

NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP  
HOSPITAL WORKGROUP

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THURSDAY  
DECEMBER 17, 2015

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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 8:30 a.m., Cristie Upshaw Travis and Ronald S. Walters, Co-Chairs, presiding.

PRESENT:

CRISTIE UPSHAW TRAVIS, MSHHA, Co-Chair

RONALD S. WALTERS, MD, MBA, MHA, MS, Co-Chair

RICHARD BANKOWITZ, MD, MBA, FACP, Premier, Inc.

ANDREA BENIN, MD, Children's Hospital  
Association

DAVID ENGLER, PhD, America's Essential Hospitals

NANCY FOSTER, American Hospital Association

SHELLEY FULD NASSO, National Coalition for  
Cancer Survivorship

HELEN HASKELL, MA, Mothers Against Medical Error

MARTIN HATLIE, JD, Project Patient Care

JEFF JACOBS, MD, The Society of Thoracic  
Surgeons

HEATHER LEWIS, RN, Geisinger Health System

SHEKHAR MEHTA, PharmD, MS, Pharmacy Quality  
Alliance

ALLEN NISSENSON, MD, FACP, FASN, FNKF, Kidney  
Care Partners

KAREN ROTH, RN, MBA, CPA, St. Louis Area  
Business Health Coalition

LESLIE SCHULTZ, PhD, Premier, Inc.

BROCK SLABACH, MPH, FACHE, National Rural Health  
Association

DONNA SLOSBURG, BSN, LHRM, CASC, ASC Quality  
Collaboration  
KELLY TRAUTNER, AFT Nurses and Health  
Professionals  
WEI YING, MD, MS, MBA, Blue Cross Blue Shield of  
Massachusetts

INDIVIDUAL SUBJECT MATTER EXPERTS (Voting):

GREGORY ALEXANDER, PhD, RN, FAAN  
ELIZABETH EVANS, DNP  
JACK FOWLER, PhD  
MITCHELL LEVY, MD, FCCM, FCCP  
DOLORES MITCHELL  
R. SEAN MORRISON, MD  
MICHAEL P. PHELAN, MD, FACEP  
ANN MARIE SULLIVAN, MD

FEDERAL GOVERNMENT LIAISONS (Non-voting):

PAMELA OWENS, PhD, Agency for Healthcare  
Research and Quality (AHRQ)\*  
DANIEL POLLOCK, MD, Centers for Disease Control  
and Prevention (CDC)  
PIERRE YOUNG, MD, MPH, Centers for Medicare and  
Medicaid Services (CMS)

MAP DUAL ELIGIBILITIES WORKGROUP LIAISON PRESENT:

THOMAS LUTZOW, PhD, MBA

NQF STAFF:

CHRISTINE CASSEL, President and CEO  
ELISA MUNTHALI, Vice President, Quality  
Measurement  
MARCIA WILSON, Senior Vice President, Quality  
Measurement  
TAROON AMIN, Staff Support  
WUNMI ISIJOLA, Senior Project Manager  
ERIN O'ROURKE, Senior Project Manager  
ZEHRRA SHAHAB, Project Manager  
JEAN-LUC TILLY, Project Analyst

ALSO PRESENT:

KYLE CAMPBELL, PharmD, MS, Health Services  
Advisory Group\*

JOSEPH CLIFT, EdD, MS, PMP, Centers for Medicare  
and Medicaid Services (CMS)

ELIZABETH DRYE, MD, Yale School of Medicine  
Center for Outcomes Research & Evaluation\*

MAYUR DESAI, PhD, MPH, Yale School of Medicine  
Center for Outcomes Research & Evaluation\*

JOSEPH MESSANA, MD, UM-KECC

VINITHA MEYYUR, PhD, Centers for Medicare and  
Medicaid Services (CMS)

KAREN PACE, PhD, RN, Health Services Advisory  
Group

CHRISTINE RANSHOUS, Mathematica Policy Research\*

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

2 (8:32 a.m.)

3 CO-CHAIR TRAVIS: I want to welcome  
4 everybody to Day 2. That's always kind of a nice  
5 thing to be able to say. We made it through Day  
6 1.

7 I personally want to thank everybody  
8 that's on the workgroup because I found the  
9 discussions that we had yesterday to be right on  
10 target in terms of the issues that we were  
11 addressing, and also extremely helpful.

12 I know that the conversation around  
13 the table helped me make my decisions about how  
14 to vote, which is what the whole purpose of us  
15 coming together is because if it was just about  
16 us preparing ahead of time, we could vote on a  
17 SurveyMonkey. It's really about the interaction  
18 of the group together.

19 I found that to be, this year  
20 especially, valuable to me as I was making my  
21 decisions. Ron always likes to say that  
22 sometimes in the past, we've still been on IQR on

1 the morning of the second day, so I think we can  
2 at least chart our own progress over time.

3 There was only one program that we  
4 didn't get to yesterday, which was cancer. That  
5 is where we're going to start this morning. We  
6 are going to make a slight change on the agenda.  
7 We do have a couple of people that have to get  
8 out early due to the flight schedules.

9 So we're going to cover cancer first,  
10 then end-stage renal, hospital outpatient  
11 quality, then we're going to do inpatient psych,  
12 and we're going to end today with ambulatory  
13 surgery. Just note that there's a slight change  
14 in the agenda as we move forward.

15 Ron -- whispering in my ear, which is  
16 why we have co-chairs -- does that work for  
17 people for us to make that kind of a change?

18 (No response.)

19 CO-CHAIR TRAVIS: Okay, thank you so  
20 much Ron. It's hard to remember everything.

21 With that little bit of background,  
22 Taroon would like some time at the beginning of

1 our meeting this morning to kind of give us some  
2 background information that I think will help us  
3 kind of frame the work that we did yesterday, but  
4 the work that we're continuing on today. Kind of  
5 understanding the big picture and how some of our  
6 work fits within it, which I think is an  
7 excellent addition to today's agenda.

8 Just for a few minutes, Taroon is  
9 going to give some remarks.

10 DR. AMIN: Thanks, Cristie. I had a  
11 number of sort of reflections from our  
12 conversation yesterday, particularly toward the  
13 end of the day. I wanted to connect some of the  
14 conversations that we're having with the  
15 Coordinating Committee with the work of this  
16 committee, so that you have a sense of some of  
17 the overarching issues that we discussed to make  
18 sure that you get a sense of how all this  
19 information is connecting back.

20 As you may know, one of the key  
21 enhancements from this year's pre-rulemaking  
22 cycle was the addition of a September in-person

1 meeting of the Coordinating Committee. The  
2 purpose of that Coordinating Committee meeting  
3 was to really set the agenda for this year's  
4 pre-rulemaking cycle, look at the preliminary  
5 analysis algorithm that staff used to make their  
6 recommendations, so the rubric, but there are a  
7 number of conversations that emerged yesterday  
8 that I wanted to just link up to some of the  
9 conversations that we've been having at the  
10 coordinating committee.

11 The first was that Nancy and Michael  
12 brought up this idea around the overarching  
13 strategic way to look at the measures that are  
14 coming into the MAP. That is not only for the  
15 individual programs, but also looking across the  
16 different programs that the workgroup is looking  
17 at, but across all the different workgroups.

18 The Coordinating Committee recommended  
19 moving forward with an idea that's tentatively  
20 being called the MAP core concepts, which is  
21 essentially a strategic framework to narrow down  
22 what are the key areas that we want to make



1 progress on across all the workgroups, and then  
2 think more strategically about what are the key  
3 levers across the different settings that can  
4 actually influence some of these outcomes?

5 The Coordinating Committee will be  
6 undergoing a discussion around how to identify  
7 and develop a set of core concepts that we will  
8 be using going forward for our MAP pre-rulemaking  
9 work going forward. This will be on their agenda  
10 for the January meeting.

11 Additionally, I think we had this  
12 discussion about the gaps in alignment. Again,  
13 this is around the impact that this has to the  
14 private sector. Dolores and Wei brought of these  
15 points up around the huge impact that the CMS  
16 programs have across the public and private  
17 sector. Again, the goal here was really to then  
18 think about using these core concepts as a way to  
19 drive alignment, and then also to drive  
20 identification of where there's still gaps across  
21 all of these programs.

22 Clearly, the goal is not to measure

1 the same thing in every program. We had that  
2 discussion last year around advanced care  
3 directives, which I won't remind anybody about.  
4 But the idea is that some of these are very  
5 important concepts, but it may not be appropriate  
6 all the time to measure in every setting.

7 We really need to think a little bit  
8 more strategically about what are the core  
9 concepts that we need to measure, and what are  
10 the contribution of all these various settings to  
11 advance all these objectives? We think this is  
12 going to be a key tool going forward next year.

13 The second is a little bit of  
14 discussion of where we ended yesterday around  
15 these program-specific goals and the nature of  
16 the incentive structures maybe driving the  
17 particular types of measures that we would select  
18 for different programs. Again, one of the key  
19 changes of this year was we were trying -- one of  
20 the things I would encourage us to keep thinking  
21 about is that as we think about the fall web  
22 meeting for the workgroup, how to use that as a

1 time to really look at the current measures in  
2 the program, the incentive structure, and really  
3 coming up with -- and also assessing the CMS  
4 program goals that have already been outlined and  
5 coming up with how the MAP, particularly this  
6 workgroup, wants to look at each individual  
7 program.

8 Again, we'll continue to work through  
9 how we can use that fall web meeting to advance  
10 that objective, but that's not lost -- again, I  
11 just wanted to -- that point was brought up  
12 multiple times yesterday. That issue isn't lost.

13 The last is this idea about data. We  
14 came back to this conversation over and over  
15 again yesterday around what's the data that we  
16 have? One of the interesting evolutionary  
17 elements of what the MAP has seen over the last  
18 five years is a continued growth in the number of  
19 measures that are under development or measures  
20 that haven't been seen by the endorsement  
21 process.

22 Again, this is another element that

1 the Coordinating Committee's going to discuss  
2 quite a bit to understand what is the date --  
3 because we traditionally relied on the NQF  
4 endorsement process to understand measure  
5 performance, understand how well -- this concern  
6 about unintended consequences and without that as  
7 the input, we're left with the situation we're  
8 in, which we've discussed a number of times.

9 I'm not here to say we have an answer  
10 to that challenge, or evolution, but it is  
11 something that the Coordinating Committee is  
12 going to have to discuss because that has been an  
13 evolutionary change in the way that the MAP has  
14 functioned, and also has some implications for  
15 the decision categories and what they actually  
16 mean.

17 With that, I just wanted to reflect on  
18 those three overarching issues. Obviously, I  
19 would welcome comments. I don't want to distract  
20 too much, but I wanted to at least make sure that  
21 we articulated that all of these overarching  
22 issues that you've been discussing that are

1 outside of the individual measures will be taken  
2 back to the Coordinating Committee for further  
3 discussion. We'll be providing that back to you  
4 at the start of pre-rulemaking at least next  
5 year, if not before that.

6 CO-CHAIR WALTERS: So yes, Taroon, I  
7 had a question that kind of tails off that. From  
8 a strategic perspective -- and people in the room  
9 that weren't involved can kind of picture this --  
10 not only did we talk about the MUC list, but we  
11 talked about the current measures also, at the  
12 very beginning. You can imagine that's why it  
13 took much longer than this one even did.

14 Obviously, we don't do that now,  
15 starting last year or this year, but as part of  
16 that framing the big picture -- because the TEPs  
17 aren't going to do that. The TEPs are very  
18 specific in their orientation. Yet to get --  
19 probably the Coordinating Committee can frame it  
20 to some degree, but again, then that gets split  
21 out into different programs.

22 Where does that strategic coordination

1 occur? We kind of alluded it -- some of the  
2 measures we talked about actually talked about  
3 their relationship to other measures, but those  
4 other measures weren't on the list for review, so  
5 how do you see that happening?

6 DR. AMIN: I think that there's two  
7 points to that, and I'd welcome other thoughts  
8 from other NQF staff that have thought about this  
9 as well.

10 The first is where we really think  
11 about this -- we as the Coordinating Committee,  
12 and then also staff as we've been thinking this  
13 -- which is the core concepts idea is, again,  
14 informed by the work from the IOM Vital Signs and  
15 other work that other workgroups have already put  
16 into this, as a way that when we're thinking  
17 about coordination across all these workgroups,  
18 it's not really at the measure level.

19 It's going to be a little bit higher  
20 than that. Therefore, we can get coordination on  
21 a concept because the data sources are going to  
22 be different. The level of analysis is going to

1 be different. It's going to drive some changes,  
2 in terms of how the measures are constructed.  
3 Alignment on an individual measure, while it may  
4 be important in some instances, it's a little  
5 bit, maybe at a higher level.

6 But I think you're bringing up another  
7 important point, which is one that we've been  
8 struggling with back and forth and I think we're  
9 going to have to work with our colleagues at CMS  
10 a bit on this next year as well, which is that --  
11 and this is one of the changes that we had, which  
12 is that CMS has made it relatively clear that  
13 we're not necessarily structured to make  
14 recommendations about existing measures that are  
15 in the programs.

16 But on the other hand -- and we also  
17 have very limited time to do this, given the  
18 volume of work we have to do, just looking at the  
19 new measures coming in. But it's really  
20 important to understand the context of the  
21 program and the measures that are currently in it  
22 -- as we had this whole PSI 90 conversation

1       yesterday, it was all about what's already in the  
2       program.

3               I think we're going to need to figure  
4       out -- we meaning staff -- we're going to have to  
5       help figure out how to use that fall web meeting,  
6       as well, to really get a good understanding of  
7       the context of the measures that are currently in  
8       it, in the programs, to be able to really make  
9       strategic recommendations about new measures  
10      coming in.

11              It's going to be increasingly  
12      important as these programs mature -- the  
13      measures in the programs mature and we get more  
14      experience, discussing what's currently in the  
15      program needs to be potentially something that's  
16      brought back into the process, but we're just  
17      going to need to work with our colleagues at CMS  
18      to figure out how we can do that most  
19      appropriately and use your time in the fall and  
20      in this in-person meeting most effectively.

21              CO-CHAIR TRAVIS:   Okay, I see some  
22      cards.   I don't know who came up first, so I'll



1 go with Andrea first because she's over there.

2 MEMBER BENIN: Taroon, I guess I would  
3 like to also see that somebody comes up with a  
4 plan around how we would see metrics revalidated  
5 with ICD-10. A lot of these metrics now are  
6 based on claims and ICD-10 is quite different.

7 It's quite different as a user and  
8 when I do coding, it's very different, although  
9 we're not talking about professional coding.  
10 We're talking about a different kind of coding.  
11 I think that should be an important part of what  
12 happens over the next year.

13 CO-CHAIR TRAVIS: Thank you, Andrea.  
14 Okay, Dan.

15 DR. POLLOCK: Taroon, thanks. My  
16 question concerns the relationship between what  
17 you're describing and the new NQF approach to  
18 measure maintenance, which emphasizes use of the  
19 measure and is de-emphasizing the reliability and  
20 validity.

21 Because I think some of our questions  
22 about measures that have been in the programs for

1 a while relate to the usefulness of the measure  
2 and what the data show. It would be an  
3 opportunity, potentially, to bring into the  
4 measure maintenance process some structured  
5 questions regarding what's happened to the  
6 clinical phenomenon of concern during the course  
7 of the measure's lifespan.

8 MS. O'ROURKE: Actually, I think  
9 that's a great idea and a great way that we can  
10 continue to build the MAP-CDP integration that  
11 we've been talking about. I think we can work  
12 with the maintenance team to see what information  
13 we can get from that with maybe some new  
14 questions to build in and how to bring that back  
15 to the MAP.

16 Because I think, as you were saying,  
17 this body's not really constituted to go into  
18 things like the reliability and validity of an  
19 individual measure. We defer that to the CDP  
20 standing committees, but how we can really look  
21 at the usefulness of a measure and what's changed  
22 about the underlying clinical conditions seems

1 like something we can build into the MAP process.

2 DR. AMIN: I would just -- rest  
3 assured that this is an active conversation that  
4 we're having and we're continuing to work on  
5 that. It's absolutely a key element to reduce  
6 the workload of measure developers in particular,  
7 but get additional information back to the key  
8 stakeholders as you're making decisions.

