patrick.

4 CO-CHAIR UPSHAW TRAUS: So noted.

5 MEMBER FLEISHER: So we went all the way

6 to the top.

7 But the important interesting question
8 is risk adjustment, which we never thought on
9 process measures that you would need it, but what
10 we found in a national sample was that the
11 incidence of CABG at your local hospital and CABG
12 in diabetics at your local hospital. So while I
13 think this is a fabulous and important measure,
14 that that particular subset of how many CABGs you
15 do and how many CABGs with diabetics change
16 whether or not a hospital is great or really
17 quite poor because essentially in that subset of
18 population, you had wilder swings in their
19 glucose levels from the measurement.

20 So I'm just saying that something --
21 this is a conditional with -- do not but
22 mitigating. So I think if you -- whether you

1 subset out that population or look at it, if they
2 are doing less CABGs, they may look better
3 because of the attempt to control glucose tighter
4 in that subpopulation.

5 CO-CHAIR UPSHAW TRAUS: Thank you, Lee.

6 We're just going to continue to go down,
7 if that's okay with you all.

8 Nancy.

9 MEMBER FOSTER: So just one note related
10 to the measure but not about the specifications
11 in the measure, per se, and that is recently the
12 FDA put out guidance to blood glucose meter
13 developers, which may mean some of the things we
14 currently use in hospitals will no longer be
15 available to us. If that comes to pass in a time
16 frame when you would launch this measure, it
17 would cause strange results to occur, perhaps.

18 So I just offer that up not as a
19 deterrent to doing the measure, per se, but as a
20 timing issue around implementation and to watch
21 what the FDA is doing.

22 CO-CHAIR UPSHAW TRAUS: Andreea.

1 MEMBER BALAN-COHEN: And just building
2 up on the comment about risk adjustments, just a
3 suggestion. I like the point that was brought up
4 about how there hasn't really been made a
5 differentiation between whether this is an
6 episode like for a patient or like multiple or
7 like repeated episodes for a given patient. And
8 it seemed to me that underlying reasons for those
9 would be very different.

10 And then maybe one of the suggestions
11 you try to see if you need additional risk
12 adjustment is like maybe comparing you know like
13 how would the data change when you do this like
14 separately. Like if you only look at like one
15 incident versus if you look at like the
16 population or have like multiple incidents and
17 that would give you like some additional
18 information on that.

19 CO-CHAIR UPSHAW TRAUS: Great. Thank
20 you.

21 Okay, any final comments, Susannah?
22 Okay.

1 All right. Well why don't we tee this
2 up the way that our process says, which is to
3 first vote on whether or not we support the
4 preliminary analysis as the workgroup
5 recommendation. And the preliminary analysis was
6 for conditional support on the condition that in
7 the staff analysis is NQF endorsement, correct?
8 It's hard for me to look at million things at
9 once. I apologize. Yes, for conditional support
10 but that was the condition that was attached to
11 it.

12 So we can start with voting for whether
13 or not we approve the preliminary analysis as our
14 formal recommendation.

15 MS. QUINNONEZ: Thank you.

16 Voting is now open for MUC2018-109. Do
17 you vote to support the preliminary analysis as
18 the workgroup recommendation and that was the
19 recommendation of conditional support for
20 rulemaking? Option 1, yes; Option 2, no.

21 Votes are coming in. I'm just looking
22 for a couple more votes. We're at 23 votes now

1 so I'll give you five more seconds.

2 All right. Okay, voting is now closed.

3 So right at this time, we have 63
4 percent voted yes and 38 percent voted no. I
5 will give you the count so you'll have a specific
6 count for that.

7 For the record, 15 individuals voted yes
8 and 9 individuals voted no.

9 CHAIR WALTERS: Yes, so I think -- I was
10 saying Cristie, I heard an awful lot of do not
11 support with mitigation possible.

12 So I think that the vote reflects
13 exactly some of the discussion that occurred was
14 there's got to be some conditions. And we talked
15 a lot about some of those risk adjustment ones
16 and about there were some things in the specs.

17 MS. O'ROURKE: Yes, I can start and
18 please feel free to chime in if I missed
19 anything.

20 Some guidance for the developer and the
21 Standing Committee that would eventually be
22 looking at this measure for endorsement, take a

1 look at that threshold of 40, as well as the
2 five-minute time frame. Also some guidance that
3 it would make this measure more feasible if it
4 focused on drug glass, rather than a list of
5 RxNorms.

6 Also perhaps some bigger picture
7 implementation events -- or as some bigger
8 picture illumination, it would be a balancing
9 measure for hyperglycemia, to keep track of what
10 the FDA is doing around blood glucose meter
11 development and to not put this measure into
12 effect at the same time that goes into effect to
13 avoid some unintended consequences.

14 And Maryellen's point about EHR vendor
15 issues and national variability and to make sure
16 CMS is working closely with the EHR vendors to
17 minimize the burden, especially on facilities
18 that may not have as many resources as others.

19 MEMBER McGIFFERT: And then there in the
20 multiple events.

21 MS. O'ROURKE: And the multiple events
22 oh, and also the risk adjustment model.

1 CO-CHAIR UPSHAW TRAUS: Okay, that seems
2 to have captured for the record. Okay, that
3 sounds great.

4 All right, well thank you all for that.
5 Let's go on and move into our next measure, which
6 gets out of IQR and into the Prospective Payment
7 System for PPS -- I'm sorry -- PPS - Exempt
8 Cancer Hospital Quality Reporting Program.

9 We're going to have an overview of that
10 program, and then we will go to public comment,
11 and then we will start with our lead discussant
12 on the one measure that we have in this program.

13 MS. JUNG: Great, thank you.

14 So this slide is just giving an overview
15 of the PPS - Exempt Cancer Hospital Quality
16 Reporting Program. Again, this was reviewed at
17 the web meeting but just to reiterate, the
18 program type is a quality reporting program. The
19 incentive structure is a PCHQR. It's a
20 voluntary quality reporting program. Data is
21 published on Hospital Compare.

22 The program goals are to provide

1 information about quality of care in cancer
2 hospitals, in particular to the 11 cancer
3 hospitals that are exempt from the Inpatient
4 Prospective Payment System and the Inpatient
5 Quality Reporting Program.

6 The other goal is to encourage hospitals
7 and clinicians to improve the quality of their
8 care, to share information, and to learn from
9 other's experiences and best practices.

10 This slide displays the recent updates,
11 the most recent federal rule to the PCHQR
12 programs.

13 MS. O'ROURKE: Sorry, Madison, to
14 interrupt you. Just to note on the public
15 SharePoint site we do have a spreadsheet that has
16 all of the measures in the programs. We know
17 this is not the easiest thing to read.

18 MS. JUNG: Yes, and then there's a
19 version of the slides on the public SharePoint as
20 well for reference. But these measures that had
21 recent updates to the program.

22 And this slide just lists the measure

1 that are currently still existing or had no
2 changes in the last rule.

3 The high priority domains that were
4 noted: communication and care coordination,
5 making care affordable, person and family
6 engagement.

7 CO-CHAIR UPSHAW TRAUS: Okay, we would
8 like to open it up for public comment on this
9 program. And we can start with people in the
10 room.

11 Anybody in the room want to make a
12 comment? Okay, I don't see any.

13 Operator, could you see if anybody on
14 the phone would like to make a comment, please?

15 OPERATOR: Yes, ma'am.

16 At this time, if you would like to make
17 a comment, please press * then the number 1.

18 And there are no public comments at this
19 time.

20 CO-CHAIR UPSHAW TRAUS: Okay, thank you.

21 So we want to go into the measure that
22 we have before us, which just went away on the

1 screen but I can probably find it over here.
2 There are so many things we have to flip between,
3 the screen is helpful.

4 Surgical Treatment Complications for
5 Localized Prostate Cancer and it's MUC2018-150.
6 And if the staff will, give us a summary of the
7 preliminary analysis.

8 MS. JUNG: So the result of the
9 preliminary analysis was we do not support for
10 rulemaking with potential for mitigation, the
11 reason being that this measure should be revised
12 as recommended by the methods panel and
13 resubmitted to NQF for evaluation and
14 endorsement.

15 CO-CHAIR UPSHAW TRAUS: Can you just
16 point out to us or remind us the MAP -- the
17 Methods Panel discussion that was around this so
18 we have that walking in as to understanding where
19 the preliminary analysis landed?