9 CO-CHAIR TRAVIS: Okay, Marty.

10 MEMBER HATLIE: One of the big  
11 discussions we had yesterday was about the  
12 pathway or framework from a reporting program to  
13 a payment program. Is that one of the concepts  
14 that the Coordinating Committee will take on in  
15 January and then work with CMS on?

16 I realize that there are statutory  
17 parameters there, but I think you've got a pretty  
18 clear message that there was a -- maybe even a  
19 consensus there that we needed some more work  
20 there.

21 MS. O'ROURKE: I think that's a very  
22 good point and it actually brings me back to the

1 guiding principles. I don't know if Ron or  
2 Cristie or some of the people who have been  
3 around the table a while remember when we  
4 developed those and have kind of moved away from  
5 them, but perhaps they still resonate with the  
6 group and it's something we should work with the  
7 Coordinating Committee to fold back into the  
8 process.

9           Maybe see what from that we can build  
10 on into things like the preliminary analysis to  
11 show how a measure would mesh with what this  
12 group has laid out.

13           DR. AMIN: I also think it probably  
14 interacts as well, with -- as we're thinking  
15 about the program goals and the way that you want  
16 to provide program -- I don't want to say program  
17 guidance because that implies something that's  
18 out of scope for the MAP.

19           Again, it's one of the challenges with  
20 all this. We're trying to make sure that you  
21 guys can get your work done, and we're not going  
22 too far out of scope, but obviously, all these

1 things interact.

2 One of the key elements here, as well,  
3 is as you're thinking about the programs, if you  
4 have guidance about how you're selecting measures  
5 into it -- so the way the measure's coming to CDP  
6 is that they have this experience, I mean we've  
7 heard that quite a bit in terms of public  
8 reporting -- that might make an impact in terms  
9 of how you're thinking about that program in  
10 particular, and we might apply that going forward  
11 and just make that more clear.

12 There's opportunity to interact in  
13 multiple different ways with that, but we heard  
14 it. We heard that feedback.

15 CO-CHAIR TRAVIS: I really like, Erin,  
16 your thought about the guiding principles. I  
17 don't remember them specifically, but I do  
18 remember that one of the reasons we developed  
19 them was to aid in this type of decision-making  
20 so that we were all on the same page from a  
21 framework as to how we moved measures along.

22 That's a great suggestion to kind of

1 bring them back out, maybe take a look at them.  
2 They may need to be refreshed, but seeing how  
3 that could help the work of our group. So thank  
4 you, Marty, for bringing that up.

5 MEMBER FOSTER: Thank you, Cristie,  
6 and Taroon, thank you for providing this  
7 framework. It's actually very useful to me and I  
8 appreciate the work that's underway. I want to  
9 make two quick suggestions.

10 One is I think that to the extent the  
11 Coordinating Committee wants to task, if you  
12 will, the workgroups to focus on certain things,  
13 to really engage on particular issues -- I, for  
14 one, would welcome that because if they're laying  
15 it out as part of a bigger, broader strategy, to  
16 be very explicit about that would be helpful, I  
17 think.

18 Secondly, perhaps just dovetailing off  
19 of Dan's point, I do think we need to be able to  
20 look at whether the measures are accomplishing  
21 their desired objective and provide feedback to  
22 CMS and others on whether we made the right bet.

1           If we ask hospitals to report on  
2       community-wide smoking prevalence, did it  
3       actually have the impact or was that the wrong  
4       thing? It's not going to be as strong a measure  
5       or as strong a lever as we hope?

6           How do we build that into the process  
7       in a thoughtful way, so that we are communicating  
8       effectively with all of the policymakers that  
9       want to be interested in this?

10          DR. AMIN: So just one quick reflection  
11       on that, just because it's such a huge part of  
12       the conversation yesterday at the PAC meeting and  
13       at the clinician meeting.

14          The need for this sort of revise and  
15       resubmit -- or we're approving and we want to see  
16       some data back -- is one thing that the NQF staff  
17       and NQF leadership are going to need to work with  
18       CMS about because this has been -- that was a key  
19       element of our conversation two years ago in  
20       terms of our improvement. That was clear to us  
21       that that was out of scope with our conversation  
22       with CMS.

1                   There's time to revisit that. I think  
2                   given a conversation with the Coordinating  
3                   Committee and with CMS, I think we can think  
4                   about how to do that, how to do some version of  
5                   that that meets the stakeholder needs. We heard  
6                   that loud and clear. So we're going to have to  
7                   work on that.

8                   CO-CHAIR TRAVIS: Allen.

9                   MEMBER NISSENSON: I think something  
10                  else we discussed yesterday I think would be  
11                  helpful is to get some distal evidence of how  
12                  metrics are eventually utilized. What I mean by  
13                  that is if we have three categories: support,  
14                  conditional support, and do not support, do we  
15                  know which metrics within those three categories  
16                  have been implemented by CMS?

17                  It's possible that even some of the do  
18                  not support ones were implemented and turned out  
19                  to be good. I think to close the loop and to  
20                  better inform the group going forward, that would  
21                  be very helpful information.

22                  CO-CHAIR TRAVIS: I don't know if this



1 helps it be more in scope, but to a certain  
2 extent, the way I'm looking at some of this  
3 discussion is that we're evaluating our own work.  
4 In other words, it's our work that we're taking a  
5 look at. We made recommendations, and then were  
6 our recommendations helpful?

7 I think having a better understanding  
8 -- because obviously the group that we've pulled  
9 together understands measure evaluation. I think  
10 it's good for us to kind of challenge ourselves  
11 in terms of our own performance, as a workgroup,  
12 and what has happened with our measures, which I  
13 know you all track, and then the measures that  
14 went into programs, what kind of impact did they  
15 have? Thinking about it more as looking  
16 internally at our own work, from that  
17 perspective.

18 DR. AMIN: Cristie, I think this is a  
19 really, really good point on the data. I just  
20 want to reflect on the fact that one of the  
21 things that NQF staff has really been thinking  
22 about is this how do we provide the feedback on

1 the measure decisions?

2 The challenge that we've had about --  
3 and I just want to give you a sense of the  
4 challenge, and we can come back and think about  
5 it some more, which is that sometimes we don't  
6 know -- it's not always clear why the measures  
7 haven't been taken off. They might be taken off  
8 two years later. They might be taken off three  
9 years later. The raw numbers are often  
10 misleading, even for us to interpret to provide  
11 feedback back to you.

12 With all that being said, we'll take  
13 it back and consider it some more and figure out  
14 what kind of information we can bring back. I  
15 would just say that it's been challenging for us  
16 to interpret the uptake rate, if you will,  
17 because it's not always clear, given the -- and  
18 it's not something that's necessarily within the  
19 MAP's control either, to change potentially.  
20 Either way, good feedback.

21 CO-CHAIR TRAVIS: I might just  
22 mention, on the SharePoint site there is a --

1 it's under what's called National Impact Report.  
2 It's an external consultant who was contracted by  
3 CMS to come in and assess the answers to a lot of  
4 the questions we just raised. What has the MAP  
5 process in general accomplished, and what are the  
6 gaps still? Again, this is an external  
7 consultant.

8 It's posted on the SharePoint site.  
9 It's about 200 and some pages, but for those of  
10 you that are interested in this feedback, I  
11 thought it was a very good review and gave me a  
12 lot of things to think about. It's called the  
13 National Impact Report, and it should be at the  
14 top there.

15 MS. SHAHAB: It's not on the public  
16 SharePoint. It's on the committee SharePoint  
17 site, but I can also add it on the public, if  
18 you'd like.

19 CO-CHAIR TRAVIS: Helen, did you have  
20 another point? That's okay. I just wanted to be  
21 sure. Thank you all for that, and thank you,  
22 Taroon, for bringing those issues to our

1 attention. Obviously, we're very interested in  
2 those, so thank you for that.

3 I think we will go on and get started  
4 this morning. Our first program that we're going  
5 to be looking at is the PPS-Exempt Cancer  
6 Hospital Quality Reporting Program. I'm going to  
7 turn it over to Zehra for an overview of the  
8 program.

9 MS. SHAHAB: Thanks, Cristie.

10 PPS-Exempt Cancer Hospital Program is a voluntary  
11 data reporting program and the data is published  
12 on Hospital Compare.

13 The goals of the program are to  
14 provide information about the quality of care in  
15 cancer hospitals, specifically the 11 cancer  
16 hospitals that are exempt from the inpatient  
17 prospective payment system and the Inpatient  
18 Quality Reporting Program. Additionally, the  
19 program is used to encourage hospitals and  
20 clinicians to improve the quality of care to  
21 share information and to learn from each other's  
22 best practices. That's a quick overview of the

1 program.

2 About the consent calendar, there's  
3 five measures on this consent calendar.  
4 Admissions and emergency department visits -- and  
5 that is an update, and MAP has previously  
6 reviewed that. SSI, CDI, and MRSA are already  
7 currently in the program, are also updates.  
8 Oncology, it's currently in the program, but it's  
9 undergoing a change to include breast and rectal  
10 cancers.

11 Before we start the consent calendar,  
12 we will open it up for public comment.

13 CO-CHAIR TRAVIS: Thank you, Zehra.  
14 Is there any comment in the room?

15 DR. PHELAN: I do. Can I make a  
16 comment?

17 CO-CHAIR TRAVIS: Sure. Did anybody  
18 show up? No? Okay. Yes, Michael.

19 DR. PHELAN: I just need a better  
20 explanation of why these 11 or 12 hospitals  
21 continue to be exempt from some of these patient  
22 safety programs. I'm wondering if CMS can give

1 some insight into that at all.

2 I'm just wondering because these are  
3 not very different, and I've wondered why 12  
4 hospitals are then exempt from a lot of these  
5 programs and we have to work differently. Is it  
6 possible to make any comment on that?

7 DR. YOUNG: So --

8 (Simultaneous speaking.)

9 DR. PHELAN: I'm thinking legacy. I'm  
10 thinking that this was some kind of legacy from  
11 20 years ago legislation or 30 years ago. It's  
12 bothered me since I've been on the MAP.

13 DR. YOUNG: Right. Well, I need to  
14 double check, but my understanding is that this  
15 is related to legislative limitations.

16 MS. O'ROURKE: I can try to illuminate  
17 a little bit. Our understanding was that these  
18 hospitals are exempt from the inpatient  
19 prospective payment system, and because of that,  
20 they are essentially exempt from IQR since the  
21 mechanism for that is an update associated with  
22 that payment.

1                   This program was put in by the  
2                   Affordable Care Act to basically close a  
3                   reporting gap that was created by the different  
4                   payment systems.

5                   DR. PHELAN: Again, I guess the  
6                   question, as we deal with this, these are  
7                   patients that are exactly the same patients that  
8                   we see in our normal hospitals, but there's 12  
9                   hospitals exempt from it.

10                  From my perspective, I'd be like, oh,  
11                  well, you don't have to be in the IQR, but we're  
12                  going to include a separate category that's now  
13                  the exact same measures that are included, but  
14                  it's going to affect the PPS hospitals.

15                  MS. O'ROURKE: You raise a very good  
16                  point, and I'll turn it to Nancy in one second to  
17                  illuminate, but I think that's something the MAP  
18                  has struggled with since the beginning is we know  
19                  the vast, vast majority of cancer patients are  
20                  treated in the normal, acute-care hospitals.

21                  To try to get some of the cancer  
22                  metrics into IQR has been a resounding theme of

1       this group, and at the same time, to put in some  
2       essential quality safety measures into the PCHQR  
3       Program, so that patients have the same level of  
4       guarantee that their care is the same standard  
5       across the board.

6               I think that's something this group  
7       has stated throughout its existence, while  
8       looking at these two programs. We've made those  
9       recommendations year after year, but I think we  
10      can echo it again that there needs to be better  
11      symmetry between the programs and that cancer is  
12      a key gap for IQR. We also need some of the  
13      overarching measures in this program.

14             MEMBER FOSTER: Michael -- Erin had it  
15      exactly right. This is structure of payment  
16      programs deciding what group somebody falls in  
17      here. Part of the reason we're looking at some  
18      of the same measures, I believe, is that there's  
19      a lot of concurrence with your thought that these  
20      hospitals need to be paying attention to the same  
21      issues and so forth.

22             I would tell you that while you come



1 from an unusual place, the thought that these  
2 hospitals are caring for the same kinds of cancer  
3 patients as everyone else may be a bit of an  
4 overreach. In fact, your average community  
5 hospital is not caring for the same severity as  
6 these, which is why there was the separate  
7 payment system created, and why we may want to  
8 think about whether the risk adjustment, when  
9 it's necessary, is strong enough to enable a real  
10 side-by-side comparison of quality.

11 CO-CHAIR TRAVIS: Thank you. I'm  
12 sorry I didn't see your card before we opened for  
13 public comment, but I'm going to now give the  
14 people in the room another chance for public  
15 comment in case any of that discussion led them  
16 to want to comment.

17 (Pause.)

18 CO-CHAIR TRAVIS: I don't see anybody  
19 in the room, so Operator, could you see if  
20 there's any public comment on the PPS-Exempt  
21 Cancer Hospital Quality Reporting Program on the  
22 line?

1 OPERATOR: Yes, ma'am. At this time,  
2 if you have a comment, please press star, then  
3 the number one.

4 (Pause.)

5 OPERATOR: There are no comments at  
6 this time.

7 CO-CHAIR TRAVIS: Okay, thank you very  
8 much. We are going to move then into the  
9 discussion of the measures that are in this  
10 program.

11 As Zehra indicated, these measures are  
12 pretty much updates. We've also discussed  
13 several of these measures yesterday, in  
14 relationship to other programs. We have had one  
15 measure that is pulled, that is Measure Number 1,  
16 but Measures 2 through 5 have not been pulled for  
17 discussion.

18 Those would constitute our consent  
19 calendar with the recommendation that comes from  
20 the staff. Zehra, could you just remind us, for  
21 each measure, what that recommendation is?

22 MS. SHAHAB: Sure, Cristie. Number 2,

1 SSI, was conditional support pending NQF update.  
2 That was the staff recommendation. Number 3,  
3 CDI, conditional support pending NQF annual  
4 update. Number 4, MRSA, conditional support  
5 pending NQF review and endorsement. Number 5,  
6 oncology, conditional support pending NQF  
7 endorsement.

8 CO-CHAIR TRAVIS: One last time, does  
9 anyone want to pull any of the measures that have  
10 not been pulled so far? Dan?

11 DR. POLLOCK: No, I don't want to  
12 pull. I just want to ask a question about the  
13 MRSA.

14 Zehra, if I heard you correctly, the  
15 condition there was pending endorsement and  
16 that's a measure that's been endorsed -- or that  
17 same measure has been endorsed and in use.

18 MS. O'ROURKE: I think that was a bit  
19 of an overreach on the preliminary analysis. I  
20 believe we meant more of pending the update of  
21 the -- the annual update.

22 DR. POLLOCK: Right, that's what Zehra

1 mentioned about the CDI measure. I think that  
2 the same verbiage applies to Number 4.

3 MS. O'ROURKE: Okay, we can change  
4 that condition.

5 CO-CHAIR TRAVIS: Yes, thank you.  
6 Thank you, Dan.

7 (Simultaneous speaking.)

8 MS. RANSHOUS: This is Christine on  
9 the line. It's also our understanding that the  
10 radiation that's found in normal tissues has been  
11 endorsed with the updates.

12 CO-CHAIR TRAVIS: Okay, that's Number  
13 5?

14 MS. RANSHOUS: Yes, ma'am.

15 CO-CHAIR TRAVIS: It appears that  
16 nobody wants to pull any of these other measures.  
17 They will move forward. We will be sure that we  
18 clean up the language to have it accurately  
19 reflect the current status, such as what Dan just  
20 brought up and we will do that for Number 5 too.

21 I guess I'd like to ask if there are  
22 any objections to this consent calendar moving

1 forward with these staff recommendations?

2 (No response.)

3 CO-CHAIR TRAVIS: Wonderful. Thank  
4 you very much for that. We will move to the one  
5 that has been pulled, which is Number 1,  
6 admissions and emergency department visits for  
7 patients receiving outpatient chemotherapy. That  
8 was pulled by Nancy and we'll hear from Nancy  
9 first, and then give our lead discussants an  
10 opportunity to respond. Nancy.

11 MEMBER FOSTER: I'm not the clinical  
12 expert in the room -- Ron. However, my  
13 understanding of cancer patient treatment is that  
14 there are lots of -- I know this basically from  
15 what Ron has told us in years past -- that the  
16 walls between the hospital and the outpatient  
17 setting are much more fluid than in other  
18 settings and one might plan for people to come  
19 back to the hospital for treatment as part of  
20 their ongoing care.

21 It's all about the measure  
22 specifications here for me and getting those

1 right so that they recognize the actual nature of  
2 cancer care treatment as it is happening now and  
3 we were not really able to look at the specs.

4 I pulled this simply to say I'm not  
5 sure I can conditionally support this unless, as  
6 we discussed yesterday, Erin can assure me that  
7 going forward, the NQF review will really look at  
8 that issue of is this consistent with how cancer  
9 care treatment is done today, in which case  
10 conditional support would make sense to me.

11 MS. O'ROURKE: That's certainly a  
12 strong condition we can put on this measure that  
13 it be reviewed by the Admissions and Readmissions  
14 Standing Committee, and we can pass along to that  
15 committee a particular concern that cancer is  
16 different than other conditions, and they should  
17 give this one a very thorough look.

18 CO-CHAIR TRAVIS: Reactions from our  
19 -- I'm trying to remember who they all are -- our  
20 lead discussants, Ron, Shelley, and Wei?  
21 Shelley.

22 MEMBER FULD NASSO: I think that's an

1 important thing to consider in the review, but  
2 when I read the way it's described, it's really  
3 looking at the complications that are expected  
4 and treatable for the people undergoing  
5 chemotherapy.

6 So much of the effort on value and  
7 cost both for patients -- they don't want to end  
8 up in the ER or be admitted when they don't need  
9 to be -- and it's part of the Innovation Center's  
10 oncology care management pilot. It's part of a  
11 lot of efforts to try to reduce unnecessary ED  
12 visits and admissions.

13 The patient-centered medical home  
14 model is one way of making sure that you're  
15 really managing those symptoms better while  
16 patients are going through chemotherapy. All of  
17 these things -- anemia, dehydration, diarrhea --  
18 these are things that we know happen and can be  
19 managed by the physician who's administering the  
20 chemotherapy so patients don't end up -- I think  
21 as long as the condition is that careful review  
22 to make sure that this reflects the right kind of

1 cancer care practice, I think this is really  
2 important from a patient perspective.

3 But I think it's also from a resource  
4 utilization perspective because there's so much  
5 focus on the cost of cancer care. This is one  
6 area where we can really make a big difference if  
7 we manage patient symptoms better, and we don't.  
8 Patients don't want to end up in the ER. They  
9 don't.

10 If we can just manage it better --  
11 some practices are doing really well at that and  
12 others are not. So many practices are now owned  
13 by the hospitals that I think that it makes sense  
14 for the hospitals and practices to work together  
15 on reducing this.

16 CO-CHAIR TRAVIS: Thank you, Shelley.  
17 Wei.

18 MEMBER YING: I will agree with this  
19 previous comment. I actually liked -- among the  
20 consent calendar, this is the measure I liked the  
21 best.

22 One reason is that as we mentioned



1 earlier, a lot of the measures being endorsed  
2 here are not just being used for these programs.  
3 The ripple effect is actually quite significant.  
4 This measure, because this doesn't rely on  
5 specific treatment and specific clinical  
6 conditions, so actually the denominator, the  
7 eligible population, is much bigger to manage.  
8 When we expand it beyond these exempt hospitals  
9 to the acute-care facility, this measure actually  
10 becomes measurable. Other condition-specific  
11 measures, sometimes it's just very hard to get  
12 enough volume for us to look at.

13 Just to share a little bit of  
14 experience, before this measure even became  
15 existent as a health plan, we even started to  
16 develop similar measures ourselves, trying to  
17 look at the complications after chemotherapy.  
18 It's very important area for us.

19 CO-CHAIR TRAVIS: Thank you, Wei.  
20 Before we open it up to everyone, Ron.

21 CO-CHAIR WALTERS: We're perfectly  
22 comfortable with conditional support pending

1 endorsement. We've not seen the specs either on  
2 this measure, although from the description, I  
3 think we have a very good feel for what's  
4 involved.

5 As was mentioned earlier -- I'm going  
6 to try not to be repetitive. I think everybody  
7 summarized it. Nobody likes to come into the  
8 hospital and to the extent you might want to call  
9 these potentially preventable admissions, I think  
10 that gets the flavor of what this measure's  
11 trying to accomplish. It's good for the patient.  
12 It's good clinical care.

13 As Nancy and I discussed in the first  
14 MAP meeting a long time ago, this is the start --  
15 and you've seen other examples of the kinds of  
16 things that might well blend into other programs  
17 over time. We support it. We just want it to  
18 get endorsed.

19 CO-CHAIR TRAVIS: Okay. Thank you to  
20 Nancy and our lead discussants. Tom.

21 MEMBER LUTZOW: I would just recommend  
22 that -- this is a ground for a review of SES

1 impact, I think, too. Anything having to do with  
2 outpatient -- our members have a very high -- I  
3 should explain that iCare only serves Medicare  
4 individuals who are dually eligible.

5 We have a very high no-show rate for  
6 anything outpatient. Transportation's a  
7 challenge. Health literacy, especially with  
8 complications like this, if there's any reaction  
9 that's not comfortable to the patient, the  
10 patient, I think, makes the decision that  
11 treatment isn't something they want to do, so  
12 there's that resistance, despite doctor  
13 recommendations and despite the treatment  
14 regimen.

15 As part of the review, I think it  
16 would be important to look at the impact of SES  
17 on anything having to do with outpatient services  
18 that if the member's not compliant results in an  
19 ER visit or an inpatient stay. I'm just  
20 surprised it's not here as a condition to look  
21 at.

22 CO-CHAIR TRAVIS: Thank you, Tom.

1 Just as a reminder, all the measures that will  
2 coming through NQF for endorsement during the  
3 trial period will be required to look at SES  
4 adjustment. What they find may be different  
5 based on the measure, as we talked about  
6 yesterday, having that conceptual framework  
7 first, and then looking at the empirical  
8 evidence.

9 Thank you for bringing that up. It is  
10 baked into the process at this point, so thank  
11 you for that. Andrea.

12 MEMBER BENIN: Ron, I'm just a little,  
13 actually, confused by your comments. We bring  
14 kids with fever and neutropenia into the ED.  
15 That's what we do with them. That's what you do  
16 with a sick kid. I don't know about on the adult  
17 side. If you have fever and neutropenia and  
18 sepsis, you don't come to the ED?

19 I'm just surprised by these diagnoses.  
20 Maybe that's a difference between what you do  
21 with adults and what you do with kids, but fever  
22 and neutropenia goes to the ED and gets admitted

1 a lot of the time, and certainly sepsis -- a  
2 diagnosis of sepsis would be an ED -- those, to  
3 me, are appropriate uses for the ED.

4 Now better if you can bring them into  
5 the clinic, treat them in the clinic, pump them  
6 up, then send them to inpatient, but we can't  
7 always get them into the clinic. Sometimes it's  
8 after hours. Sometimes the clinic is full. It's  
9 better to do it faster if you can get them  
10 through the ED.

11 I feel, just by the limited  
12 information listed here -- clinically extremely  
13 uncomfortable with sort of just saying this is  
14 not a good thing to be doing. I would want  
15 whatever the technical review to look at be  
16 pretty robust. I'm sure that it will be, but I  
17 wouldn't -- without knowing a little bit more  
18 about this and understanding it a little bit  
19 better, that's not a quality metric I would want  
20 my kid -- or my mother, whichever the adult  
21 version is. I don't know -- or myself. I'm just  
22 a little bit confused by what is delineated here.

1 CO-CHAIR WALTERS: Let me reply to  
2 that. A common conclusion reached when both  
3 measures are discussed is that the proper end  
4 result should be zero. It usually is never -- is  
5 that what you're going to say, Sean?

6 Yes, the result is not going to be  
7 zero. What you're really looking for is to make  
8 sure you find what "the normal" rate is and what  
9 is the standard deviation and variation around  
10 that, and analyze the variation, when it's too  
11 high, as to why that's occurring.

12 So I agree with you completely, but we  
13 do not expect the rate to be zero. We expect it  
14 to be some background rate of, depending on the  
15 disease you're talking about, and then to look at  
16 preventable causes if that rate is too high, or  
17 if one place is 40 percent and another place is 5  
18 percent. There's an opportunity for performance  
19 improvement there.

20 That's what measurement gets you, but  
21 it's very commonly believed that the right answer  
22 is zero. No, the rate is seldom zero, except for

1 maybe cutting off the wrong body part.

2 CO-CHAIR TRAVIS: I'm glad you  
3 clarified that. There may be a few others in  
4 that category, actually, but we won't go there  
5 right now. Michael.

6 DR. PHELAN: Maybe Ron can address  
7 this, but why was leukemia excluded from this?  
8 Was there a reason? I know you're not the  
9 measure developer. Was it because they have such  
10 high rates of these? I just couldn't figure out  
11 why leukemia -- and if it is, wouldn't your  
12 argument bear for the same thing for leukemia  
13 patients, that there's going to be a baseline  
14 rate? I just didn't know why it was excluded.

15 CO-CHAIR WALTERS: Click on the  
16 measure specs from what we have in the discussion  
17 guide. Number 1 exclusion is patients with a  
18 diagnosis of leukemia any time during the  
19 measurement period.

20 CO-CHAIR TRAVIS: Why? He's --

21 (Simultaneous speaking.)

22 DR. PHELAN: I guess why, yes.

1 MS. RANSHOUS: This is Christine --  
2 (Simultaneous speaking.)

3 MS. RANSHOUS: Sorry, Ron, this is  
4 Christine Ranshous, one of the measure  
5 developers. I can start that, but maybe you can  
6 build on it.

7 We excluded patients with leukemia  
8 because leukemia patients often have a higher  
9 toxicity in their treatment and an expected  
10 recurrence of disease. They're also often  
11 treated in the inpatient setting for their  
12 chemotherapy, not in the outpatient setting.  
13 When you look at their rates of admissions in  
14 these categories, they're much higher than all of  
15 the other cancer patients.

16 They just seemed to be categorically  
17 different and to make this measure more effective  
18 and understandable and directly useful, it seemed  
19 to make sense to exclude them and focus on some  
20 of these other cancer patients.

21 DR. PHELAN: But wouldn't that argue,  
22 then, for a separate measure on the same



1 category? If it would sway your results either  
2 way because you have too many admissions and  
3 stuff like that, wouldn't that really call for a  
4 separate measure then for leukemia patients, the  
5 same type of measure, but it would have a  
6 different rate because it would be higher for the  
7 complications, but the same idea that you'd be  
8 looking at a baseline rate, and then significant  
9 deviations from that with, of course, including  
10 some SDS adjustment and other risk factor  
11 adjustment?

12 To me -- from a perspective from a  
13 patient, I don't know what the numbers are -- I  
14 don't know if there's 80 cancer patients to every  
15 20 leukemia patients -- but to me, it would seem  
16 like it would be a call for another similar type  
17 measure.

18 MS. RANSHOUS: This is Christine  
19 again. I think that is a good idea that can be  
20 explored. I think one of the challenges with  
21 leukemia patients is the planned versus unplanned  
22 and getting more of that preventable aspect of

1 it. To your point of having -- if we expect some  
2 of this to go in and we're looking at variation,  
3 then maybe there's an argument to be made for  
4 making this a paired measure.

5 CO-CHAIR TRAVIS: Thank you. Mitch.

6 MEMBER LEVY: I was just going to  
7 respond to Andrea. I don't think this is about  
8 driving people to the clinic for me. I think  
9 it's just as Ron said, this is just about looking  
10 at preventable complications and using it as a  
11 quality metric. I'm comfortable with it being an  
12 ED-based measure, rather than -- I don't think  
13 that it's driving people into the clinic.

14 MEMBER BENIN: I think the question is  
15 whether you really think you can properly risk  
16 adjust for this. I think that's what the review  
17 will have to be. When you have fever and  
18 neutropenia and sepsis, to the extent to which  
19 some of those are preventable or may or may not  
20 be preventable, you don't want to deter them from  
21 an ED. That's not the goal of what any of us  
22 want to do.

1 I'd feel very differently from Ron  
2 about how you should make quality metrics and  
3 what their goal should be, but if it's truly  
4 risk-adjusted properly, then that's one thing.  
5 If that's the direction that you people want to  
6 go, that's fine.

7 I think that the proof will be in the  
8 pudding eventually on this and we'll see what  
9 happens. I think, also, that this will come down  
10 to coding and different things --- and how you  
11 code.

12 CO-CHAIR TRAVIS: Okay. I think this  
13 has been a really good discussion. I know -- I  
14 see Erin and her team over here taking notes.

15 This is an example of something that  
16 I think the comments and the thoughts from the  
17 MAP can be shared through the CDP process, the  
18 consensus process, in terms of the measure  
19 endorsement when it comes through, so thank you  
20 for your thoughts on that.

21 Seeing no other cards, I think we will  
22 move on and go to a vote.

1 MR. TILLY: The polling is now open  
2 for admissions and emergency department visits  
3 for patients receiving outpatient chemotherapy,  
4 MUC15-951. The options are support, conditional  
5 support, and do not support.

6 (Voting.)

7 MR. TILLY: The results are 38 percent  
8 support, 63 percent conditional support, 0  
9 percent do not support, so the recommendation is  
10 conditional support.

11 MS. O'ROURKE: Just to clarify the  
12 conditions, that would be pending NQF review and  
13 endorsement with a special consideration for the  
14 Admissions and Readmissions Standing Committee to  
15 consider the diagnoses included in this measure  
16 and pay particular attention to the exclusions  
17 and risk adjustment.

18 CO-CHAIR TRAVIS: Okay. Thank you all  
19 very much. I'll turn it over to Ron.

20 CO-CHAIR WALTERS: Thank you. You may  
21 notice from the schedules we're doing fabulous on  
22 time. I expect a lot of the next couple hours

1 will take the end-stage renal.

2 We have seven measures, which in  
3 total, six of them have been pulled. Melissa's  
4 going to give an overview of the program,  
5 momentarily.

6 MS. MARINELARENA: Good morning. As  
7 soon as the slides come back up --

8 (Simultaneous speaking.)

9 CO-CHAIR WALTERS: That'd make it easy  
10 for you.

11 MS. MARINELARENA: Right, so I can  
12 share them with everybody else. Thank you. ESRD  
13 is new to our group this year. Welcome to ESRD.  
14 We're happy to have you here.

15 Quick review on the program. This is  
16 a pay-for-performance and public reporting  
17 program. The incentive structure is, as of 2012,  
18 payments to dialysis, facilities are reduced if  
19 facilities do not meet or exceed the required  
20 total performance. Payment reductions are on the  
21 sliding scale, and they amount to a maximum of 2  
22 percent per year. The program goals are to

1 improve the quality of dialysis care and produce  
2 better outcomes for beneficiaries. That is the  
3 overview. I will hand it over, and we can start  
4 the discussion.

5 CO-CHAIR WALTERS: Are there any  
6 public comments in the room?

7 (No audible response.)

8 Seeing none, Operator, would you open  
9 up the line for comments?

10 OPERATOR: At this time, in order to  
11 make a public comment, please press Star 1 on  
12 your telephone keypad. There are no public  
13 comments at this time.

14 CO-CHAIR WALTERS: Okay, thank you.  
15 As I mentioned, there is one measure that, right  
16 now, is on the consent calendar, measurement of  
17 phosphorous concentration. That preliminary  
18 staff analysis on that was support. Is there  
19 anybody in the room that would like to pull that  
20 measure?

21 (No audible response.)

22 MEMBER BENIN: I have a question just

1       about the program. To what extent is this  
2       program intended to involve children? When I  
3       look on Dialysis Compare, there's some pediatric  
4       metrics that have some reporting there. I'm just  
5       wondering what are we looking at here? Is this  
6       just adults right now?

7               DR. YOUNG: No, it does include  
8       pediatric. Anybody who has end-stage renal  
9       disease can apply to Medicare. This is not just  
10      a Medicare population, meaning over 65. We do  
11      have ESRD beneficiaries who are less than 65,  
12      including kids.