20 MS. MARINELARENA: Sure, this is Melissa
21 for those of you on the phone.

22 So this measure was submitted to NQF for

1 review in the fall of this year, fall of 2018.
2 It went to the Methods Panel because it is an
3 outcome measure. And the Methods Panel did not
4 recommend it because there were some issues not
5 with the concept of the measure but with the
6 actual testing that was provided to them at the
7 time.

8 In your preliminary analysis we did
9 provide the Methods Panel's very specific
10 recommendations. As Karen explained this
11 morning, the MAP -- or the Methods Panel has
12 evolved over the past year. So this measure was
13 discussed over a public telephone call and then
14 the measure developer was provided
15 recommendations. There are recommendations that
16 the Methods Panel, overall, would like to see but
17 then very specific recommendations that they
18 provided that would meet NQF criteria.

19 So it was around their reliability and
20 their validity testing. They have provided some
21 face validity testing, some data element validity
22 testing that just did not meet NQF criteria, just

1 giving them some more specifics about if you're
2 going to do face validity, this is what we are
3 going to need if you're going to do data element.
4 And I believe they are on the phone as well and
5 can provide you some more specifics on what we
6 require for data element validity testing.

7 So we did include their very specific
8 recommendations. So that's why this one received
9 the mitigation because they have to tighten up
10 their specs a little tighter. They have received
11 those recommendations and then they can tell you
12 themselves what they plan to do with the measure.
13 So that's why this received the do not support as
14 it is with mitigation.

15 CO-CHAIR UPSHAW TRAUS: Thank you very
16 much.

17 Well, let's go to our lead discussants
18 first and then we'll give opportunities for the
19 developers and others to answer questions and
20 concerns that may have arisen.

21 So we'll start with Andreea.

22 MEMBER BALAN-COHEN: Thank you. So to

1 begin with, I do -- we do think that this is a
2 very important measure. There are many things to
3 like about it. This surgical treatment
4 complications for localized prostate cancer are
5 certainly very frequent and something that really
6 matters to patients. So something very important
7 from a patient perspective.

8 I had some concerns about in addition to
9 some of the ones from the Method Panel in terms
10 of like both a little bit conceptually and also
11 in terms of the measurement. And I think that's
12 why I would go with the current staff
13 recommendation, which was not supported with
14 potential for mitigation.

15 And the concerns that I had were around
16 -- one was around like the measurement. So it
17 wasn't very clear whether this is something that
18 is going to be separately reported for different
19 types of surgeries. It seems that minimally
20 invasive versus open surgeries would have very
21 different types of complications. So accounting
22 for that would be important.

1 The other issue was around like the time
2 interval, like the one-year time interval and
3 also the types of complications. Again, not my
4 main area of expertise, per se, but I did do some
5 literature review and it seems that a lot of
6 these complications tend to occur over like a
7 longer time frame, so like between two to four
8 years.

9 And also some of these complications
10 tend to sometimes happen in opposite directions.
11 So you have like a higher prevalence of one like
12 might mean that you won't have the other one.
13 And there might be some other complications that
14 weren't necessarily captured in the measure.

15 So this seems to me like it would be
16 like more maybe better suited as a kind of like
17 almost like index of like complications. So
18 that's something that I think would be
19 interesting to address.

20 And also like a little bit in terms of
21 like the risk adjustment, again, there are
22 different patients that have like different risk

1 and there are certainly like high-risk like
2 prostate cancer patients. And then accounting
3 for that, like there didn't seem to be like a way
4 to risk adjust. It seems like that would be
5 important as well.

6 And then finally, this is a very
7 specific set of hospitals. There aren't that
8 many. They are in very specific geographies and
9 it would be interesting to see if like some kind
10 of adjustment was made when the data and then
11 like in terms of the validity of the data to make
12 sure that it pertains like specifically for these
13 specific geographies.

14 And I will turn it over to my fellow
15 discussants.

16 CO-CHAIR UPSHAW TRAUS: Thank you.

17 Frank.

18 MEMBER GHINASSI: Well that was a very
19 thorough set of recommendations. I agree with
20 all of them.

21 Just a couple of small points. I think
22 the concerns around reliability and validity were

1 really well laid out in the comments and they are
2 of concern to me. A lot of this is not clearly
3 specified and it looks like a lot of questions
4 were left in the minds of the individuals who
5 looked at it. I'm assuming that a rigorous NQF
6 process would ferret out that on the basis of
7 scientific acceptability. So I think that's
8 critical for this.

9 The second thing is I was curious. I
10 was curious about the age of 66 and I wondered
11 why that was chosen as the cutoff. And so then I
12 went to the American Cancer Society page and it
13 does turn out that that is the arithmetic mean
14 for onset but that only accounts for, according
15 to the Cancer Society page, at least, it only
16 accounts for six out of ten cases, which means
17 four out of ten happen between 40 and 65. And
18 I'm wondering why the measure would leave out
19 those four out of ten cases by choosing 66.

20 So those were the questions I had. And
21 I agree with the recommendation of the counsel.

22 CO-CHAIR UPSHAW TRAUS: Thank you.

1 Lee.

2 MEMBER FLEISHER: I'll start big
3 picture. I'm totally confused by it's in this
4 program, as opposed to the physician program. So
5 for full disclosure, I am an anesthesiologist to
6 many for many of these cases, more in the past
7 than in the current.

8 But as watching these cases, this is
9 entire -- this is so much more operator-dependent
10 than system-dependent except for two factors.
11 One is did they buy a robot and what generation
12 robot may or may not influence that. And number
13 two, is how young are their surgeons in both
14 extremes. In other words, do they allow a
15 surgeon who is newer at this? They may be better
16 or an older surgeon may be worse. Do they allow
17 them to operate?

18 So there's technology issues which may
19 be something they are talking about and there are
20 surgeon issues.

21 Complications after prostate surgery
22 that are not incontinence and erectile

1 dysfunction I'd say are the systems issues. This
2 is the operator issues. So that's why I got
3 confused.

4 So if you wanted to say in-hospital
5 complication, I, my hospital, the surgeon can
6 take credit. So that's I think an overarching --
7 so good measure; different program. Put it for
8 the surgeons.

9 The second is the number of days. And
10 I find the use of calculating the days out of the
11 year in which somebody experienced this based --
12 did I get it right -- based upon the claims, is a
13 really surveillance-biased assessment. I mean a
14 yes/no of somebody who is having these problems I
15 could be more comfortable with but because they
16 talked about it with one physician who may or may
17 not -- if you have Epic, it's going to carry over
18 to every single encounter, so you're going to get
19 more days than if you are the private doc in the
20 office who is the PMD who might see him one time
21 and mark it down and put it on a code but they
22 might not the next time. So I think that's a

1 very contrived way of assessing.

2 I love days at home. Please change your
3 readmission measures to days at home within 30
4 days so you've got it right conceptually. I've
5 been pushing for that. Yes, methodology but this
6 is, I think, the wrong way.

7 It's a great measure. Change it. Put
8 it in a different program. So I do not support
9 at all for this program. I don't know if there's
10 a way -- it's a different sort of answer.

11 MS. O'ROURKE: I think that that's -- we
12 can capture that all in the report and say that
13 conceptually, the measure is on point and should
14 potentially be put forward for a different
15 program after re-specification to the clinician
16 level of analysis.

17 CO-CHAIR UPSHAW TRAUS: Yes and just as
18 a reminder, that is what our job is today is to
19 say whether or not these measures actually work
20 within these programs. So you know they may be
21 good measures and may have value but should it be
22 in this program?

1 So thank you very much for actually
2 bringing this up, Lee.

3 Sarah had to leave early. She let me
4 know. She apologizes.

5 Karen.

6 MEMBER SHEHADE: Yes, the only other
7 point to add I think around refinement would be
8 to look at the open versus MIS versus robotic as
9 three very separate and distinct procedures with
10 different rates of complications. And being able
11 to cull that out I think is important. To
12 cluster all non-open procedures under one header
13 in the old days may have worked but with almost
14 90 percent now being robotic, it may not make
15 sense. So it would be very interesting to see
16 how those pan out.

17 And I agree with the other comments from
18 the lead discussants.

19 CO-CHAIR UPSHAW TRAUS: Which way would
20 lean on the four voting categories?

21 MEMBER SHEHADE: As recommended by NQF.

22 CO-CHAIR UPSHAW TRAUS: Okay, thank you.

1 Okay, Marisa.

2 MEMBER VALDES: Thank you. So totally
3 out of my element. I never worked in oncology
4 but I haven't read as much about prostate cancer
5 as I did in the last five days.