13             MEMBER BENIN: So some of these  
14      metrics have been tested in children and some of  
15      them haven't?

16             CO-CHAIR WALTERS: I think as we go  
17      through the measures that have been pulled  
18      individually, we can talk about that.

19             MEMBER BENIN: Okay. Does the  
20      reporting happen -- when they do the reporting,  
21      though, it happens as a whole group, by facility,  
22      or does it happen by ages?

1 DR. YOUNG: It's by facility.

2 CO-CHAIR WALTERS: Okay, so Measure  
3 No. 3, which the recommendation was support, will  
4 stand on the consent calendar. We'll begin  
5 discussion of Measure No. 1, which is avoidance  
6 of utilization of high ultrafiltration rate.  
7 That was pulled by Allen, who is also one of the  
8 lead discussants, so we'll start out with that  
9 one.

10 MEMBER NISSENSON: This, there are  
11 just a few almost housekeeping issues. No. 1, if  
12 you look in the specs, everywhere you see a  
13 greater than 13 should say greater than or equal  
14 to. If you look at what's actually in the  
15 material, and that's not what it says.

16 It's a small nuance, but just  
17 something that needs to be corrected. Secondly,  
18 in the staff summary, the metric which has been  
19 endorsed is stated to be a CMS and KCQA metric.  
20 It's actually a KCQA metric, not a CMS metric.  
21 CMS had a similar metric, which was not endorsed,  
22 so that's, just again, not accurate.



1           The third is a question, which is one  
2   of the exclusions in the metric that was  
3   endorsed, which relates to the number of patients  
4   in the facility, which was less than 25, is  
5   crossed out. This is more a question. Was that  
6   done intentionally, inadvertently? What was sort  
7   of the thought process? Because that's different  
8   from the metric that was actually endorsed.  
9   Other than that, this is a key area. We're very  
10  supportive of this and would agree with the staff  
11  assessment, with those few modifications.

12           CO-CHAIR WALTERS: I understand it,  
13  actually you supported the staff recommendation.  
14  It was just kind of some typographical and some  
15  formatting things.

16           MEMBER NISSENSON: Essentially, yes.  
17  The substance we don't disagree with. The  
18  exclusion needs to be explained. I think that's  
19  not clear. Then the attribution, the developer  
20  needs to be corrected.

21           CO-CHAIR WALTERS: Let's take that  
22  one, then. Is there any other discussion about

1       that measure, or any other questions?

2               DR. PHELAN:  Allen, can you explain  
3       that measure to us a little bit?  I'm just not  
4       familiar enough with end-stage renal disease to  
5       know what it means, actually.

6               MEMBER NISSENSON:  It relates to the  
7       rate of fluid removal during an individual  
8       dialysis treatment.  It's based on evidence that  
9       suggests that if you remove fluid too rapidly  
10      during a single treatment, you'll get episodes of  
11      hypotension and all kinds of bad consequences.

12              DR. PHELAN:  Why would people want to  
13      be doing that -- I'm just curious -- to patients?  
14      What would be the -- to go faster through the  
15      dialysis system or --

16              MEMBER NISSENSON:  No, it's more the  
17      interdialytic weight gain.  You have more or less  
18      a fixed time period.  The prescription is four  
19      hours.  Patient comes in and gains 20 kilograms.  
20      They don't want to stay longer than four hours,  
21      so the staff might say, "All right, we'll just  
22      turn up the dials to remove all the fluid," and

1 exceed the filtration rate. It's more that kind  
2 of a thing. It's more patient driven by  
3 excessive interdialytic weight gain.

4 DR. PHELAN: Thank you.

5 CO-CHAIR WALTERS: I have to go back  
6 to public comment in just a sec. There was a  
7 technical glitch, but Elizabeth first.

8 MS. EVANS: I just want to point out  
9 that I was part of the renal standing committee.  
10 We approved this. There were two measures, two  
11 metrics. One was an individual time period, and  
12 one was per week. We selected the metric for the  
13 week long, mainly because of the issue of  
14 potential gaming for that individual metric,  
15 which is a very important thing in all aspects of  
16 healthcare, like we discussed yesterday.

17 CO-CHAIR WALTERS: So you support the  
18 measure?

19 MS. EVANS: Yes, I do support it.

20 CO-CHAIR WALTERS: Sean. We had a  
21 technical glitch, so let's go back to public  
22 comment on the phone.

1 MS. O'ROURKE: Operator, can you open  
2 up the line for Lisa McGonegal, please?

3 OPERATOR: Lisa's line is open.

4 MS. MCGONEGAL: Thank you. Can you  
5 hear me?

6 MS. O'ROURKE: Yes, Lisa, we can.

7 MS. MCGONEGAL: Okay, great. Sorry  
8 about that. She didn't seem to pick up on my  
9 cue. This is Lisa McGonegal from Kidney Care  
10 Partners. First, thanks for the opportunity to  
11 comment, and again, apologies for the glitch  
12 there.

13 Kidney Care Partners is a coalition of  
14 members of the kidney care community. It  
15 includes the full spectrum of stakeholders  
16 related to dialysis care. We encompass patient  
17 advocates, healthcare professionals, dialysis  
18 providers, researchers, manufacturers, suppliers,  
19 all organized to advance policies and improve the  
20 quality of care for individuals with chronic  
21 kidney disease and end-stage renal disease.  
22 First, we'd like to thank the MAP and the

1 hospital workgroup for undertaking this very  
2 important and grueling work that you're doing  
3 here these two days.

4 We just want to offer one comment on  
5 a single measure under consideration that you'll  
6 be discussing in a few minutes. This is  
7 MUC15-761, which is ESRD vaccination full-season  
8 influenza vaccination submitted by CMS for your  
9 consideration. First of all, we'd like to note  
10 that KCP, of course, recognizes the high  
11 importance of influenza vaccination in patients  
12 with ESRD.

13 This is a vulnerable population, and  
14 obviously vaccinating them against the flu is  
15 extremely important, but we do oppose MUC15-761,  
16 primarily because the measure is not endorsed.  
17 You heard Taroon speak this morning about the  
18 increasing number of measures that are being  
19 advanced to the MAP that aren't endorsed. We  
20 believe that CMS should work within the NQF  
21 rubrics to seek modification for a measure that  
22 has already been endorsed that addresses

1 influenza immunization in the ESRD population.  
2 This is NQF 0226. This measure was endorsed in  
3 2007, was re-assessed in 2013, and re-endorsed at  
4 that time. The measure is fully aligned with the  
5 standard NQF influenza specification. It's been  
6 fully tested, and it's already in the NQF  
7 portfolio.

8 We think, at this time, that this  
9 measure should be considered, rather than  
10 pursuing a new measure being advanced through the  
11 MAP. At this time, I'd like to urge the MAP and  
12 the hospital workgroup to urge CMS to work within  
13 the NQF rubric and include the measure that is  
14 already endorsed. Thank you for your time.

15 CO-CHAIR WALTERS: Thank you very  
16 much, Lisa. Let's return to Measure 1. Is there  
17 any discussion about Measure 1?

18 (No audible response.)

19 Seeing none, let's proceed to vote.

20 MEMBER FOSTER: I should have used my  
21 microphone. Is it, or is it a change in the  
22 specifications? What are we voting on?

1                   MEMBER NISSENSON: That was the  
2 question. Was it just a mistake or intentional?

3                   DR. YOUNG: It's an error.

4                   MEMBER FOSTER: Thank you.

5                   DR. YOUNG: It's intended to be --

6                   (Simultaneous speaking.)

7                   MEMBER NISSENSON: So we are voting to  
8 support or not support or conditionally support  
9 the endorsed measure.

10                  MR. TILLY: Okay, the polling is now  
11 open for avoidance of utilization of high  
12 ultrafiltration rate, MUC15-758. The options are  
13 support, conditional support, and do not support.

14                  (Voting.)

15                  The results are 85 percent support, 15  
16 percent conditional support, 0 percent do not  
17 support, so the measure recommendation is  
18 support.

19                  CO-CHAIR WALTERS: Thank you very  
20 much. We'll move on to Measure 2, which is the  
21 vaccination measure. Allen asked that be pulled  
22 for discussion.

1                   MEMBER NISSENSON: I don't have a lot  
2                   to add to Lisa's comment. I seem to recall when  
3                   I was on the post-acute-care workgroup these past  
4                   few years, in 2013, when this came up, we had the  
5                   same discussion. I think it's the same  
6                   discussion now, which is there is an endorsed  
7                   measure, which was re-endorsed, that applies to  
8                   the ESRD patients and has worked perfectly well  
9                   for many years. It's just not clear why a  
10                  modified measure is needed, or what value that  
11                  really gives, other than to potentially create  
12                  confusion in the community, who I think have  
13                  worked quite diligently and quite well to  
14                  immunize almost all patients with ESRD under the  
15                  current metrics.

16                 CO-CHAIR WALTERS: Give CMS a chance  
17                 to respond to that in just a second. Elizabeth.

18                 MS. EVANS: I agree with Allen. I  
19                 don't have anything else to add.

20                 CO-CHAIR WALTERS: Sean. Would you  
21                 like to answer the question that's been brought  
22                 up, or the issue that's been brought up by three



1 people?

2 DR. YOUNG: Would I like to, is that  
3 the question? One, thank you for support for the  
4 topic area because we do agree that this is an  
5 important area to measure on quality. The  
6 endorsed measure, the data source for that is  
7 claims. The reason we put this particular  
8 measure on the MUC list is for consideration as  
9 using NHSN as a possible data source to obtain  
10 data on flu vaccinations with dialysis  
11 facilities. That's the rationale behind putting  
12 this measure up.

13 CO-CHAIR WALTERS: All right. I  
14 suspected there were going to be cards up after  
15 that. Sean.

16 DR. MORRISON: Yes, just a clarifying  
17 question for Pierre. Pierre, then if this goes  
18 through, will CMS reconcile the two measures that  
19 are now in existence? Just to respond to Allen's  
20 question about why do we have two measures  
21 looking at the same thing? I guess that's my  
22 confusion. I know we went through this

1 yesterday, but I'll just ask a clarifying  
2 question again.

3 DR. YOUNG: We certainly will take  
4 this under consideration. Thank you.

5 DR. PHELAN: I guess leaning back to  
6 you for the same question, does CMS prefer to  
7 NHSN database data, or do they prefer the claims,  
8 and is there a difference in the outcome of both?  
9 Because I guess that's the question. Obviously,  
10 if this is coming up for consideration, there  
11 must be a reason. Does CDC prefer the data from  
12 the CDC, rather than the claims-based data, and  
13 if it does, Allen -- then the second question to  
14 Allen is would you expect a difference between  
15 the two because my expectation would be that they  
16 would align pretty closely.

17 MEMBER NISSENSON: Let me just add a  
18 clarifying question. Where does NHSN get its  
19 data?

20 DR. POLLOCK: NHSN has a feature built  
21 into it that enables patient influenza  
22 vaccination coverage to be reported, but at

1 present time, there's only voluntary use of that  
2 feature. It is not a heavily used feature.

3 We offered to enable NHSN to be used  
4 for this purpose and continue to offer that, but  
5 if there are compelling reasons to use an  
6 existing approach that works -- the fact of the  
7 matter is NHSN is essentially serving as a  
8 functional system, but if there is already a  
9 functional approach that is effective, I could be  
10 sympathetic to the point of view of why change it  
11 if it's not broken.

12 MEMBER NISSENSON: I guess just to add  
13 another point, Michael, right now CMS is using  
14 claims data. We also have a new data system  
15 called CrownWeb, which is an electronic system.  
16 That's what was identified for this new measure,  
17 which is capturing data through CrownWeb, which  
18 -- and Pierre, I'm sure, would be happy to  
19 comment -- is still a work in progress. It's  
20 going to eventually be very good and a valuable  
21 system. It's still a work in progress.

22 Some of the data elements that are

1 necessary for the metric are not currently  
2 captured in CrownWeb. Again, this seems more  
3 aspirational, for when we have data collection  
4 systems in the future that capture the data. I  
5 come back to if it's not broken, why are we  
6 working on fixing it now?

7           Because this seems to be something not  
8 only is the metric working, in terms of people  
9 understanding it, but immunization rates in  
10 dialysis patients have gone up dramatically in  
11 the past five years to now, influenza vaccination  
12 is occurring throughout the population at a rate  
13 of greater than 90 percent. It's one of those  
14 things that if we're looking for areas where we  
15 don't want to add additional measures or new  
16 burdens of data collection and reporting, this  
17 doesn't seem to be an area that should be focused  
18 on.

19           DR. POLLOCK: With that -- Allen,  
20 thank you -- if the options are existing claims  
21 based, yet be built CrownWeb functionality, or  
22 existing NHSN functionality, and if the option

1 actually is really more between CrownWeb yet to  
2 be built and NHSN, NHSN's already built.

3 From the vantage point of having a  
4 system that's already available for use, that's  
5 being used to capture healthcare worker  
6 vaccination coverage, as well, which is to say  
7 NHSN is used to capture dialysis facility  
8 healthcare worker vaccination coverage, then I  
9 would change what I said earlier and say yes,  
10 let's go with a system that's already built. It  
11 depends on what CMS is looking at, in terms of  
12 its options. I would toss it back to Pierre just  
13 to clarify what's at stake.

14 DR. YOUNG: Is Tamara Garcia -- she's  
15 on the line, but she said she's on mute.

16 MS. SHAHAB: Operator, can you open up  
17 the line for Tamara Garcia, please?

18 OPERATOR: One moment, please. Her  
19 line is open.

20 DR. GARCIA: Hello, this is Tamara  
21 Garcia. I just sort of wanted to let you all  
22 know that we will provide you all with

1 information for both data sources for this  
2 immunization measure.

3 In terms of what we're looking to  
4 propose and the policy that we're currently  
5 developing, we can't really speak too much to  
6 that, but we will say that both the NHSN system  
7 and the CrownWeb system are going to be  
8 considered viable options as data sources for  
9 this measure. In terms of what the -- if the  
10 committee has any comments on a preferred system,  
11 we would love to hear back from you all on that.

12 DR. POLLOCK: I think systems are very  
13 important, but I think measures are important,  
14 too. I think, really, what's before the group  
15 here is a question about the measure. Certainly,  
16 what system would be used to enable the measure  
17 to be reported is important, but I have to admit  
18 I'm a little bit confused here about whether the  
19 measure itself is different than the measure  
20 that's currently in use.

21 Measures have numerators,  
22 denominators, exclusions, risk adjustment if

1 appropriate. Without having studied the existing  
2 measure and the proposed measure for this group,  
3 what's the analysis of the Delta?

4 DR. GARCIA: We are currently still in  
5 the process of developing the specifications for  
6 the measure that we will look to propose. Those  
7 are things that are still under consideration.

8 In terms of what you think is  
9 appropriate, with respect to the measure, are you  
10 stating that you think that the measure that's  
11 currently in place, or the measure that's up for  
12 discussion, whether or not it will be directly  
13 aligned with the QIP measure, do you think that  
14 it's appropriate?

15 What are your thoughts there, in terms  
16 of the current measure and what we currently are  
17 discussing, and then what we'll look to propose  
18 for the QIP, is there anything that you think is  
19 inappropriate based on what's currently -- the  
20 measure in question today, or do you have any  
21 sort of thoughts that you'd like to share with us  
22 while we are in the process of developing what

1 we're going to propose?

2 CO-CHAIR WALTERS: Mitchell, I suspect  
3 you and Nancy are going to say about the same  
4 thing because your cards went up identically, at  
5 the same time.

6 MEMBER LEVY: I'm sorry you can't see  
7 everybody's face because everybody is so puzzled.  
8 I guess, Pierre, you're going to say something.  
9 It sounds to me like you're describing developing  
10 a measure, and we think we're voting on a  
11 measure. I think we really need some  
12 clarification.

13 (Simultaneous speaking.)

14 DR. GARCIA: No, I apologize. Pierre,  
15 you can clarify if you'd like.

16 DR. YOUNG: Thanks, Tamara. So I do  
17 want to clarify. It is a fully developed  
18 measure. If you have questions, we have our  
19 measure developer on the line, if you have  
20 specific questions. The additional piece here is  
21 potentially using NHSN as a data source.