6 I agree with the NQF assessment. I'm
7 not a statistician. One of the things I like
8 about the methodology is that it works in some
9 scaling that I think it is easier for hospitals
10 to look at. If this were to remain a hospital
11 measure, that is a nice way to look at the
12 methodology, though I'm not a statistician.

13 I don't think this measure, while it's
14 a good measure and obviously this is a very
15 prevalent form of cancer, it doesn't seem to
16 address the gaps in this particular program, as
17 they were on a prior slide.

18 The other thing that I think -- I agree
19 with all the other comments and the only thing I
20 would add is that in this particular type of
21 complication, maybe patient-reported outcomes
22 would be a better way to get at this particular

1 result. So I think the measure developer
2 probably should consider. In a lot of the
3 literature reviews that I did to be ready for
4 today, talk about that particular method of
5 gathering information about these two
6 complications for patients who have partial
7 prostatectomies. So maybe the measure developer
8 can consider that.

9 And I would agree with the NQF
10 recommendations.

11 CO-CHAIR UPSHAW TRAUS: Thank you very
12 much.

13 So we do have with us this afternoon
14 Kristen McNiff, who is in the room. And is Tom
15 going to join us by phone? Tom, are you on the
16 line?

17 MS. O'ROURKE: Operator, could you make
18 sure Tom Ross has an open line?

19 OPERATOR: His line is open.

20 MR. ROSS: Good afternoon.

21 CO-CHAIR UPSHAW TRAUS: Oh, hi, Tom.

22 MR. ROSS: I'm on the line and also

1 Corinna Andiel from Memorial Sloan Kettering,
2 Chair of the Quality Committee has also joined
3 us.

4 CO-CHAIR UPSHAW TRAUS: Okay, wonderful.

5 So, thank you. I'm going to give you
6 all a few minutes, if you'd like, to kind of give
7 an overall response to some of the issues that
8 you've heard. And if for some reason some of
9 them aren't covered, we'll try to bring them back
10 up again.

11 So, thank you.

12 MS. McNIFF: Perfect. Thank you.

13 Again, I'm Kristin McNiff. I'm here today
14 representing the Alliance of Dedicated Cancer
15 Centers, which is a group of the 11 freestanding
16 cancer hospitals that are part of PCHQR. So all
17 of the hospitals that report in are part of the
18 Alliance of Dedicated Cancer Centers and that
19 group sponsored development of this measure.

20 And I will get into more of the details
21 but I want to clarify that this measure was
22 developed not specifically only for use within

1 PCHQR and as such, we used national Medicare data
2 as the data source for this with SEER, which is
3 based on the Federal Cancer Registry Program
4 which is implemented through the states as a
5 testing source and I'll describe why, as we get
6 further into addressing some of your questions.

7 So while we are recommending this for
8 use in PCHQR because we think it's important for
9 discriminating outcomes within our own hospitals,
10 there is nothing that would prevent the use of
11 this measure in any other setting, except that we
12 tested it at the hospital level. So, I'll put
13 that out there.

14 So we think it's important for us but we
15 do not think by extension that it's not important
16 for other providers.

17 So I wish I could go in a logical order
18 but I think I'm going to have to just kind of go
19 backwards from the order of the discussants. And
20 yes, please, keep me honest if I miss anything.

21 So first there was a comment about PRO-
22 based measurement maybe being the ideal source

1 for this measure. We could not agree more. In
2 fact, we are in the midst of a measure-testing
3 project trying to collect this information using
4 PRO-based performance measures. Needless to say,
5 there are two barriers to collecting this via
6 PRO. One is obviously, the workflow and
7 implementation challenges of a PRO-based
8 performance measure we all know well. And then
9 the second -- which are working to address.

10 The second for this measure specifically
11 is that there is a year between the recommended
12 pre-post assessment. So it's a long testing
13 cycle when you have to wait a year even to get
14 your testing data but that is seven, I believe,
15 of our centers currently are working on that
16 measure testing projects. We agree that that is
17 ultimately the best way to do this.

18 In the interim, however, using claims in
19 a novel way to try to look at some of these
20 outcomes we think is the way to get us nearer-
21 term data that are very useful, we think, and
22 bring no burden associated with its collection.

1 So I'll go backward here. Again, there
2 were questions about specifically using the
3 measure for this program and I reiterate that we
4 think it's important for our program but we also
5 have tested it in a way that it should be
6 appropriate for any use in any hospital. Again,
7 we use the Medicare claims as the data source.
8 That's also the reason why age 66 is the cutoff
9 is because Medicare claims is the data source.

10 So there are, obviously, some
11 individuals who are under age 65 who are included
12 in Medicare claims but because they tend to come
13 in because they have ESRD or some other condition
14 that would influence our outcome, we wanted to
15 limit to those who are in Medicare due to age.
16 So that's why we have that cutoff.

17 Absolutely, this could be useful to look
18 at in private payer claims as well but that's not
19 the -- you know obviously that's a different
20 specification and testing project.

21 All right, I think I'll keep going and
22 hope I hit them here.

1 There have been several questions about
2 risk adjustment. In this testing, to be clear,
3 one of the things that was really important to us
4 is that we were able to really validate using
5 claims as a data source. Without going into too
6 many details, for oncology it's very challenging
7 to use claims as a data source because there is
8 such limited information in claims related to the
9 cancer itself, the clinical factors that are
10 important for both the prognosis and treatment.

11 So, in claims, there is no information
12 for prostate cancer, for instance, about the
13 stage of disease. There's no information about
14 the grade. All of these things that really are
15 critical for not only the treatment and prognosis
16 but also related to some of these patient-
17 sensitive outcomes as well.

18 So that's why we used a combined SEER-
19 Medicare data set for the testing. SEER, again,
20 comes from the federally mandated and funded
21 Cancer Registry Program, which is implemented
22 through the states. The SEER program collects a

1 very rich data set of clinical information and
2 the federal government provides SEER-Medicare as
3 a linked data set. It's not very identified,
4 which may get to some of the questions that you
5 have, but allows you really to look at those
6 combined claims and clinical data at the patient
7 level. And as such, we were able to see whether
8 we needed to have clinical richness in order to
9 have a valid measure.

10 So that's why when we were testing we
11 were able to look at things in risk adjustment
12 that really are clinical that aren't usually in
13 claims. If in fact we needed those for risk
14 adjustment, then we would have questioned whether
15 this was a measure that could come from claims
16 alone.

17 It turns out that when we looked at lots
18 of clinically important information for risk
19 adjustment that, actually at the patient level,
20 there were a variety of patient-level factors,
21 covariate, and there were a variety of hospital-
22 level covariates that were -- that did

1 significantly impact outcome but when we tested
2 that at the hospital level, it did not impact.
3 We were very surprised. There actually was no
4 need to risk adjust this measure because the
5 correlation coefficient was 0.96.

6 And that information was all provided.
7 I know it's hard to believe we couldn't -- you
8 know we found it a little challenging but, in
9 fact, that is true that in our data set we did
10 not find the need to risk adjust. So it's not
11 that we didn't test those clinical factors. We
12 did but we didn't need it.

13 I also would like to just make sure that
14 it's clear that we were able, and as part of our
15 validation, we were able to validate that using
16 our claims algorithm alone, that we were able to
17 remove almost of all of the advanced prostate
18 cancer patients which we don't want in this
19 measure but that again you can't identify, just
20 based on one ICD-9 or ICD-10 code. So that's
21 included in the testing documentation that 96 or
22 98 percent of our patients included did in fact

1 have localized prostate cancer. So we didn't
2 have those advanced stage cancer population
3 included at all.

4 And then again, beyond that, we did not
5 find that we needed to include stage, grade, or
6 other clinical factors for risk adjustment.

7 Okay, then we had questions about the
8 types of complications. So in the submission
9 materials we included the whole list of the
10 different complications that we tested. We used
11 the report ICHOM Localized Prostate Report for
12 the basis for most of the source documentation
13 for this measure. And one of the things that we
14 looked at there is the list of all of the patient
15 outcomes that they included as meaningful.

16 We tested all of them that we could
17 capture in claims. Again, there's quite a long
18 list and the vast majority of the claims that we
19 found were for erectile dysfunction and urinary
20 incontinence. So that really was -- including
21 the rest of them got you a very tiny benefit for
22 a lot of codes that needed to be maintained and

1 that's why we limited it to ED and UI.