22 CO-CHAIR WALTERS: Nancy.



1                   MEMBER FOSTER: I think what you're  
2                   hearing around the room is consensus on the fact  
3                   that this is an important thing to measure, and  
4                   that we ought to do it right. As Dolores knows,  
5                   I'm not a huge fan of claims-based measures  
6                   generally speaking, but I think this one might  
7                   actually work. I would urge you to look at the  
8                   existing claims-based measure. If, for some  
9                   reason, you think the validity/veracity of it is  
10                  not what you need it to be, then tell us about  
11                  that. But otherwise, the only other  
12                  consideration I would put on the table is if, in  
13                  fact, you think that there is some greater  
14                  capability to use NHSN or some other platform  
15                  across all sectors of the healthcare system in  
16                  some way that allows greater coordination on flu  
17                  vacs.

18                         Then maybe there's a reason to do  
19                         this. But you've got something that's working  
20                         right now. I'm with Allen. Why break that  
21                         unless there's a substantial reason to do that if  
22                         you want flu vacs measures?

1 CO-CHAIR WALTERS: Mitchell.

2 MEMBER LEVY: Pierre, I'm sorry to be  
3 so thick. I hear that you're putting a measure  
4 on the table that's going to use NHSN data, but  
5 Dan's expressing concern about the validity of  
6 using those -- no, you're saying it's volunteer?

7 DR. POLLOCK: We would welcome use of  
8 NHSN for this purpose, but not if it means  
9 something that's already working is abandoned.  
10 We have an investment in NHSN. The taxpayer has  
11 an investment in NHSN. Something's built. But  
12 if something's already working, my goodness, we  
13 have enough work to do with what we've got. We  
14 don't need more. If it's not working, if there  
15 are, indeed, deficiencies/shortcomings with a  
16 claims-based approach -- and I'm not an expert on  
17 that.

18 I don't know -- then by all means  
19 let's use something that's already built, namely  
20 NHSN, rather than new functionality in CrownWeb.  
21 But isn't this really about a measure? If the  
22 measure's the same, then what are we talking

1       about here? I remain a little bit puzzled.

2                   CO-CHAIR WALTERS: I think we've done  
3       a good job of getting what the issue is out on  
4       the table. Allen, after your comment, I'm going  
5       to ask you and Beth -- because you seem to be  
6       collaborating a lot over there -- for  
7       recommendations about what you would make to the  
8       group for how to vote on this measure -- on this  
9       measure. Allen.

10                  MEMBER NISSENSON: One, it would be do  
11       not support, but I want to answer Dan's question.  
12       I'll just give you a few examples because these  
13       measures aren't the same. One, the vaccination  
14       dates are different. You don't have to go into  
15       the details, but the existing metric is  
16       consistent with other NQF-endorsed influenza  
17       vaccination metrics, in terms of the dates.  
18       There's no discussion of any contraindications in  
19       the exclusion. I'm just give you a few examples.

20                  It doesn't address inactivated  
21       vaccine, which is something that's addressed in  
22       the currently endorsed measure. This one also

1 excludes patients who are incident patients, at  
2 least in the first 30 days, which the existing  
3 metric includes patients from Day 1. There are  
4 substantive differences compared to the existing  
5 measure.

6 DR. POLLOCK: That's very helpful,  
7 Allen. Now we're talking about the potential  
8 need to get clinical data that would be relevant  
9 with respect to a decision about whether to  
10 vaccinate a patient or not. Those data may not  
11 be available in a purely claims-based approach.  
12 Again, I think the issue really, here, should be  
13 much more about the measure itself, the proposed  
14 measure, which would use clinical and other  
15 records that are maintained and not be purely  
16 claims, if I'm understanding that correctly. If  
17 the discussion is around is there a value in  
18 going beyond a claim in order to understand some  
19 of the factors that you just mentioned, I think  
20 that there's inherent value in the claim --  
21 inherent value in an alternative approach to a  
22 claims based, but I think that's really the

1 central issue, not -- whether we use CrownWeb or  
2 NHSN, that's something that ultimately is an  
3 operational consideration. I've laid out what  
4 I'd be concerned about. But if the measure's a  
5 better measure, by all means, let's shift to that  
6 one.

7 CO-CHAIR WALTERS: Beth, do you have  
8 a suggestion about a registry-based measure?

9 MS. EVANS: My only comment about NHSN  
10 or CrownWeb is the additional time for staff to  
11 input that data. That does have some relevance.  
12 But generally, based on what Allen has said,  
13 comparing the two measures, I think the older  
14 measure or the endorsed measure is the  
15 appropriate measure to stay with using  
16 claims-based data right.

17 (Simultaneous speaking.)

18 CO-CHAIR WALTERS: Sean, you're the  
19 other lead discussant.

20 DR. MORRISON: I am still trying to  
21 wrap my head around this. I appreciate Dan's  
22 comments about the advantage of moving beyond

1 claims-based data. Thinking about this measure,  
2 it's conditional, based upon NQF endorsement, and  
3 actually, I think I would like to see that go  
4 through the endorsement process first. So I  
5 would not reject it out of hand. I'd like to see  
6 it go through the NQF endorsement process. I'd  
7 like to see the specs. I'd like to see how it  
8 compares to the other measures which would be  
9 part of that endorsement process, and then I'd  
10 like to see it back again.

11 CO-CHAIR WALTERS: Allen.

12 MEMBER NISSENSON: I want to go back  
13 to --

14 CO-CHAIR WALTERS: I think we're going  
15 to draw this to a close pretty soon. Allen and  
16 Dan.

17 (Simultaneous speaking.)

18 MEMBER NISSENSON: -- Dan's point,  
19 which is my interpretation of the difference is  
20 that all of the differences are negative  
21 differences. They're not enhancements. The  
22 things that I rattled off are things that are not

1 included in the new metric, or changed, that make  
2 the metric worse. My second point, and Pierre  
3 can correct me if this is inaccurate, I don't  
4 know that the current metric has to use claims  
5 data. That may be the way it's endorsed right  
6 now, but in terms of the actual specs, whether  
7 that exact set of specs could be documented using  
8 either CrownWeb or going through NHSN -- I think  
9 to your point, which is an appropriate metric?  
10 The existing one is more in line with other  
11 endorsed influenza metrics. The new one does not  
12 include the things that I mentioned which, I  
13 think, make that metric worse, not improve it,  
14 from a clinical point of view.

15 CO-CHAIR WALTERS: Dan, last comment.

16 DR. POLLOCK: Two comments.

17 CO-CHAIR WALTERS: Last comments.

18 DR. POLLOCK: First, to Beth's point  
19 about data burden, it's not built into CrownWeb  
20 yet. We don't know what the data burden is, so  
21 how can we compare without having a system to  
22 compare it against? In terms of what are the

1 negatives that Allen's alluded to, there are  
2 contraindications to administering influenza  
3 vaccination. If those contraindications are not  
4 taken into account in a measure that uses the  
5 denominator of the patient population and the  
6 numerator, those for whom a claim has been  
7 submitted for influenza vaccination, then that  
8 doesn't capture or enable a facility or group of  
9 facilities to report that the reason for  
10 non-submission of a claim is the  
11 contraindications. That would be a gap that I  
12 think should be addressed.

13 CO-CHAIR WALTERS: After this very  
14 rich and deep discussion, is there any of the  
15 non-renal experts in the room that don't  
16 understand all the issues that have been brought  
17 up? Okay, let's vote.

18 MR. TILLY: Okay, the polling is now  
19 open for ESRD vaccination for full-season  
20 influenza vaccination, MUC15-761. The options  
21 are support, conditional support, and do not  
22 support.



1 (Voting.)

2 The results are 8 percent support, 23  
3 percent conditional support, and 69 percent do  
4 not support. The recommendation is do not  
5 support.

6 CO-CHAIR WALTERS: That's a pretty  
7 strong mandate. We'll move on to Measure No. 4,  
8 which is hypercalcemia measure. That was pulled  
9 by Allen.

10 MEMBER NISSENSON: This one, I think,  
11 is a little bit simpler. There are two issues  
12 with this one, really. One is that this is  
13 already a topped-out measure. In fact, NQF has  
14 already recommended it for reserve status.

15 But probably more importantly, from a  
16 clinical point of view, when this metric was  
17 added, it was because it was felt -- and I think  
18 there was a legislative mandate to include some  
19 kind of metric related to bone and mineral  
20 metabolism, which is an important clinical area  
21 for kidney patients.

22 This one was picked because there was

1 a hypercalcemia metric already endorsed by NQF  
2 for other settings. That all perfect sense. The  
3 unfortunate part is that it's not clinically  
4 important in this population because almost  
5 everybody has calciums below this target level.

6 We've just, as a group, endorsed the  
7 phosphorous measure, which is another metric that  
8 applies to bone disease, which is not perfect  
9 entire, but it's more perfect than hypercalcemia.  
10 So for both of those reasons, this measure is not  
11 relevant. Again, as we're looking to economize  
12 on a number of metrics out there, this one really  
13 doesn't add any value for clinical care.

14 CO-CHAIR WALTERS: Beth.

15 MS. EVANS: I actually brought the  
16 paper from the renal standing committee, and we  
17 had down that 1454 NQF, proportion of patients  
18 with hypercalcemia, was endorsed on reserve  
19 status. We thought it was a topped-out measure.  
20 We alluded to the fact that we needed to have  
21 some sort of bone mineral metric, but this really  
22 was not an indicated one. That was our way that

1 we would just review it, but we didn't find it to  
2 be necessary.

3 CO-CHAIR WALTERS: Sean.

4 DR. MORRISON: I had a couple of  
5 questions about that. The first was that I'm not  
6 sure that making the argument a topped-out  
7 measure, so it should be discontinued, is a good  
8 argument. Because what we know, based upon many  
9 of the quality metrics, is that once we put  
10 something in place, the big issue is how do you  
11 continue it.

12 The fact that it's topped out could  
13 have two issues. One is it's working, and we  
14 should continue it because it's working? Two,  
15 what's the unintended consequence of dropping it  
16 out, and are we going to see a return back to  
17 where things are? The second, which I would  
18 appreciate both Allen and Beth's comment about,  
19 is that in the developer response to the measure,  
20 they did note that there is still variability in  
21 terms of hypercalcemia, ranging anywhere from 0  
22 up to 4 percent, and the developer again pointed

1 out that this measure was continually important  
2 for safety monitoring.

3 Again, I'd appreciate hearing back  
4 those comments. Again, every time somebody says  
5 a measure is topped out, I ask is that because  
6 it's working and we should continue it, rather  
7 than we've made the accomplishments, time to pack  
8 up, go home, and we can move on to something  
9 else, and then we just watch it slide back again  
10 because our attention is focused on something  
11 else.

12 CO-CHAIR WALTERS: Thank you. I do  
13 want to get back to CMS, but let's see if we  
14 accumulate some more questions.

15 (Simultaneous speaking).

16 DR. PHELAN: Along the same lines as  
17 Sean, although I disagree a little bit that if  
18 it's topped out -- I don't know. We can always  
19 come back and review it and see what happens. My  
20 concern is A, is it topped out? You mentioned 4  
21 percent. I'm reading, in our agenda that we have  
22 today, that it the gap was 15 percent of

1 facilities performing worse than expected.

2 This goes back to our discussion we've  
3 had a couple times before. Bringing this kind of  
4 data back to us, so we can see what actually is  
5 the rate of hypercalcemia in these ESRD  
6 facilities, so we can say oh, yes, it looks like  
7 it's topped out. I'm not sure I would -- if it's  
8 15 percent, that doesn't sound like it's topped  
9 out to me. If it's 4 percent, I'm not sure  
10 that's topped out.

11 I think I would still want to  
12 encourage the use of this type of measure. Not  
13 knowing what the actual rate is now makes me a  
14 little bit worried about not supporting this.  
15 Because initially, I was kind of leading towards  
16 do not support, until I read the comments that,  
17 at least in what we have, I'm hearing 15 percent.  
18 Sean's mentioned 4 percent. That's where I'm  
19 concerned. Is it topped out is my first  
20 question. If it is topped out, I would be  
21 comfortable, but what does the definition of  
22 topped out mean? That's my comment.

1 CO-CHAIR WALTERS: We're going to get  
2 back to Allen and CMS in just a second. Jeff.

3 MEMBER JACOBS: I wanted to chime in  
4 on this concept of topped out, also. This is  
5 more in my hat, sometimes, as a measure developer  
6 and as a heart surgeon. I've been sitting in  
7 this chair here before, presenting measures about  
8 cardiac surgery, which were good measures, which  
9 had the discussion about being topped out, and  
10 then were put into reserve status because they  
11 were topped out.

12 One of the unintended consequences of  
13 taking a good measure and turning it into a  
14 reserve status because it's topped out is that  
15 the funding that an institution allocates to  
16 comply with that measure suddenly disappears.  
17 These measures are sometimes used as a weapon  
18 when a clinician is meeting with a middle manager  
19 in a hospital to request allocation of funds for  
20 an important quality activity within a hospital.  
21 When the measure disappears because it's topped  
22 out, then the funding magically disappears, also,

1 because the middle manager can advance their own  
2 career by using that funding to make their bottom  
3 line look better. That's kind of a pessimistic  
4 way to look at it, but it's also a realistic way.  
5 I would echo the sentiments that just putting  
6 measures into reserve status or making them  
7 disappear because they're topped out may have  
8 some unintended consequences that are not so  
9 good.

10 CO-CHAIR WALTERS: Let's go to Allen,  
11 and then Mitchell.

12 MEMBER LEVY: Although I really  
13 appreciate what you're saying and what Sean's  
14 saying. There's so much metric fatigue amongst  
15 hospitals and data collectors. That's how it's  
16 happening. Our job here is to add metric after  
17 metric after metric.

18 What we've done in my work, or at a  
19 certain point when you're over 80-90 percent,  
20 it's fine to take it off the table. It doesn't  
21 mean you never revisit it again. You can still  
22 monitor it. If it turns out that it's slipping

1       into the 50s and 60s, then it's time to  
2       re-invigorate it, but I do think at a certain  
3       point, you have to acknowledge that when you get  
4       to a certain level, it's time to stop.

5                   CO-CHAIR WALTERS: I think we're  
6       settling in on what the key issue is here.  
7       Allen.

8                   MEMBER NISSENSON: Sean, in response  
9       to your question, I agree with the general  
10      concept of removing topping out. We have  
11      metrics, for example, adequacy of dialysis, where  
12      the curve has shifted way to the right, very  
13      little variation, but where the vast majority of  
14      people don't believe that should be removed.

15                   What's different about this metric is  
16      that it wasn't needed in the first place. When  
17      it was first introduced, there were very few  
18      facilities that exceeded the benchmark, which is  
19      arbitrarily set in very small percentage of  
20      patients with hypercalcemia, but that metric was  
21      picked.

22                   Since the metric has been in place,



1       there's no evidence that I'm aware of that it's  
2       changed at all. It sort of was addressing a  
3       problem that wasn't a problem. For that reason,  
4       this one, I think, is in a little different  
5       category of topped out than some others might be.

6               DR. MORRISON: That's very helpful.  
7       As I say, I'm a geriatrician, not a nephrologist,  
8       so extremely helpful, thank you.

9               CO-CHAIR WALTERS: Okay, you should  
10      have a lot to respond to by now.

11              DR. YOUNG: There are two things we  
12      wanted to respond to. One was on the topped out  
13      issue. As Beth indicated, this was endorsed for,  
14      I guess -- I don't know if that's the word, but  
15      reserve status under recent consideration from  
16      the renal standing committee. Though in those  
17      discussions, there was not small percentage of  
18      facilities which still were not performing at  
19      this high level, compared to the other  
20      facilities. I was wondering if Casey, if you are  
21      on the line, can you talk a little bit about the  
22      performance data?

1 DR. MESSANA: Yes. Pierre, this is  
2 Joe Messana at U of M KECC. I'm here with Stacy.  
3 For the committee members, I'm a nephrologist and  
4 work with U of M KECC on quality measure  
5 development.

6 CO-CHAIR WALTERS: You're cutting out  
7 real bad. We're getting about every other word.  
8 We're kind of getting the gist of what you're  
9 saying, but not easily.

10 DR. MESSANA: Is this better?

11 CO-CHAIR WALTERS: We'll see. Okay,  
12 go ahead.

13 DR. MESSANA: I'll try -- and I can go  
14 on the handset if need me. Please let me know.  
15 Please interrupt. We submitted a request for  
16 reconsideration to the standing committee after  
17 the topped-out argument was made. We presented  
18 data that showed that many facilities were very  
19 successful in their ability to achieve extremely  
20 low rates of hypercalcemia.

21 Over half the facilities, or about  
22 half the facilities -- 3,000 or so facilities

1 have 1 percent or less of their patients with  
2 hypercalcemia. So this metric, I should add, was  
3 developed as a safety measure. So it wasn't just  
4 looking at individual patients. To be flagged,  
5 one had to have an average calcium over a  
6 three-month period above the generally accepted  
7 normal range that was the original percent. So  
8 it's a fairly conservative measure of  
9 hypercalcemia as a safety measure. If you look  
10 at the distribution of this measure, something on  
11 the order of 23 percent of dialysis facilities  
12 have 4 percent or greater of their patients.

13           Although we think that there is a  
14 distinct performance gap, in that many --  
15 including, I'm sure, many of Dr. Nissenson's  
16 facilities have no patients with hypercalcemia,  
17 where nearly 25 percent of facilities in the  
18 country have 4 percent or more of their patients  
19 with hypercalcemia. We think that's an eloquent  
20 argument for the persistent gap.

21           MEMBER NISSENSON: Say that last thing  
22 again -- 25 percent of facilities have what

1 percent of their patients with hypercalcemia?

2 DR. MESSANA: Have 4 percent or more  
3 of their patients, so 23 percent of facilities in  
4 the U.S., in the year that we looked at -- I  
5 believe it was 2014 data, 23 percent of U.S.  
6 facilities had 4 percent or more of their  
7 patients with a quarterly average calcium value  
8 that was considered hypercalcemia.

9 CO-CHAIR WALTERS: I think that's  
10 helpful data. I hope we're getting closer to a  
11 conclusion. Allen.

12 MEMBER NISSENSON: Joe and I have  
13 discussed this at length in the past. I think  
14 it's for the group to decide if 4 percent of  
15 patients represents a huge gap. For those 4  
16 percent of patients who are hypercalcemic, that's  
17 a problem. On a population basis, when we look  
18 at all the other metrics we have and the  
19 performance distributions, whether it's  
20 phosphorous, in the case of bone disease, or  
21 other things, there's a much wider gap of  
22 performance and a need to focus on issues.

1           Again, it's not to take anything away  
2     from the importance of the very small number of  
3     patients who are hypercalcemic. That's something  
4     that needs to be addressed, but whether that  
5     really makes the cut as a true performance metric  
6     for an organization or a facility, I think I  
7     would still challenge that.

8           CO-CHAIR WALTERS: Your recommendation  
9     to the committee was?

10          MEMBER NISSENSON: Mine was to not  
11     support.

12          CO-CHAIR WALTERS: Is there any other  
13     discussion? Does everybody understand the issue  
14     at hand? Let's go with a vote.

15          MR. TILLY: The polling is now open  
16     for proportion of patients with hypercalcemia,  
17     MUC15-1165. The options are support, conditional  
18     support, and do not support.

19                 (Voting.)

20                 We're just looking for a couple more,  
21     if you guys want to try again. The results are  
22     25 percent support, 8 percent conditional

1 support, 67 percent do not support. The  
2 recommendation is do not support.

3 CO-CHAIR WALTERS: Thank you very  
4 much. I know that took a little time, but it's  
5 very important to clarify what -- I think we're  
6 doing a good job of getting to what is the issue  
7 on the table? You can lay that out as easily as  
8 possible, so that people can make a decision.

9 MEMBER BENIN: Another programmatic  
10 question?

11 CO-CHAIR WALTERS: Sure.

12 MEMBER BENIN: I am trying to learn a  
13 little bit more about this program, make sure I  
14 understand it properly. It looked as though, for  
15 some of the metrics, if you have small numbers,  
16 you don't count. Does that mean you don't count  
17 just on Dialysis Compare, or do you not count  
18 also for the payment program? If you have less  
19 than 25 patients in your dialysis program, these  
20 percentage -- one or two patients makes a  
21 difference in these numbers in a big way. I'm  
22 just wondering does that impact the payment

1 incentive, also, or is it just Dialysis Compare?  
2 What's the situation?

3 DR. YOUNG: Tamara, can you answer  
4 that question?

5 DR. GARCIA: Sure. For the ESRD-QIP  
6 program, we have a small facility adjuster for  
7 facilities that have 11 to 25 patients that are  
8 eligible for any given measure. That accounts  
9 for the impact of patients who might be outliers,  
10 one or two patients who have outcomes that are  
11 extreme on one end or the other. For the  
12 ESRD-QIP program, that's how we account for that.  
13 Again, it's 11 to 25 patients. It's a small  
14 facility adjuster. It's applied on a  
15 measure-by-measure basis. Did that answer your  
16 question?

17 MEMBER BENIN: Partially. What does  
18 that mean? It just gets adjusted to -- I'm just  
19 not sure what that means.

20 (Simultaneous speaking.)

21 DR. GARCIA: Yes. If a facility  
22 performs below the benchmark, which is the 90th

1 percentile -- if they're not in the top 10  
2 percent of performers for any given measure, they  
3 will have an adjustment applied to that measure  
4 if they have 11 to 25 patients. That will  
5 prevent those -- the patients who, again, have  
6 extreme outcomes from impacting the measure  
7 score, to the point where they would, in essence,  
8 receive a reduction based on one or two folks.  
9 It prevents that from happening. It adjusts  
10 their score up and accounts for that small sample  
11 size.

12 MEMBER BENIN: People generally have  
13 been happy with that adjuster?

14 DR. GARCIA: Yes, they are very much  
15 happy with that adjuster. We received very  
16 positive feedback on it when it was finalized in  
17 the Calendar Year 2016 rule, which was published  
18 in early November.

19 CO-CHAIR WALTERS: Okay, moving on to  
20 Measure 5, standardized mortality ratio. That  
21 was pulled by Nancy.

22 MEMBER FOSTER: It is a hospitalization



1       measure. This is one of those measures that we  
2       think will be exquisitely sensitive to SDS,  
3       sociodemographic factors, so really wanted to  
4       explore that with this group and emphasize the  
5       need for that to be looked at by the NQF panel as  
6       they consider it.

7               CO-CHAIR WALTERS: The staff  
8       recommendation was conditional support pending  
9       NQF endorsement.

10              MEMBER FOSTER: With my enhanced  
11       understanding of how this works, I would support  
12       the conditional support, as long as we can point  
13       to the SDS factor, as well, in this measure.

14              CO-CHAIR WALTERS: Yes, Pierre.

15              DR. YOUNG: You said mortality, but  
16       we're talking about hospitalization, correct?

17              CO-CHAIR WALTERS: This one's  
18       hospitalization, that's correct. Allen.

19              MEMBER NISSENSON: This comment is  
20       going to apply both to this one and the  
21       standardized mortality ratio. We have a number  
22       of issues with using standardized ratios for

1       these metrics. The issues include one, there's  
2       no way for us to reproduce the information, since  
3       the denominator is calculated, and we have no way  
4       of calculating that ourselves, so we can't  
5       actually track this. Secondly, when you look  
6       longitudinally, we think it's much more valuable  
7       -- and we've recently published some data on this  
8       -- to look at rates, rather than standardized  
9       ratios, so hospitalization rates, mortality  
10      rates. We can follow those over time and look at  
11      trends. Whereas, with standardized ratios, we  
12      can't really demonstrate trends.

13               In addition -- and you'll notice in  
14      the specs, the developer describes using --  
15      applying a risk adjustment model to risk adjust  
16      these standardized ratios -- and applies, again,  
17      to both -- but it has not been possible to  
18      actually get the risk adjustment model, so it can  
19      be looked at.

20               Sociodemographic status is one factor  
21      we've talked about a lot, but there are a bunch  
22      of other things that have now been demonstrated

1 in the ESRD patients that drive outcomes,  
2 including mortality and hospitalization, besides  
3 SDS, geography. There's a whole list of things.  
4 Possibly, they're all included. I'm skeptical.  
5 But without actually being able to see the  
6 methods, it's very difficult to have confidence  
7 in this. The final thing is that for those  
8 measures where there is some comorbidity  
9 adjustment -- and I'm sure Pierre will want to  
10 comment on this -- CMS just recently had a TEP  
11 looking at what the best source of information is  
12 for comorbidity, obtaining comorbidity data. For  
13 some of these standardized metrics, what's  
14 currently used is a form -- without getting too  
15 deeply into the weeds, but this is fairly  
16 superficial -- a form called the 2728 Form.

17 It's a Medicare ESRD attestation form  
18 that a nephrologist has to sign when a patient  
19 starts dialysis. On that form is a checklist,  
20 where you check off comorbidities. That's done  
21 once when the patient starts dialysis. That is  
22 now used as the comorbidity list for adjustments

1 in some of these standardized ratios, despite the  
2 fact, as we all know, these chronically ill  
3 patients have changing comorbidities, but there's  
4 no opportunity to change.

5 So we're strongly in favor of using  
6 claims data, which is more contemporary and more  
7 accurate. CMS, I think, agrees, and just had a  
8 TEP that met and, my understanding was, made that  
9 recommendation. But these ratios don't use that  
10 methodology, or they don't comment on that. It  
11 seems to me if there's going to be a change in  
12 methodology that endorsing these metrics kind of  
13 doesn't make sense, besides the other things that  
14 I think are important.

15 CO-CHAIR WALTERS: Do your comments  
16 apply to Measure 7, too? There's going to be a  
17 method to my madness here in just a second.

18 MEMBER NISSENSON: Four --

19 CO-CHAIR WALTERS: You said 5 and 6.

20 MEMBER NISSENSON: Four, five --

21 CO-CHAIR WALTERS: Five and six you  
22 talked about.

1                   MEMBER NISSENSON: Four, five and six.  
2 They largely apply to all three of these.

3                   (Simultaneous speaking)

4                   CO-CHAIR WALTERS: Five, six, and  
5 seven?

6                   MEMBER NISSENSON: Five, six, and  
7 seven, yes.

8                   CO-CHAIR WALTERS: Nancy, did your  
9 comments apply to 7, also?

10                  MEMBER FOSTER: Yes, thank you.

11                  CO-CHAIR WALTERS: All right. Because  
12 the other person who pulled No. 6 was Sean. I'm  
13 going to ask you to talk about not only 6, but as  
14 a lead discussant, your opinion about 5, 6 and 7  
15 is.

16                  DR. MORRISON: Let me do 5 and 7  
17 first, Ron, and then come back to 6 because  
18 they're different issues. I think part of this  
19 -- what I'd like to say is 5 and 7 are all  
20 pending NQF endorsement.

21                  I think this comes back to how much do  
22 you trust the NQF process to look at the issues

1       that both Nancy and Allen raised about does the  
2       measure include the right risk adjustment? Are  
3       the models correct? I think that all of us are  
4       appropriately skeptical, but I do come from the  
5       bias, having sat on those panels, that it is a  
6       very rigorous and scientific process that these  
7       issues are looked at and that we can be pretty  
8       confident, when they come forward to us, that the  
9       science behind them is good.

10               What I'm hearing is concerns about the  
11       science. I think the conditional support for  
12       those measures is appropriate, and that they go  
13       through the NQF endorsement process, and that  
14       these will be resolved. I do trust that will  
15       happen, but I do come from that bias. Those are  
16       related to the re-admission and to the  
17       hospitalization rate. The reason that I asked  
18       that the mortality rate be pulled -- and those of  
19       you who have been on this committee for a long  
20       time with me know how I feel about mortality  
21       rates -- but it really is, I think, that  
22       mortality for end-stage renal disease is really

1 quite a poor measure as it's written now.

2 Most people who discontinue dialysis  
3 elect to discontinue dialysis. They determine at  
4 some point that continuing on dialysis is a fate  
5 worse than death. For the people with advanced  
6 dementia who get started on dialysis in the  
7 hospital because their kidneys fail, they  
8 continue that afterwards.

9 This measure would penalize those  
10 people who elect to discontinue it, particularly  
11 older adults, over Age 70, where the median  
12 survival is only about three and a half years.  
13 It's not like the younger dialysis population,  
14 you can expect to live many, many years. This is  
15 a very short life expectancy. As a clinician, I  
16 will typically say to my patients considering  
17 this, "Let's do a three or four-month trial of  
18 dialysis and see what it's like for you, with the  
19 option that you can discontinue that." That then  
20 penalizes the dialysis center for whom that  
21 person says, "This is just not for me." I would  
22 like to see this measure go back. I would at

1 least like to see a provision that excludes  
2 patients who are referred to hospice, for  
3 example, from the denominator because those  
4 people have made an informed choice to  
5 discontinue. We expect them to die after they  
6 discontinue, or Buck would accept it. That's why  
7 I asked the mortality measure to be pulled, Ron.

8 CO-CHAIR WALTERS: We'll get to Beth  
9 next, but let's clarify the endorsement status of  
10 5, 6, and 7.

11 MS. MARINELARENA: Six and seven are  
12 endorsed.

13 CO-CHAIR WALTERS: That's what I want  
14 to make sure we --

15 DR. MORRISON: Is that the case, Ron?  
16 Because 6 says pending endorsement, sorry.

17 CO-CHAIR WALTERS: That's why we're  
18 just double checking. Because staff  
19 recommendation for 5 was pending endorsement, for  
20 6 was pending endorsement, and for 7 was support.  
21 As I look in the notes, it has been through the  
22 board vote and everything, so let's just make



1       sure everybody understands 5, 6, and 7. Can you  
2       make sure you check that? So we can get that  
3       resolved in everybody's mind.

4               MS. MITCHELL: Sean, just to clarify,  
5       are you recommending do not support No. 5?

6               DR. MORRISON: I'm sorry, Dolores.  
7       I'm recommending support 5 pending NQF  
8       endorsement, but Ron is checking on that. I'm  
9       recommending do not support the mortality issue  
10      because on this one, I think there's an important  
11      group that's been -- and then 7, I was  
12      recommending -- I was recommending support 7, and  
13      that that's been NQF endorsed.

14              MS. MITCHELL: That's helpful. Thank  
15      you.

16              MS. MARINELARENA: All of these  
17      measures are endorsed. They're up for  
18      maintenance, and we do have a renal project that  
19      opened up.

20              PARTICIPANT: A what?

21              MS. MARINELARENA: A renal project  
22      that's opening up for next year, so they'll be up

1 for maintenance in 2016, but they are currently  
2 endorsed.

3 CO-CHAIR WALTERS: I see you had your  
4 card up first.

5 MS. EVANS: Yes, have several things  
6 to say with this. I do agree with Allen that the  
7 hospitalization ratio and mortality ratio, having  
8 sat through the QIP many times and listening to  
9 it, everybody's face just kind of zones out when  
10 they say that. It has no relevance to the staff.  
11 They don't understand it.

12 We need to make it an understandable  
13 metric, in order for it to be valid for us to  
14 use. Changing it to a rate would make it more  
15 ability to be trended and tracked. The second  
16 thing on the mortality ratio, I totally agree  
17 with Sean. I can't tell you how many times we  
18 look at when patients go on hospice, which is a  
19 horrible thing for us to look at how long do they  
20 live on hospice and stop dialysis?

21 That was discussed on that 31 days  
22 they get the palliative care consult. The same

1        thing for us. When our patients go on hospice,  
2        how long do they live on the hospice, so we're  
3        not penalized for that aspect of it? It's not a  
4        good thing to look at. To remove that if  
5        patients go on hospice, that should be an  
6        appropriate measure that we use without a time  
7        frame. Then the final thing is the standardized  
8        re-admission ratio. Yesterday it was discussed  
9        over and over how the hospitals have the burden  
10       for so many aspects of care. It's the same thing  
11       with dialysis clinics.

12                They have the burden for these care  
13       which really is not within their regimen to be  
14       able to provide. This re-admission ratio is  
15       pretty much out of their ability to make a  
16       difference. That really is the nephrology  
17       provider's role. We really would like to work  
18       with CMS to have some sort of a transition  
19       coordinator.