2 We also looked at claims days and I'm
3 not sure -- I want to just make sure that this is
4 clear. You may like or not like this methodology
5 but we looked at the number of claims days that
6 were billed in that time frame prior to the
7 diagnosis and then we looked at the number of
8 claims days that were billed after. So that's
9 the comparison for the numerator so that a
10 patient is really being compared to him or
11 herself.

12 All right. We did not have information
13 about the age of the surgeon. So that is not
14 something that we were able to look at.

15 And then there were a whole variety of
16 questions about the different types of surgery
17 and then I know it came up in our discussion
18 about a recommendation for stratification. So we
19 did look at open versus non-open. I hear the
20 feedback that we may need to refine that further.

21 The data set that we were looking at was
22 2009 to 2013 because that was the most recent

1 data that was available via using SEER-Medicare
2 as a combined data set. And as this measure
3 moves forward into contemporaneous claims sets,
4 then you could -- I think that's a very good
5 point that we may need to consider breaking it
6 out further.

7 For this measure, again, at the patient
8 level we did see a significant difference between
9 type of surgery. When we looked at the hospital
10 level, that difference went away. But we still
11 think for both face validity and for future kind
12 of acceptance and meaningfulness of this measure,
13 that it would be useful information for the
14 hospitals who are receiving the data to see their
15 data stratified by surgery type.

16 And so we propose that the measure score
17 that would be used for accountability is the
18 overall score so it's not a true stratification
19 both for the purposes of understanding and being
20 able to find meaning in the measure that actually
21 would be reported broken out by open versus not.
22 So it's not true stratification but it is broken

1 up for the reason of meaningfulness, ultimately,
2 at the point of reporting.

3 Did I miss anything?

4 CO-CHAIR UPSHAW TRAUS: I think you did
5 a pretty good job.

6 MS. McNIFF: Thank you.

7 CO-CHAIR UPSHAW TRAUS: Thank you. It's
8 always difficult to listen and take notes at the
9 same time. So thank you for doing such a good
10 job.

11 Before we move into voting, are there
12 other questions, especially after hearing her
13 response in terms of from the developer's
14 perspective?

15 Dan?

16 MEMBER POLLOCK: Yes, thank you for that
17 great response.

18 I may have missed it but how many
19 patients were included in the sample in which you
20 evaluated potential clinical risk factors?

21 MS. McNIFF: So we started out, again,
22 looking at Medicare claims from 2009 to 2013. At

1 the highest level, our patient population were
2 those with at least two ICD-9 diagnosis codes for
3 prostate cancer and they need to be separated by
4 at least 30 days. And we had 347 to 128,000.

5 MEMBER POLLOCK: So those were all the
6 prostate cancer patients that fit the criteria?

7 MS. McNIFF: Yes and once we -- so then
8 we added -- and there's -- I don't know what
9 documentation you all have but there's the flow
10 diagram. Then we looked at those who had
11 prostate surgery. That did bring the overall
12 population down to 25,422. And once we applied,
13 they needed to be 66 and above, survive at least
14 a year, and be continually enrolled in Medicare
15 Fee-for-Service because, of course, we didn't
16 have Medicare Advantage in here. We have 15,545
17 patients included.

18 MEMBER POLLOCK: Thank you.

19 CO-CHAIR UPSHAW TRAUS: Shannon.

20 MEMBER PHILLIPS: Thanks. Can I just
21 ask you to clarify again? I appreciated Lee's
22 comment about the difference between is this

1 really about -- is this a hospital measure or is
2 this a measure at the surgeon level?

3 Can you reflect again on why we think
4 these complications, which are technical in
5 nature, should be accountable at the hospital
6 level?

7 MS. MCNIFF: I think one reason is
8 because you are going to have real problems with
9 small ends once you get down to the surgeon
10 level. I mean, we didn't look at the surgeon
11 level. We looked at the hospital level but even
12 so, once you get -- despite me talking about
13 looking at Medicare claims, once you are
14 attributing patients to an individual hospital,
15 we set a minimum threshold in order to calculate
16 the measure. And at that point, there were --
17 and don't hold me to this number and I can get it
18 for you if you'd like to, but maybe 30 percent of
19 the hospitals dropped off because they didn't
20 even have that number of patients. So then if
21 you imagine applying that to a physician instead
22 --

1 We did look, by the way, at -- I don't
2 want to go into it too much but we looked at was
3 there a difference between higher and lower
4 volume hospitals. And actually, there weren't,
5 which again, was surprising we didn't see a
6 difference based on volumes, though we felt okay
7 about making that distinction of it but I think
8 that's the first challenge is that you wouldn't
9 have sufficient and that for any except the
10 highest volume surgeons.

11 And then the second is we wanted to --
12 we just wanted to recognize the importance of the
13 team. I mean there may be a whole team involved
14 in providing the support and intervention that
15 prevents these from occurring or minimizes their
16 impact.

17 So since we're counting claims days, if
18 you had one of these -- if you had the issue show
19 up but then it's addressed quickly, that is going
20 to count differently in your numerator than if
21 you have it and it extends and it extends. And
22 we feel that's a reflection of that team. You

1 know it's really a team-based approach.

2 CO-CHAIR UPSHAW TRAUS: Frank.

3 MR. ROSS: Yes, I would like to add from
4 somebody who was a cancer quality director for 24
5 years. Lee had asked the same question. And I'm
6 thinking the hospital investment in the
7 technology, the training, the peer review, you
8 know the medical staff review, the cases all feed
9 into creating the environment, providing the
10 equipment, and the feedback that I do think
11 influences to lend itself as a hospital measure.

12 CO-CHAIR UPSHAW TRAUS: Thank you for
13 that and I'm sorry I didn't hear you earlier.

14 Frank.

15 MEMBER GHINASSI: Just a clarification
16 point. And if you've already answered this,
17 don't feel like you have to answer it again. I'm
18 sure they wrote it down.

19 But since it appears there are a number
20 of different procedures that are being looked at,
21 it mentioned open and closed, it mentions
22 robotic, there is generations of robotic devices,

1 et cetera, et cetera, is this measure going to be
2 looking at those separately or are those all
3 going to be lumped into one measure?

4 MS. McNIFF: So we looked at them as one
5 and then we looked at it as open versus closed.
6 And yes, there are a variety of different
7 surgical types that encodes that MAP up to each
8 one of those.

9 Again, since we didn't see hospital-
10 level difference in the data set we were looking
11 at, which is not last year's data set, we
12 recommended that overall measure be reported as
13 one score but then that for informational
14 purposes that you are able to see open versus
15 closed.

16 I again the feedback that there may need
17 to be additional categories there to be maximally
18 meaningful is important.

19 MEMBER GHINASSI: Yes, the reason I am
20 asking is the purpose of these measures is to
21 increase the likelihood of -- or reduce the
22 likelihood of negative. And so you're wanting

1 this to be actionable.

2 MS. McNIFF: Yes.

3 MEMBER GHINASSI: And if I look at a
4 number that has four, or five, or six procedures
5 in it, I'm not sure I know what to fix.

6 CO-CHAIR UPSHAW TRAUS: Lee.

7 MEMBER FLEISHER: I appreciate it,
8 Michelle, and the CMS team so that I can get some
9 clarity.

10 So if I were to say whether or not Sloan
11 is a good place to go versus I should go to
12 Texas, et cetera, part of that is going to be end
13 up follow-up is how far I'm going to travel. So
14 that's an interesting question about follow-up,
15 which is a further complicating.

16 And I agree that it's the group and it
17 may not be the physician but it's the physician
18 group but if I want to see if Sloan is a good
19 hospital and there is a great surgeon who moved
20 from one hospital to another, that's what's
21 driving this. And maybe it's you have more money
22 to recruit, maybe you don't, but I'm still -- I

1 agree with the N and the value of a group of
2 surgeons. I'm still not sure, if CMS is looking
3 to measure cancer hospitals, if this is the right
4 measure to assess whether cancer hospitals are
5 doing a good job.

6 So what are your goals from the CMS to
7 put it into this program? Yes, I don't know if
8 I'm totally clear but I'm fine with rolling it up
9 as a group.

10 DR. SCHREIBER: So I'll give you an
11 opinion. First, as we've heard, it was developed
12 by the cancer hospitals because this was
13 something that they felt was important. And my
14 personal answer to your question is it's bull.