20                Our hospitalization re-admission is  
21       phenomenally higher than people not ESRD. We  
22       know it is a big problem, both financially and

1 the outcomes from it are very bad. To put this  
2 in here is selecting the wrong way of monitoring  
3 it. There's other, better methods that we really  
4 feel should be placed in action.

5 CO-CHAIR WALTERS: What are your  
6 recommendations for 5, 6, and 7?

7 MS. EVANS: For 5 it's conditional if  
8 it's changed to a rate; 6, I will say, also, do  
9 not support, and 7 is do not support.

10 CO-CHAIR WALTERS: Allen.

11 MEMBER NISSENSON: Just a quick  
12 comment that I completely agree with Sean. I  
13 think mortality, whether you make it a rate or a  
14 ratio, however you calculate it, the way it's  
15 currently viewed for ESRD patients is an  
16 inappropriate metric. Unless it's fixed, in  
17 terms of the exclusions, which have to do with  
18 the initial trial -- all the things you  
19 mentioned, I totally agree with that. I, you  
20 might guess, for all three of these metrics, I  
21 would recommend not supporting, but I feel very  
22 strongly about the mortality one, as Sean has

1 articulated.

2 CO-CHAIR WALTERS: Thank you.

3 Mitchell.

4 MEMBER LEVY: I'm going to disagree  
5 with Sean and Allen. If you remember, we  
6 struggled with this with COPD last year. For me,  
7 especially working in the MICU, finally having  
8 advanced care planning with a COPD patient and  
9 getting them to hospice is a very important  
10 therapeutic intervention for us. We had this  
11 discussion last year, where it was shocking that  
12 in the metric, hospice was not an exclusion  
13 criteria for measuring COPD mortality. I've come  
14 to accept that, in that I agree that it's a very  
15 crude measure, but no more crude for ESRD than it  
16 is for measuring mortality from COPD and CHF in  
17 the hospital.

18 I've come to accept the imperfection  
19 of it. I think as a broad stroke, it's going to  
20 drive change. Perhaps we'll refine the metric.  
21 But I also think that if your mortality is much  
22 higher because you're putting all your ESRD

1 patients on hospice, it's hard for me to imagine  
2 that there are going to be a lot of outliers like  
3 that. I think it'll come out in the wash. I'm  
4 comfortable with that imperfection for this  
5 measure, in the same way that I was for COPD.

6 CO-CHAIR WALTERS: So far we've got  
7 Nancy, Ann Marie, Wei, and Helen. Nancy.

8 MEMBER FOSTER: Seeking further  
9 clarification around the NQF process here. You  
10 said the measures are endorsed, but they're up  
11 for review. I assume when they went through  
12 endorsement before, we really didn't have the SDS  
13 trial period open. My original request around  
14 SDS is something that would be entirely  
15 appropriate for the upcoming review. I'm seeing  
16 nods, so that sounds like (Simultaneous  
17 speaking).

18 MS. MARINELARENA: During the trial  
19 review, all measures are subject to SDS. We  
20 especially look at the outcome measures, but we  
21 do that. When the staff gets the measure  
22 submission forms, if it's not provided to us, we

1 need to have a rationale, but we do ask for that.

2 MEMBER FOSTER: Good. Secondly, I'm  
3 curious about how to respond to Beth's comment  
4 around conditional support, but only if it's  
5 changed away from an SIR. To me, that's a  
6 different measure. I'm looking at Beth. I would  
7 be perfectly happy saying, based on what you  
8 said, that we should not support this, but  
9 encourage the development of a similar, but  
10 different measure that is not a ratio. Am I  
11 misinterpreting, in your aspect, whether we're  
12 talking about two different measures or the same  
13 measure?

14 MS. MARINELARENA: Talking about  
15 suggesting a rate would be a completely different  
16 measure. So right now, you're going to be voting  
17 on what's on the table before you, which is the  
18 ratio. It's currently endorsed, and I believe  
19 it's already in the program.

20 CO-CHAIR WALTERS: Ann Marie.

21 MS. MARINELARENA: And so is 7. It's  
22 also in the program. So the new introduction to

1 the program is the mortality measure.

2 DR. SULLIVAN: Two things. First, I  
3 think that the issue about re-admissions and it  
4 being difficult is something that comes up every  
5 time someone is involved in being responsible for  
6 some degree of the re-admission numbers. I think  
7 the wider you spread that, the better off you  
8 are. I think hospitals felt they couldn't do it  
9 when it first came, and I think wherever you see  
10 it, you get that initial reaction.

11 I think that the re-admission should  
12 stay. My other question, though, is on the  
13 ratio. Since often rates have been used, was  
14 there any specific reason that a ratio was used  
15 with this population? Did people think this in  
16 any way was a good idea at the time? I'm just  
17 curious as to why it's here. I know most people  
18 here feel it's not a good idea, but is there  
19 anything positive about having a ratio versus a  
20 rate, or it was just happenstance?

21 CO-CHAIR WALTERS: I think you can  
22 take a break to answer that question, that



1 specific one.

2 DR. YOUNG: Actually, I'm going to ask  
3 if Casey or somebody from UM-KECC can address  
4 this specific question about why a ratio, though  
5 we are, I will add, cognizant of the express  
6 concerns about the usability of a ratio, and we  
7 are actively looking at a rate measure.

8 DR. SULLIVAN: Then could you just  
9 clarify are you really, seriously considering  
10 going to a rate? Because then I think that would  
11 influence how much we would support or not  
12 support this.

13 DR. YOUNG: Can somebody from UM-KECC  
14 address the question?

15 JOHN: Hello, this is John again. As  
16 a clinician, and not a biostatistician, I may not  
17 be able to fully answer it, but we've had  
18 extensive discussions over the years regarding  
19 direct versus indirect standardization. Because  
20 of the very low rate events, particularly for  
21 mortality, indirect standardization approaches  
22 have been strongly recommended by our

1 biostatisticians and have not been questioned by  
2 the NQF standing committees for initial  
3 certification and re-endorsement. Whether one  
4 expresses the results of indirect standardization  
5 as a ratio or as a rate, multiplying the ratio by  
6 the national average, as is done in Hospital  
7 Compare, seems to be less important an issue than  
8 the methodologic one of using indirect  
9 standardization based on data structure.

10 CO-CHAIR WALTERS: Okay, thank you.  
11 Helen, your card went down, right?

12 MS. HASKELL: I just have a question  
13 about hospice. I can see that there's fairly  
14 complex time limits on when people are considered  
15 to be on or off dialysis, but if going on hospice  
16 is going off dialysis, can the measure not be  
17 adjusted so that hospice is not reflected if it's  
18 up for maintenance?

19 CO-CHAIR WALTERS: We'll put that on  
20 the list of later questions. Wei.

21 MEMBER YING: I want to say that this  
22 is not the first set of measure ratio being used.

1 The standardized infection ratio has always been  
2 there, so not just this set. Whenever ratio is  
3 used, there is always this trending question. I  
4 don't think this should be the reason either we  
5 endorse or not endorse in this measure. Another  
6 thing about the rate is even it becomes a rate --  
7 for example, the re-admission rate, actually I'm  
8 leaving out that this year actually convened a  
9 workgroup to look at the trending issue. Even if  
10 it becomes a rate, when it's risk adjusted, it  
11 still has the trending over time problem. I  
12 don't think this is one of the key factors that  
13 should prevent us from supporting this measure.

14 CO-CHAIR WALTERS: Jack.

15 DR. FOWLER: Just one more comment on  
16 the rate ratio. I went and looked up what's the  
17 ratio of. Anyways, I'm clear about that.  
18 Somebody creates an expected number, and then  
19 it's the ratio of what's observed to what's  
20 expected. It's the way that the statisticians  
21 adjust it for whatever the model is, which I  
22 can't attest to. But that's what it is, in case

1       you wondered what the ratio was about.

2                   CO-CHAIR WALTERS:   Okay, Pierre.

3                   DR. YOUNG:   Thank you for the very  
4       rich discussion here.   I think just to offer a  
5       general comment, we've included on the MUC list,  
6       but also in programs, measures of re-admissions  
7       and mortality, not just in hospitals, but also in  
8       other facilities, too.   I think that reflects a  
9       viewpoint from CMS that there is a joint role for  
10      all providers to work together in sort of taking  
11      care of patients.

12                   Certainly, there is always this larger  
13      question of who has the primary responsibility  
14      for doing that, but we hope that there is  
15      agreement that everybody does need to work  
16      together in order to take care of patients, and  
17      that these measures encourage care coordination  
18      in the interest of the patient's health.   That's,  
19      I think, the intent, from our standpoint, for  
20      including these measures in these programs to  
21      drive quality improvement.

22                   There are a couple issues, also, that

1 Allen had raised that we are also actively  
2 working on, such as the use of claims data for  
3 comorbidity. That was just recently discussed at  
4 this TEP, and they were supportive of that. I  
5 will say that the measure -- as Melissa just  
6 mentioned, there is a renal project opening up.  
7 We are planning to submit the measures to that  
8 committee for consideration for maintenance in  
9 April, so they will be reviewed in that process,  
10 under the CDP process.

11 CO-CHAIR TRAVIS: I just wanted to  
12 kind of reinforce some of what Pierre said, as  
13 well as Ann Marie. During the review process,  
14 through the CDP process and endorsement, the  
15 issue relative to re-admissions was thoroughly  
16 discussed, and rightfully so.

17 But I think that from the CSAC's  
18 position, when we looked at it, was really  
19 looking at this joint accountability issue that  
20 Pierre brought up. One of the things we heard,  
21 and we've heard in the MAP originally from the  
22 hospital group, was they're not the only ones

1       that impact re-admission.

2               I think it's actually a good sign that  
3       CMS is beginning to bring re-admission into these  
4       other programs because the answer is it isn't  
5       just one provider's responsibility to be held  
6       accountable for that. It is really trying to  
7       encourage this care coordination and providers  
8       working with each other, including the  
9       nephrologist and the other providers. To Ann  
10      Marie's earlier point, I think there is  
11      definitely people who are uncomfortable with it  
12      when it first gets introduced. They may never  
13      like it, but I think it is kind of an effort that  
14      we're seeing to spread the re-admission measure  
15      into the continuum of care and, therefore,  
16      actually encourage that working together for care  
17      continuation.

18             The other thing that I just bring up  
19      a little bit -- and I appreciate the interest and  
20      the need, really, for facilities to be able to  
21      kind of calculate what they're going to look like  
22      -- as Wei brought up, we have the risk

1 standardized approach in a lot of other measures.  
2 But one of the things that I've noticed in my own  
3 market is that sometimes the measures that  
4 purchasers need or consumers need may be  
5 different than the measures that providers need  
6 for internal quality improvement.

7           They make sense to us, but they don't  
8 always give the level of detail or the ability to  
9 recreate them to the providers. I think it's  
10 fair to have both sets of measures because these  
11 programs are also used by purchasers and  
12 consumers. I recognize the tension. I do think  
13 the fact that we use those types of measures in  
14 other programs also, I think, is an important  
15 piece that Wei brought up. Those are my  
16 thoughts.

17           CO-CHAIR WALTERS: I agree. There are  
18 other viewpoints and considerations to achieve  
19 that cross-programmatic stuff that Taroon was  
20 talking about earlier, as well as different  
21 perspectives for both those considerations.  
22 Andrea.

1                   MEMBER BENIN: Sorry, I just have a  
2 question to try to resolve this in my mind,  
3 understanding this rate and ratio issue. Is this  
4 just a matter of how the report is formatted?  
5 Couldn't it just be reported with the rate on it,  
6 as well? Because we deal with this all the time.  
7 I tell everybody what our central line infection  
8 rate is, but then I tell them how it stands  
9 statistically based on what the SIR is.

10                   I'm like, "You're doing okay; you're  
11 not doing okay." We do that with mortality, too.  
12 We say the mortality rate is 1 percent, and  
13 that's an ODE ratio of 0.65, and it's adjusted,  
14 and it's good or it's not good. So to my mind,  
15 this isn't actually -- because statistically,  
16 based on what we just heard, we want this done  
17 statistically, probably, in the way that it's  
18 being done. So isn't it just a matter of then  
19 adding the actual percentage to -- I'm just a  
20 little bit -- I'm not sure if the issue is really  
21 a methodological one, or if the issue is a desire  
22 to have, as Cristie says, some information that



1 people can use that feels more actionable. If  
2 that's the case, then it sounds to me like it's  
3 just a matter of tweaking the report, but I'm --  
4 so I'm confused as to whether this is a  
5 substantive issue or not because it doesn't  
6 (Simultaneous speaking).

7 CO-CHAIR WALTERS: Sean.

8 DR. MORRISON: Andrea, yes, it's very  
9 simple to do. You have an observed to expected  
10 ratio. You have your actual rate, and you can  
11 then look at both of them. So statistically,  
12 yes, it's very easy to do. You're right. That's  
13 what my institution does, as well.

14 CO-CHAIR WALTERS: Allen.

15 MEMBER NISSENSON: That all sounds  
16 great. The problem is with how you determine  
17 what the expected rate is. I think if that were  
18 totally transparent and people agreed on that  
19 methodology, then I agree with you. Then you can  
20 just do arithmetic, and you can translate that  
21 into a rate. But right now, it's opaque. It's  
22 not that standardized ratios are not a

1 statistically valid approach. It's that if  
2 you're comparing actual to expected, how do you  
3 determine what is expected? Because it's not  
4 just simply the average death rate across the  
5 country or the average hospitalization rate.

6 It's adjusted for a bunch of  
7 characteristics which, unless you know what those  
8 are, you don't have a chance to comment on  
9 whether those are appropriate, or whether all of  
10 the appropriate things are included. But again,  
11 I'm not a statistician either, but I can tell you  
12 this has been an ongoing dialogue with the  
13 measure developers that work with CMS on the ESRD  
14 program for over a decade. We have yet to come  
15 to some unanimity of opinion about this.

16 CO-CHAIR WALTERS: Okay, we're  
17 approaching a vote. As Erin just reminded me,  
18 the reason I did this in this way, because there  
19 were issues that were shared amongst those three  
20 measures, and then there are also some unique  
21 differences. For Measure No. 5, we're heading  
22 into a vote, but not quite ready to vote yet.

1 Are there any issues specific to 5 that someone  
2 would like to bring up that has not already been  
3 mentioned? Does everybody in the room understand  
4 the issues related to the hospitalization ratio?  
5 Cristie.

6 CO-CHAIR TRAVIS: I apologize because  
7 I've gotten kind of confused as to what the NQF  
8 status is with some of these. I would just like  
9 to hear it one more time what the status is.

10 CO-CHAIR WALTERS: For 5. Let's do 5,  
11 just 5.

12 CO-CHAIR TRAVIS: What is the status  
13 for 5?

14 MS. MARINELARENA: Five is endorsed,  
15 and it's up for maintenance. Based on the  
16 information that we received, the change would be  
17 to the risk adjustment model. That will be  
18 reviewed. In SDS, it is -- we'll evaluate it for  
19 SDS, as well, as part of our trial period.

20 CO-CHAIR TRAVIS: I apologize. Can I  
21 ask a clarifying question? I was trying to  
22 figure this out, and I didn't hear your

1 instructions ahead of time, so I apologize. I  
2 guess my question is, just to be sure I  
3 understand, it's been endorsed, it's up for  
4 maintenance, the risk adjustment is probably  
5 what's going to come through and have SDS as part  
6 of it, but is it clear how the expected is -- is  
7 that part of the specs in this endorsed measure  
8 (Simultaneous speaking.)

9 DR. AMIN: Cristie, I think you're  
10 bringing up a really good point. The question  
11 here is -- it's almost a versioning question.  
12 There are updates to this measure, and the  
13 updates are substantial, in the sense that it's  
14 related to the risk adjustment model.

15 For these outcome measures, obviously  
16 risk adjustment model is an important element.  
17 Maybe a good way to characterize this is that a  
18 previous version was endorsed. This new version  
19 will be reviewed by the renal committee for the  
20 full specifications, which include updates to the  
21 risk adjustment model.