15 So I think to use it within the cancer
16 hospitals, frankly, to perhaps use it in all
17 hospitals is not unrealistic because hospitals do
18 have some responsibility for this, for their OR
19 staff, for their training, for their training
20 around the da Vinci robots, for their training
21 around their house officers, quite honestly who
22 are doing this. I think there are hospital

1 elements that are very real that play into
2 supporting this being a hospital measure.

3 Do I also think that something like this
4 could be a physician-based measure? Yes, I do
5 but I don't think that necessarily negates it
6 being a hospital measure.

7 CO-CHAIR UPSHAW TRAUS: Thank you for
8 that.

9 Andreea.

10 MEMBER BALAN-COHEN: I was also going to
11 make a plug for having this like perhaps even
12 like in both programs. So certainly I see the
13 appeal of having this like at a physician group
14 level but from the hospital point of view, I
15 think there are like two arguments that have been
16 made. So one is the one that you just mentioned
17 like even for the specific cancer hospitals
18 provide transportation. Maybe not everybody has
19 like specific access to certain types of
20 hospitals. That's one. And also maybe they
21 don't have access to specific physicians and,
22 therefore, having the choice be made at the

1 hospital level would be a little bit easier.

2 There is also a lot of evidence there is
3 more visibility patients than to choose like
4 hospitals first and sometimes like physicians
5 like afterwards, especially for some types of
6 group of patients. Where again, like having some
7 accountability at the hospital level I think
8 would be very helpful.

9 The other point there I was going to
10 make is that also making hospitals accountable
11 might drive some of these investments. Like I'm
12 sensitive to the point that was made earlier
13 about how maybe it's all moving towards let's
14 like say toward robotic surgery. So maybe all
15 hospitals should be investing in certain types of
16 surgeries and maybe if there is enough evidence
17 that the results really are better for certain
18 types of procedures, then if you see hospitals
19 that are doing better, you are going to try to
20 find out why and make this specific investment.
21 So I think that's an argument in favor of having
22 this at the hospital level.

1 The other comment I was going to make is
2 about risk adjustment. So one thing that I noted
3 in your comments was about there is a difference
4 at the patient level like in terms of the risk
5 adjustment but not at the hospital level.

6 One thought I had about that one is that
7 it might be driven by selection within hospitals.
8 Maybe certain types of patients are going to
9 specific hospitals and maybe that's why you see
10 some of those effects wash away. It doesn't mean
11 it's not important. Just something to look into.

12 CO-CHAIR UPSHAW TRAUS: Thank you.

13 Lisa.

14 MEMBER MCGIFFERT: I just want to
15 reiterate what an important measure this is and
16 to pick up, I can't remember who said it, but the
17 importance of having a patient-reported outcome
18 measure on this and would encourage the
19 developers to create one of those measures to go
20 along with this one. It is probably the number
21 one thing that is feared and experienced by
22 people going through these procedures that really

1 changes their lives.

2 So I think that it's really important.
3 I agree that it does have something to do with
4 the hospital and how the hospital does it
5 business but I also would support a physician-
6 level measure, too. Thanks.

7 CO-CHAIR UPSHAW TRAUS: Anne Marie.

8 MEMBER SULLIVAN: Just to add to that,
9 I think it's so important as a patient outcome
10 but also as gone over time. And I think that
11 that's very interesting. I think a lot of our
12 measure don't go out that far. Maybe people say
13 it should be more than a year but I think by
14 going to a year, you're getting information you
15 wouldn't get like at two months, or just
16 infection rates, or just initial impressions of
17 what's happening post-surgery.

18 So I think that's something important to
19 keep in mind in measures generally that if you're
20 looking -- even if the surgery occurred or the
21 incident, or the hospitalization occurred at a
22 point in time, what are the long-lasting effects

1 of that? And I think this measure really begins
2 to get into that world of functionality post, not
3 just a few months but actually a year, which I
4 think is really valuable.

5 And then just to say on the issue of
6 hospital versus I think that's a tough one. You
7 know I could say the same thing about caesarians.
8 I could say you know that the doctors -- there
9 are doctors who do lots of caesarians and there's
10 doctors who do very few. You know I think almost
11 every procedure, when you're talking about that
12 with surgeons, there's a differential to what
13 surgeons do. And then there's things that happen
14 in the hospital that contribute to the bad
15 effects.

16 So I think it's good to measure the
17 hospital system, too, because I think that that's
18 where the quality sits and that's where people
19 make their choices about -- you know systems make
20 their choices about what procedures they are
21 going to kind of really have happen or not and
22 who they are going to hire to do things. So I

1 think it's an important hospital measure.

2 But I really like the fact that this one
3 went out over time. I think that that's really
4 good.

5 CO-CHAIR UPSHAW TRAUS: Okay. I think
6 everybody with a card up has already spoken. So
7 trying to bring this, I think, to a point now
8 where it's probably time to vote.

9 We'll start where we did before, which
10 was the staff recommendation, which was do not
11 support for rulemaking with potential for
12 mitigation.

13 We certainly heard a lot from our lead
14 discussants as supporting the staff
15 recommendation. I think we had one that felt
16 like perhaps this wasn't the right program for
17 that but I think we have had a discussion around
18 that. So clearly thinking about how you want to
19 vote personally, hopefully you found that
20 helpful.

21 So if we want to start with the vote,
22 that would be great.

1 MS. QUINNONEZ: Thank you.

2 So we will now be voting for MUC2018-
3 150. And the questions reads: Do you vote to
4 support the preliminary analysis as the workgroup
5 recommendation, and that is the recommendation of
6 do not support for rulemaking with potential for
7 mitigation?

8 Option A is yes and option B is no. You
9 may enter your votes.

10 Okay, so I will close voting at this
11 time.

12 And the results are 87 percent of
13 individuals agreed yes and 13 percent of
14 individuals voted no. And I will give you a
15 specific count for that. So that is 20
16 individuals who voted yes and three individuals
17 who voted no.

18 CO-CHAIR UPSHAW TRAUS: Okay, that
19 concludes our individual measure work. I want to
20 thank everybody. I think it was very thoughtful.
21 We do owe back after this meeting some feedback
22 on the process that was used. Personally, I

1 thought it was great and much easier than what we
2 tried to navigate last year, in terms of our
3 voting.

4 So I want to thank the team, and the
5 coordinating committee, and whoever else was part
6 of that.

7 MEMBER MCGIFFERT: Cristie, before we
8 move on, on this measure, there was a lot of
9 discussion --

10 CO-CHAIR UPSHAW TRAUS: Oh, I'm sorry.
11 Thank you for that.

12 MEMBER MCGIFFERT: -- of the major
13 issues and I think while I won't repeat all of
14 them for today, I think there was a robust
15 response from the developer and CMS on this. So
16 we'll make sure to include both the committee
17 discussion and the developer responses to this
18 and make sure that that's relayed to the
19 Coordinating Committee.

20 Because it wasn't, interestingly in this
21 discussion, which was very rich, it wasn't that
22 these were issues that weren't considered. They

1 were considered and there may be a difference of
2 opinion among how the workgroup considered them
3 vis-a-vis the developer.

4 CO-CHAIR UPSHAW TRAUS: Thank you.
5 Thank you for that. I appreciate your support in
6 getting that documented as we move forward.

7 So I think what we want to do at this
8 point is we've got two things left to do. We do
9 have a public -- actually three -- a public
10 comment period, summarizing what the next steps
11 are relative to our work on the measures here,
12 and then we want to circle back on the opioid
13 discussion that we delayed until the end of the
14 meeting. I think it's probably best to do it in
15 that order so that we can kind of close out the
16 measure consideration.

17 So I am going to open this up for public
18 comment and would like to see if there's any
19 public comment in the room. None? We used to
20 actually, every now and then, have a little bit.

21 So, Operator, could you see if there's
22 any public comment on the phone, please?

1 OPERATOR: Yes, ma'am.

2 At this time, if you would like to make
3 a comment, please press * then the number 1.

4 And there are no public comments at this
5 time.

6 CO-CHAIR UPSHAW TRAUS: Thank you.

7 I'm going to ask Desi to kind of go
8 through the next steps. We will have one last
9 final opportunity at the end, after our opioid,
10 to be sure we get our thanks in and everything
11 but if you could go through the next steps, at
12 least in terms of the measures.

13 MS. QUINNONEZ: Thank you, Cristie.

14 So the slide that you see before you is
15 just a high-level update of what's going to be to
16 come. So it's not only for hospital but also for
17 PAC/LTC, as well as the Clinician Workgroup. So
18 you'll be able to see things that you can look
19 forward to as we move on.

20 And just to keep this impressed in your
21 mind, PAC had their workgroup meeting yesterday.
22 It was successful. We have almost concluded our

1 Hospital Workgroup meeting. And tomorrow the
2 Clinician Workgroup will be meeting.

3 And just to give you a heads up, in
4 January, so that you can keep this on your
5 calendar, the 22nd and 23rd will be the
6 Coordinating Committee meeting.

7 And we will also have to look forward to
8 our public commenting period, the second one, and
9 that's going to be, again, on December 21st and
10 it will end on January the 10th.

11 All right, so at this time, I just want
12 to say thank you to Cristie and Ron, our
13 wonderful co-chairs. Thank you for all of our
14 workgroup members, and CMS, and all of the
15 developers that have come out and joined us
16 today.

17 And do you want to pause here now to see
18 if you all have anything else to say or do you
19 want to wait for public comment?

20 CO-CHAIR UPSHAW TRAUS: Yes, we're going
21 to go back to the pain but --

22 CHAIR WALTERS: Just feel free to let us

1 know or maybe next year we won't have to make any
2 more process changes. Next year might be the
3 first year where we keep the prior year.

4 CO-CHAIR UPSHAW TRAUS: Since we're
5 usually the one that finds the fault with the
6 process, I think that maybe this is true.

7 CHAIR WALTERS: No, let us know if there
8 is anything that you didn't like or want to see
9 improved upon.

10 CO-CHAIR UPSHAW TRAUS: And of course I
11 would be remiss if I didn't thank the staff for
12 all their hard work on the measures, themselves,
13 and getting us to a place where we have the
14 resources we need at our fingertips to actually
15 be ready and prepared for our meetings. So thank
16 you all for that.

17 Okay, I'm going to turn it back over to
18 Michelle for our final presentation.

19 MEMBER WISHAM: So thank you. I know
20 that we've completed the work of looking at the
21 measures and people may have flights and escape
22 early but we did want to take the opportunity to

1 seek feedback from this committee on what we
2 think is now a gap measure, quite honestly, and
3 that's around pain and pain assessment.

4 So there's a slide here, if we can pull
5 it up, please.

6 All of you, obviously, know that we've
7 removed the pain questions from HCAPHS because of
8 the concern of the unintended consequences with
9 giving patients opioids and, frankly, leading to
10 an opioid epidemic. And we are considering
11 alternative questions regarding pain to replace
12 these, recognizing absolute importance of pain
13 control to patients.

14 But the question really is before the
15 group components under consideration include
16 addressing sort of a multifaceted approach to
17 pain management because it's obviously not just
18 giving opioids for pain but there are multiple
19 modalities for pain management and a focus on the
20 overall pain management.

21 We'd like to know what other areas CMS
22 should consider or what suggestions and ideas you

1 have. And I do recognize this probably could go
2 on for days and so we'll ask you know to keep us
3 honest with time but we would like feedback
4 really from the group here.

5 CO-CHAIR UPSHAW TRAUS: Okay, are you
6 doing this or me?

7 CHAIR WALTERS: Lee.

8 MEMBER FLEISHER: I'm the
9 anesthesiologist in the room.

10 So it's been very interesting watching
11 what's been happening and, again, we've actually
12 been interviewing patients, a kidney donor and
13 what has happened is they actually are stopping
14 using pain management until post-op day number
15 one because of the opioid crisis. And then when
16 they finally get their relief, they're saying I
17 was really stupid or something to that effect.
18 But they recognize that we're in a difficult
19 situation here.

20 So trying to figure out a balancing
21 measure is going to be really important.

22 The other issue because of my interest

1 of why I'm coming down next month is the delirium
2 issue in hospitalized patients. So what we're
3 doing is we're using multimodal analgesia, things
4 like gabapentin, ketamine, all kinds of other
5 drugs which, in the elderly is actually
6 increasing the risk of delirium. In particular
7 ketamine, so that's in my space, increases
8 hallucinations and nightmares, in a large-scale
9 randomized trial.

10 So I think as you go into this space for
11 the hospital, since we are the Hospital
12 Workgroup, I think you should look at delirium
13 and you should look at -- and the hard thing is
14 getting to patient-reported outcomes. The
15 patients are getting -- are not understanding.
16 In fact, we are selling opiate-free care and that
17 may actually be worse than opiate-sparing care.

18 So I think the right question is did we
19 meet your expectations, which really gets to are
20 hospitals correctly setting their expectations
21 for pain management, not was your pain well-
22 managed. So I think that's a huge differentiator

1 that is really getting to all of Lisa's comments
2 about if you want a prom, it's about expectations
3 and then you get both sides of the equation.

4 CHAIR WALTERS: Sean.

5 MEMBER MORRISON: So three quick
6 comments. The first is the importance of
7 language. And there are absolutely no data that
8 hospital prescribing of opioids for pain have
9 been associated with quote, unquote, the opioid
10 epidemic in this country. And it's very
11 important that that language be A) corrected; and
12 B) CMS does not continue to propagate that
13 because there are absolutely no data on that.

14 And in fact, there are very few data but
15 what we're seeing is you know the unintended
16 consequences of that. So that's number one.

17 Number two is the original CMS pain
18 measures actually did not have anything to do
19 with opioids. There was no recommendation in
20 those measures that the appropriate treatment of
21 pain was opioids. That was an interpretation by
22 physicians but there was absolutely nothing --

1 it's the same as the CDC guidelines that
2 everybody is criticizing. The CDC guidelines say
3 that there is absolutely no reason not to
4 prescribe opioids for people with serious
5 illness, cancer, pain, or who need it.

6 So I think, again, with language in
7 terms of new measures to treat pain, we should be
8 focusing on pain. And linking that to saying oh,
9 these measures led to inappropriate opioid
10 prescribing was a response to hysteria, and a
11 reason to make policy changes, and a quick fix.

12 So again, the second piece around that
13 is language.

14 And the third piece, again, is what is
15 the problem you are trying to fix? If the
16 problem is untreated pain in hospitalized
17 patients, which is what our workgroup is, and we
18 know that untreated pain in hospitalized patients
19 leads to, particularly post-surgery, the
20 development of chronic pain syndromes, it leads
21 to increased sympathetic stress, then A) we
22 should be measuring pain; B) we should be

1 focusing on how it is treated appropriately,
2 rather than simply on the number that it goes
3 down to.

4 So I would encourage CMS not only to
5 begin to reassess pain because it is an important
6 quality measure but with doing that focusing are
7 appropriate treatments being implemented.

8 And certainly, as Lee said, what we're
9 seeing now is we're seeing the unintended
10 consequences of that, in terms of high incidence
11 of delirium, which has adverse consequences,
12 certainly the high probability of chronic pain
13 syndromes in the setting of absolutely no data
14 that hospital prescribing has led to the problems
15 we're seeing with opioids in this country.

16 CHAIR WALTERS: Shannon.

17 MEMBER PHILLIPS: The comments of both
18 were wonderful.

19 I reflect on yes, we need to treat pain
20 and I think Sean's described the unintended
21 consequences of that. I also wonder -- I think
22 the discussions that have happened with the

1 removal of the measure and the focus on the
2 opioid crisis has been really good at our
3 institution. And I wonder if we ought to be
4 focused with patients on did we set good
5 expectations. We need to manage the pain when
6 it's there but maybe getting a little upstream.
7 And were you offered, whether in addition to or
8 singularly, other ways to manage and control your
9 pain in the hospital so that that is encouraging
10 the wave of there's -- you know it's multimodal.
11 It's not simply the drug or the right choice of
12 category of drug but did we present you with what
13 might work for you in your value system and meet
14 you where you are?

15 So those sorts of things come to mind in
16 the discussion but I appreciate the other
17 comments so far.

18 CHAIR WALTERS: Jack.

19 MEMBER JORDAN: I think there's another
20 group that all of us across the country I think
21 really tried to change our practice with the
22 opioid-naive person coming for a procedure and

1 such and have made see change, things that are
2 kind of -- but there are the people who already
3 have addiction problems that are there and I
4 think there is a lot of room for us on a large
5 scale to kind of think through doing that better,
6 you know to have more people that are effectively
7 know how to wean patients.

8 So I think there are room -- well, that
9 goes kind of outside the hospital to more of an
10 outpatient setting but I think that's the next
11 wave of opportunity for us to improve in this.
12 So you know I really want to encourage CMS to
13 really thinking about how they can support that
14 effort because I don't think we have the right
15 people out there. You know the poor primary care
16 docs kind of getting this thrown on their back
17 and in many cases there really aren't adequate
18 kind of addiction specialists to help out with
19 this.

20 So I mean it's going to be suboptimal
21 but I think we can do better than what we're
22 doing and I think CMS helping with that would be

1 really important.

2 CHAIR WALTERS: Nancy.

3 MEMBER FOSTER: So I want to second what
4 everybody has said and particularly, Jack,
5 picking up on your point, this is obviously a
6 very complex problem with a lot of different
7 steps that need to resolve it -- need to happen
8 to resolve it.

9 Maybe the part of the problem is when
10 CMS incorporates a measure into a program,
11 particularly a payment program. It suddenly
12 takes on more emphasis than maybe you intended.
13 And so it may not be the ideal time to be
14 thinking in terms of a measure yet, other than I
15 think the patient expectation measure that Lee
16 and others have been talking about makes sense so
17 we all know are we getting it right. And once we
18 know we're getting it right, then the question of
19 well what did we do to get it right and how do we
20 measure that becomes natural.

21 And otherwise, I think there's a --
22 because we're a walking a thin line here between

1 managing pain and creating an ugly problem. And
2 hospitals, other settings of care, docs are all
3 struggling with that right now.

4 And Sean, I will disagree with you
5 somewhat here. Hospitals today are not just the
6 inpatient setting by far and we have a lot of
7 opportunity to be better stewards of opioids and
8 many, many are working on that. Jack shared some
9 information with me a little while ago. There
10 are just some great things going on to be better
11 stewards and we need to learn from all of that
12 and make that happen at the same time we're
13 managing pain. Good luck.

14 CHAIR WALTERS: Marty.

15 MEMBER HATLIE: I want to just pile on
16 to the comments already made to say this, to make
17 this point. I mean whether it's monotonic
18 consequences, language, different kinds of
19 patients, I mean I'm involved in the Transforming
20 Clinical Practice Initiative, which is ambulatory
21 and we find patients there who are not prone to
22 addiction or don't have substance use issues but

1 are having a hard time getting off of really
2 powerful pain killers that they needed for a
3 reason.

4 So there are different kinds of patients
5 and it underscores for me the importance of
6 bringing patient and family engagement into the
7 measurement development process, just to make
8 sure that those inputs are there, especially on
9 an issue like this, which is really complex and
10 really would benefit from that.

11 And one of the exciting things about the
12 Meaningful Measures Project is that they are
13 doing that. I mean there is just much more
14 emphasis on PFE across CMS programs but I think
15 especially the measurement area. It's exciting
16 to see.

17 And I have a suggestion, actually, that
18 might be our last 15 minutes but I'd like to see
19 more in the analysis that we get as MAP members
20 of the level of person and family engagement that
21 went into the measurement development that we
22 consider. I don't ever see that really reflected

1 in the analysis. CMS has mentioned it several
2 times today. The panels they have taken this to
3 and the input they've gotten is a valuable input
4 but it would help me I think give me another
5 dimension on the measurement development process
6 that we're seeing.

7 So thank you.

8 CHAIR WALTERS: Maryellen -- oh, is that
9 Ann Marie?

10 MEMBER SULLIVAN: I'd just like to say
11 that I agree a lot with what Marty just said.

12 I think that you know if you're going to
13 do some personalized care, this is probably the
14 area where you really need to pay attention to
15 that. We need to talk to patients about what
16 pain means to them, what they're afraid of when
17 they leave the hospital.

18 I agree by and large I don't think the
19 use of it after an acute episode in the hospital
20 has caused the opioid epidemic but at discharge,
21 when you're sending people home with
22 prescriptions, and you're telling them how to use

1 the medication, and why to use the medication,
2 that's where you really have -- and it takes time
3 to talk to people about this. You just don't
4 hand them a bottle of pills and say when you have
5 pain, try this.

6 So I think you've really got to talk to
7 the individual what it means to them. Do they
8 have an addiction history of any sort? It makes
9 them probably more likely, even if they are not
10 addicted right now to get addicted if you give
11 them the wrong thing.

12 You have to have these discussions I
13 think in detail. Think about the ramifications
14 of what is happening and then be very cautious
15 about what you give at discharge, while
16 recognizing that people can be in a lot of pain.

17 You know and I think there is still an
18 ease with which it is given at discharge. I just
19 know from personal experience and friends who
20 have been in the hospital that if they think
21 you're not likely, you get kind of a pretty big
22 prescription for these pain meds without a lot of

1 discussion about what -- how else maybe you can
2 deal with it.

3 So I'm just saying real personalized
4 care around this, talking with people, offering
5 them other options if they're reluctant or
6 scared. But if they have a low threshold for
7 pain, maybe they do need them but they need to
8 know how to use them. And maybe you need to
9 check in on them, not say here's something for a
10 month but maybe in a week you call and say how
11 many of these have you been taking and that kind
12 of thing. Give them the smaller prescription but
13 then give it to them if they need it.

14 So I think the devil is in the detail of
15 this and I think we just have to pay a lot more
16 attention to how we're prescribing than we have
17 in the past.

18 CHAIR WALTERS: Lisa.

19 MEMBER McGIFFERT: Well, I support a lot
20 of what has been said and I do think bringing in
21 people -- patients into the discussion is really
22 important. And I would suggest you know

1 narrowing that even further with people with
2 chronic pain.

3 A lot of the people I have worked with
4 who have chronic pain have it due to a medical
5 implant, for example, that is in their bodies and
6 they can't get out. So I think that it's
7 important to bring them in.

8 The other things that the group of
9 patients that I talk to regularly have talked
10 about is that some people are being given more
11 invasive treatments as an alternative that can be
12 more damaging. And also just generally, that
13 there needs to be more exploration of other ways
14 to manage pain, that the drug is a quick fix, and
15 our system is pretty keen on quick fixes and it
16 takes care of the problem.

17 So I think exploring other ways to
18 handle pain is a really important issue and I
19 think it would be a really interesting measure
20 about discharge instructions and things like
21 that. And boy, we need to include dentists. I
22 just I had a couple teeth pulled and I was sent

1 home with enough opioids to last me for months
2 and that should never happen.

3 CHAIR WALTERS: Lindsey.

4 DR. SCHREIBER: Obviously, all of the
5 comments about patient-centered care ring true
6 and I think just for future consideration I want
7 to bring up that I word, which is
8 interoperability and the fact that pain does not
9 know a specific care setting. And if we're truly
10 looking at person and patient-centered measures
11 around pain, it carries from setting to setting.

12 So again, as we're looking at
13 development of new measures, I think this would
14 be a perfect opportunity to truly try to develop
15 a measure that, again, maybe it has to be tested
16 across all care settings, but something that can
17 be transferrable because that pain travels with
18 the patient, as they go along their journey.

19 CHAIR WALTERS: Dan.

20 MEMBER POLLOCK: Clearly, this is a very
21 complex problem. No single measure really is
22 going to capture all of it so I think it's better

1 to try to conceptualize this from a number of
2 different perspectives.

3 And it may be helpful to just perhaps
4 place it in context and refer to overuse of
5 antibiotics, where there's some real
6 comparability here, and in fact there is some
7 suggestive data geographically that in many of
8 the locations around the country where
9 antibiotics are seemingly overused, there is also
10 overuse of opioids.

11 To that effect, stewardship, to use the
12 word Nancy used, is really important and
13 underdeveloped. And measuring stewardship I
14 think is another dimension to all of this.
15 Measuring and providing metrics for opioid
16 prescriptions, including at the point of
17 discharges Ann mentioned. In fact that is one of
18 the major stewardship targets in antimicrobial
19 use now is patients leaving the hospital with
20 extended courses of antibiotics for which there
21 isn't a compelling use.

22 So I would say both the antimicrobial

1 overuse problem and the opioid overuse problem in
2 the therapeutic context, or the multifaceted
3 attention that includes measures of the
4 indication for use, includes measure of the
5 infectious disease burden, or the pain burden,
6 but also these other dimensions of what's being
7 done to marshal resources more successfully,
8 what's being done to measure and provide feedback
9 on the extent to which those resources are being
10 deployed, particularly at critical milestones in
11 episodes of care.

12 CHAIR WALTERS: Andreea.

13 MEMBER BALAN-COHEN: So piling on the
14 comment it seems to me that this is one situation
15 where like maybe an outcome measure might not be
16 ideal. Like here's where the goal, per se,
17 although it's important as we all recognize, it's
18 more like the unintended consequences of all of
19 the affecting factors and that's why you need
20 like a series of like process measures.

21 So not reducing the level of pain but
22 how do you get there? And you know like are you

1 doing it for specific patients, in which context,
2 and for how long. And you know like how many
3 measures were taken? And I would say like that
4 in particular, like maybe with a goal to
5 incentivize like other different types of measure
6 for reducing pain, again, like for certain
7 specific types of patients was like physical
8 therapy or whatever is appropriate tried first,
9 or maybe a couple of other of these other options
10 as well.

11 And certainly also the importance of
12 care coordination and like extending it like
13 beyond the acute setting.

14 CHAIR WALTERS: Frank.

15 MEMBER McGIFFERT: Just echoing some of
16 this but just a small additional point. If you
17 do in fact move forward with this, I would
18 recommend you consider involving behavioral
19 specialists in this as well.

20 I think a great example is when you're
21 working with somebody who has a severe anxiety
22 disorder. If as part of your treatment

1 anxiolytics are involved and that's not cast as
2 one step in a very different treatment plan, and
3 that the anxiolytics are put in the context of
4 the eventual goal, which is a behavioral
5 management of the cognitions and behaviors, but
6 feed that anxiety, there is an enormous
7 difference between patients who are given
8 anxiolytics without that as opposed to ones who
9 are. It's more work but I think the output is
10 much better.

11 And I think that if you're going to be
12 looking at something, I would recommend
13 technologies around motivational enhancement, MI
14 work, and stages of change models that are part
15 of a conversation and measure that, it's labor
16 but I think it's labor that bears the kind of
17 fruit that you're looking at there.

18 CHAIR WALTERS: Sean.

19 MEMBER MORRISON: I'm sorry but I didn't
20 want to let this go because I have been deeply
21 involved in this multiple times and actually was
22 at a National Academy of Medicine workshop last -

1 - two weeks ago. But Dan's comment about
2 equating this to antibiotic overuse is one that I
3 actually hadn't heard before and is one that I
4 would very strongly encourage us to think about.
5 I mean at least the data that about 15,000 people
6 die of prescription opioid-related deaths in this
7 country every year, about 25,000 die of resistant
8 antimicrobial infections.

9 And somehow, you know the opioid quote
10 unquote epidemic has sort of eclipsed that but I
11 think these are two issues that we should be
12 thinking about very similarly because they are
13 both around probably inappropriate prescribing in
14 the setting of serious medical issues. And I
15 don't think any of us would say that we shouldn't
16 be drawing blood cultures or checking urine
17 cultures because we wouldn't want to be
18 prescribing antibiotics if we found those. And
19 if you take the analogy to control of pain, what
20 we're saying is we shouldn't be assessing or
21 measuring pain because we might prescribe an
22 opioid if we found it.

1 And they are both, you know when you
2 look at the mortality rates, they are both about
3 the same.

4 CHAIR WALTERS: More blood pressure,
5 anything else?

6 Maryellen, close us out.

7 MEMBER GUINAN: Oh, no, I didn't want
8 you to make me have the last word. So someone
9 else say something eloquent afterwards.

10 I think coming from the Essential
11 Hospitals or the Safety Net, and I tip my hat to
12 Michelle at Henry Ford and whatnot, but we very
13 much deal with a patient population and the
14 opioid epidemic is one that we're facing day-to-
15 day in our hospitals and in various amount of
16 ways.

17 And so I think kind of what I have heard
18 here and what we've heard consistently is there
19 is somewhat of a misalignment of incentives. And
20 I know Nancy touched on it briefly in terms of
21 tying payment to patient experience, tying
22 payment to pain management, insofar as measures

1 being put into payment programs, puts physicians
2 in a somewhat difficult position in terms of
3 where they're focus lies or kind of redirecting
4 where their focus should be. And really what we
5 want to do is incent the use of proper
6 prescribing guidelines and that's very much along
7 the lines of the AMR world and kind of where
8 stewardship has gone. And so I definitely fully
9 support that.

10 And I think the general kind of takeaway
11 that I at least gain from this is flexibility
12 being key in terms of allowing the provider to
13 kind of meet the patient population where they
14 are in terms of in the hospital who they treat in
15 the best way possible.

16 So for folks in our membership that have
17 offices of opioid safety, they do things in
18 various ways in terms of prescribing patterns or
19 having dashboards for their physicians to see how
20 they prescribe. Others offer up the non-opioid
21 treatment alternatives and that's a whole
22 separate conversation in terms of cost that needs

1 to be kind of directed towards those non-opioid
2 treatments.

3 But I think the key takeaway there is
4 just the flexibility to not box people in to
5 directing their program or their improvement
6 activities towards a specific measure and
7 allowing flexibility to kind of develop programs
8 where they see is going to have the most
9 meaningful impact on their patient population.

10 So, thank you.

11 CHAIR WALTERS: Thank you. I agree.
12 This might be the biggest issue diagram you've
13 ever seen in your life but people need to be --
14 we need to relieve pain. We need to relieve it
15 appropriately. Don't back down from making
16 people not suffer.

17 And all the points that are made are
18 very appropriate. It's a huge system thing.

19 CO-CHAIR UPSHAW TRAUS: There's been a
20 lot of discussion about having measure sets and
21 measuring systems and you know not thinking about
22 this, as someone mentioned earlier, about a

1 particular setting of care. This may be -- well,
2 actually somebody -- and I'm really just
3 repeating what somebody else said now that I
4 realize it. This really maybe the opportunity to
5 look at that you know where we can look at the
6 issue, regardless of where the patient is and
7 think about it as a measure set and we're
8 measuring a system, which is pain management,
9 that goes across all settings.

10 I know that NQF has done some work
11 around opioid stewardship. So I'm not an expert
12 on that document but I would certainly anticipate
13 that there could be value in there. It was
14 really done right after the antibiotic
15 stewardship document and some work around that.

16 But the other thing is there is a lot,
17 as you all know, there is so much work being done
18 at the state level that is around this and a lot
19 of it regulatory, a lot of it still struggling to
20 figure out what to do within those states that
21 have particular issues relative to opioid abuse.

22 And I think thinking through how CMS

1 could potentially amplify some of the work that
2 is being done at the state level to think about
3 what are some of the best practices that states
4 are identifying that you could bring into your
5 programs so that there could be alignment because
6 the states are addressing this. Whether or not
7 it is effective, I don't know but they are having
8 to deal with it.

9 CHAIR WALTERS: Well, thank you,
10 everyone, for showing up and providing input.
11 And we got 15 minutes back.

12 DR. SCHREIBER: Ron, can I second the
13 thanks?

14 I'd just like to thank everybody, also,
15 first of all for the feedback on all of the pain
16 discussion that we had and for the really very
17 important feedback that you provided us on all of
18 the measures. It really is taken seriously. It
19 does impact rulemaking and we really appreciate
20 kind of the struggles that everybody went through
21 trying to decide what are the right votes, what
22 are the right categories but it's really the

1 discussion that is so meaningful.

2 So thank you to each and every one of
3 you and certainly to our co-chairs and, again, to
4 NQF. Thank you.

5 MS. O'ROURKE: I just want to jump in on
6 the thank you. Thank you to all of the workgroup
7 members for your very insightful conversation
8 today. We really appreciate you making the time.
9 Also to our CMS colleagues for all your help in
10 planning and support, to the measure developers
11 for joining and providing such essential input,
12 and especially to our co-chairs, Ron and Cristie,
13 for all your guidance and leadership. We
14 appreciate you getting us through this very
15 packed agenda, even though we only had four
16 measures --

17 CO-CHAIR UPSHAW TRAUS: It was painless.

18 MS. O'ROURKE: -- and all of your
19 leadership and prep with us ahead of time.

20 Especially, thank you to the Hospital
21 Workgroup Team for all of their hard work.

22 So we can let everyone go and please

1 keep your eye out for the draft recommendations
2 that will be out for public comment. And the
3 Coordinating Committee will meet to finalize
4 everything January 22nd and 23rd.

5 (Whereupon, the above-entitled matter
6 went off the record at 2:44 p.m.)
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C E R T I F I C A T E

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Before: NQF

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