22 All of the clarity around the new risk

1 adjustment model is up to interpretation if you  
2 have enough, or whether it's sufficient. That's  
3 up to this committee to decide. Is that fair?  
4 You can make some conditional recommendations to  
5 the renal committee to specifically look at the  
6 concerns that have been raised here.

7 CO-CHAIR TRAVIS: Just so that --  
8 because I know we're going to do this on the next  
9 two measures, and this will help me not have to  
10 ask these questions again. Just for my  
11 understanding, the adjustments to the risk  
12 adjustment model, I'm thinking, would probably  
13 have an impact on how the expected gets  
14 determined. So all of that will be reviewed in  
15 2016? Okay, thank you.

16 CO-CHAIR WALTERS: Okay, let's move to  
17 a vote on Measure 5, the hospitalization.

18 (Simultaneous speaking.)

19 DR. MORRISON: Ron, I'm sorry, just to  
20 be clear in my mind, if we vote support, what we  
21 are voting for is that this -- we support this  
22 pending the re-review of this measure within the

1 NQF endorsement?

2 CO-CHAIR WALTERS: That would be a  
3 conditional support.

4 DR. MORRISON: Okay, that's what I was  
5 clear -- okay, thank you.

6 MR. TILLY: The polling is now open  
7 for standardized hospitalization ratio modified,  
8 MUC15-693. (Voting.) The results are 12 percent  
9 support, 81 percent conditional support, 8  
10 percent do not support. The recommendation is  
11 conditional support.

12 CO-CHAIR WALTERS: Thank you. Now  
13 we're going to go to Measure 6. Specific issues  
14 related to 6, I think you've heard a lot of them.  
15 It is, again, a ratio. It's about the mortality  
16 side of things. Its NQF endorsement status is --

17 MS. MARINELARENA: This measure is  
18 also endorsed, and it will be up for review.

19 CO-CHAIR WALTERS: Okay, are there any  
20 other questions that anyone would like to ask  
21 about Measure 6 specifically? (No audible  
22 response.)

1 MR. TILLY: The polling is open for  
2 standardized mortality ratio modified, MUC15-575.  
3 The options are support, conditional support, do  
4 not support. (Voting.) The results are 15  
5 percent support, 38 percent conditional support,  
6 46 percent do not support. The recommendation is  
7 do not support.

8 CO-CHAIR WALTERS: Okay, now let's  
9 move on to Measure 7, which is the re-admission  
10 ratio, and clarify, again, what its NQF status  
11 is.

12 MS. MARINELARENA: This measure is  
13 already endorsed. It is an NQF-endorsed measure,  
14 and it will be up for maintenance.

15 MS. O'ROURKE: To clarify this one,  
16 this is one of the ones that's in the SDS trial  
17 period, so the re-admissions standing committee  
18 will be taking a look at this in the spring to  
19 make a decision about including SDS factors in  
20 the risk adjustment model. I just wanted to  
21 point that out, in case that is important for  
22 your voting.

1 CO-CHAIR WALTERS: Are there any other  
2 specific questions that we've talked about  
3 Measure 7 that I wanted it to be clarified before  
4 the vote? Okay.

5 MR. TILLY: Polling is now open for  
6 standardized re-admission ratio for dialysis  
7 facilities, MUC15-1167. (Voting.) I hate to do  
8 this, but it looks like we need just one more, so  
9 if you all could just try again. (Voting.) The  
10 results are in, 38 percent support, 46 percent  
11 conditional support, 15 percent do not support.  
12 The recommendation is conditional support.

13 CO-CHAIR WALTERS: Thank you for  
14 everybody working their way through some  
15 difficult issues in this program.

16 MEMBER LEVY: Before you move on,  
17 could I just understand what the conditional  
18 support is? This one is a little less than --

19 MS. O'ROURKE: I would say my  
20 understanding would be that this is pending the  
21 results of the SDS trial decision of the standing  
22 committee.



1 CO-CHAIR WALTERS: Sorry, is everybody  
2 okay with that, if we don't catch the conditions?

3 MS. O'ROURKE: And NQF re-endorsement.  
4 Yes, it's the standing committee's decision to  
5 support the endorsement as is or add SDS factors.

6 CO-CHAIR WALTERS: I believe it's time  
7 for a short break, correct?

8 (Whereupon, the above-entitled meeting  
9 went off the record at 10:52 a.m. and went back  
10 on the record at 11:06 a.m.)

11 CO-CHAIR TRAVIS: Okay, we're going to  
12 go on and get started. We've almost gotten  
13 ourselves exactly right back. We're a few  
14 minutes past being on schedule, but almost right  
15 there. Our next program is the hospital  
16 Outpatient Quality Reporting program. I'm going  
17 to turn it over to Jean-Luc, who's going to  
18 provide an overview of the program for us.

19 MR. TILLY: Thank you, Cristie. The  
20 hospital Outpatient Quality Reporting program,  
21 OQR, is a pay-for-reporting program, where data  
22 is reported on Hospital Compare. Hospitals that

1 don't report data receive a 2 percent reduction  
2 in their annual payment update.

3 The program's goals are to establish  
4 a system for collecting and providing data on  
5 outpatient services, which include clinic and  
6 critical care visits, and provide consumers with  
7 that information to help them make informed  
8 decisions. There are two measures under  
9 consideration for OQR. First on your list is  
10 admissions and emergency department visits for  
11 patients receiving outpatient chemotherapy.

12 This measure is also under  
13 consideration of the PCHQR program. The second  
14 measure is NQF endorsed. It measures risk  
15 standardized hospital visits within seven days  
16 after hospital outpatient surgery. I'll turn it  
17 over to Cristie for public comment.

18 CO-CHAIR TRAVIS: Okay, thank you. Do  
19 we have any public comment from the room relative  
20 to this program? (No audible response.) Okay,  
21 seeing none, Operator, can you open up the lines  
22 and see if there's any public comment from those

1 on the phone?

2 OPERATOR: Yes, ma'am. At this time,  
3 if you would like to make a public comment,  
4 please press star, then the No. 1. There are no  
5 public comments at this time.

6 CO-CHAIR TRAVIS: Okay, thank you. As  
7 Jean-Luc indicated, we have two measures, and  
8 we've had some robust discussion about,  
9 certainly, Measure No. 1, which was also in our  
10 cancer hospital, but now you'll see it over here  
11 in the hospital outpatient reporting. This kind  
12 of goes back to the comments earlier about  
13 looking at cancer care not just in the cancer  
14 hospitals, but also where a large part of it is  
15 delivered, which is in the community.

16 Then the second one is a risk  
17 standardized hospital visits within seven days  
18 after hospital outpatient surgery, which kind of  
19 gets us back to our previous discussions on risk  
20 standardized approaches. Both of these have been  
21 pulled by Nancy. We will take these one at a  
22 time because they are different. Nancy, if you

1 would like to talk about why you pulled these  
2 measures for discussion -- this first measure for  
3 discussion.

4 MEMBER FOSTER: I pulled the first  
5 measure for discussion here for the very same  
6 reason that we talked about it in the cancer care  
7 hospitals. Because of that, if we would just  
8 simply repeat the same recommendations that were  
9 made in the cancer care hospitals, I would be  
10 happy with the conditional support. I think  
11 that's where we ended up with this measure for  
12 cancer care hospitals.

13 MS. O'ROURKE: Yes. We had ultimately  
14 decided to conditionally support it, pending NQF  
15 review and endorsement, with instructions to the  
16 standing committee to pay particular attention to  
17 the diagnoses included in this measure, as well  
18 as risk adjustment for socioeconomic factors and  
19 the appropriate exclusions.

20 CO-CHAIR TRAVIS: Okay, so that's  
21 Nancy's recommendation, that it be consistent  
22 with what we agreed to for the cancer hospitals.

1 The lead discussants for these were Helen and  
2 Shek. Would either one of you -- want to go  
3 first, Shek?

4 MEMBER MEHTA: Yes, I don't have  
5 anything else to add. I think we talked about it  
6 this morning.

7 CO-CHAIR TRAVIS: Okay, thank you.  
8 Helen?

9 MS. HASKELL: Really, the only thing  
10 I have to add to the previous discussion is a  
11 question. I see my role as asking dumb questions  
12 here. It seems to me that this is a measure that  
13 could have unintended consequences, in terms of  
14 treatment. That's a question I'd like to raise  
15 with people who know a lot more about cancer care  
16 than I do, if these side effects are related to  
17 things like dose, might it have unfortunate  
18 consequences on the initial treatment? That's my  
19 only thought.

20 CO-CHAIR TRAVIS: So is there someone  
21 who can address Helen's questions relative to the  
22 potential unintended consequences of this

1 measure?

2 CHRISTINA: This is Christina, one of  
3 the measure developers. I guess I would ask for  
4 a little bit more clarification. Are you  
5 thinking that maybe treatments would be changed  
6 to less effective treatments in the chance of  
7 reducing an admission?

8 MS. HASKELL: That's what I'm  
9 wondering, yes.

10 CHRISTINA: I suppose that's a  
11 possibility. The measure is risk adjusted and  
12 takes into account things like age, sex, the  
13 cancer type, and comorbidities, as well as the  
14 frequency of the chemo treatment being received.  
15 I do think that the risk adjustment might help  
16 level that playing field and remove the concern  
17 from providers.

18 CO-CHAIR TRAVIS: Andrea.

19 MEMBER BENIN: I'm sorry that I missed  
20 the beginning of your comment, Nancy. This  
21 metric goes right into a pay program, without any  
22 experience with it first, that's what's different

1       than the reporting.

2                   MS. MITCHELL:  If you said it, I was  
3       zoned out, but isn't the point of this that with  
4       proper outpatient care by the attending and other  
5       physicians that these should not be necessary?  
6       In fact, I would think the hospitals would, in  
7       fact, welcome that kind of spreading around or  
8       coordinating or better collaborating with people  
9       outside of the hospital.  I would think it would  
10      be a good thing.

11                  MEMBER FOSTER:  I think this is a  
12      measure of hospital performance, so I'm not sure  
13      what the coordination is you're anticipating.

14                  MS. MITCHELL:  If the other people are  
15      doing their job, then the hospital measure will  
16      look good.  No?

17                  MEMBER FOSTER:  True.  I guess this is  
18      sort of looking at, as I understand it, potential  
19      unintended consequences of treatment from  
20      patients who were hospitalized.

21                  MS. MITCHELL:  Were hospitalized.

22                  MEMBER FOSTER:  Who were hospitalized.

1 MS. MITCHELL: You had treatment in  
2 the hospital. You're discharged.

3 MEMBER FOSTER: (Simultaneous  
4 speaking.)

5 MS. MITCHELL: Other people in the  
6 delivery system are following you, no?

7 MEMBER FOSTER: (Simultaneous  
8 speaking.) You don't have to be -- let me look  
9 at the specs again. I don't think you have to  
10 have been hospitalized to begin with to get into  
11 this. You just have to be in chemotherapy.

12 MS. MITCHELL: Hospital outpatient  
13 departments.

14 CHRISTINA: Yes, this is Christina  
15 again, one of the measure developers, just to  
16 confirm where you guys landed on that. The  
17 denominator are patients who are receiving their  
18 chemotherapy in an outpatient hospital  
19 department. It's not a re-admission measure. It  
20 just looks at first admission, I guess, related  
21 to following an outpatient chemotherapy. So it  
22 is focusing on, like you described, that care and



1 management of the treatment and symptoms in the  
2 outpatient setting there they're receiving their  
3 treatment to prevent those inpatient admissions.

4 MEMBER FOSTER: Dolores, it's  
5 patients, who are our patients, coming back to us  
6 with complications is what it's intending to look  
7 at. Per our discussion earlier today, one would  
8 need to look at the specs to know whether that's,  
9 in fact, what it's capturing. That's why we were  
10 deferring to the NQF steering committee to look  
11 at this and to make sure that is what they're  
12 capturing. Andrea and Michael and others -- I'm  
13 trying to remember who else raised some concerns  
14 about what could happen as unintended  
15 consequences if the measure is not properly  
16 constructed was my recollection of the earlier  
17 discussion. I was raising some questions about  
18 whether it's going to need to be adjusted for  
19 sociodemographic factors because people in some  
20 settings may go to a private physician instead of  
21 going back to the hospital.

22 Lots of questions about is it

1 constructed right, but support for the concept of  
2 having this measure, for the very reason you've  
3 outlined, that if it's constructed right, it will  
4 get at an important issue of whether we're  
5 treating patients appropriately and not inducing  
6 these bad complications. Then any clinician that  
7 wants to correct that should please do so.

8 MS. MITCHELL: It gets into this  
9 slippery area of were you treating them  
10 correctly, but also what's happening out there,  
11 and that, in fact, if you're aware of where your  
12 patients have gone and the attending physician  
13 has picked up where you left off, temporarily at  
14 least, that's a good thing. Then the system is  
15 working as a system ought to work. I would think  
16 -- one worries about when everybody's  
17 accountable, then nobody's accountable, or at  
18 least that sometimes is the case. But in this  
19 case, when it's working well, it's that  
20 everybody's working together. An unintended  
21 consequence -- I guess what I'm struggling with  
22 is what is the nature of an unintended

1 consequence in this scenario?

2 I can't figure out what it is. If  
3 you're doing your job at the hospital outpatient  
4 department, and the doctors in the community are  
5 doing their job when the patient goes home, then  
6 what is the unintended consequence of measuring  
7 how many people go back that maybe didn't need to  
8 go back because one of you isn't doing your job?

9 MEMBER LEVY: I completely agree with  
10 you, Dolores. I think that every metric, we  
11 always worry about unintended consequences, to  
12 the extent that sometimes, that's the big bugaboo  
13 that we use to push away any possible metric.  
14 What you said is exactly right. These are known  
15 complications of chemotherapy. What this is,  
16 it's a quality metric looking at does an  
17 institution track that? When people leave with  
18 the potential of known complications -- diarrhea,  
19 nausea, sepsis -- how well are they doing? Yes,  
20 there are some complicating and confounding  
21 factors, like socioeconomic status, where are  
22 they being seen, in a clinic or a private

1 practice? On the other hand, this is a good area  
2 of accountability when administering agents with  
3 known complications.

4 I fear that we're overthinking it a  
5 little bit and using this unintended consequence  
6 a little too liberally. If the fact that someone  
7 might adjust a dose to prevent this, that, to me,  
8 that's a tough one. I really think so. I feel  
9 like this is a pretty clean measure.

10 MS. MITCHELL: I guess what I'm  
11 thinking about, in terms of, you know, what would  
12 a hospital have done that would end up in their  
13 having a bad score? It would, I assume, mean  
14 that when -- poor discharge planning is the  
15 common phrase, not saying to somebody, if you  
16 have any symptoms of the following order, this is  
17 who you probably need to call, not necessarily to  
18 rush back to the ER.

19 That kind of consequence is  
20 foreseeable and could be prevented and taken care  
21 of in good discharge planning. That's where, if  
22 the hospital didn't do it, that's bad. If the

1 doctor out in the community says, I'm busy, go  
2 back to the ER or ED, then that's where it's been  
3 the failure at that level.

4 MEMBER LEVY: Well I could see in  
5 safety net hospitals, where you have populations  
6 with high degree of non-compliance, but I think  
7 that's a very specific subset, and in general, it  
8 feels to me you wouldn't want that to drive the  
9 value of a quality metric.

10 CO-CHAIR TRAVIS: Just for me to have  
11 a clarification -- and I know I could probably  
12 read it on this screen right here, but if  
13 somebody can tell me what the numerator and the  
14 denominators are, I think that would help us  
15 focus our -- be sure we're focusing our comments  
16 around how this measure is actually constructed.  
17 Is there -- I don't know if there's someone on  
18 the line, or --

19 MS. RANSHOUS: This is Christine  
20 Ranshous again, one of the developers. I can  
21 restate that denominator and the numerator. The  
22 denominator are Medicare patients 18 years and

1 older who have a diagnosis of cancer and have at  
2 least one outpatient chemotherapy treatment at  
3 the facility. Then the numerator looks -- each  
4 of those patients within 30 days after one of  
5 those outpatient chemotherapy treatments, did  
6 they then be seen at an ED or an inpatient  
7 admission for ten specific conditions, which  
8 include anemia, dehydration, diarrhea, over a  
9 certain fever, nausea, neutropenia, pain,  
10 pneumonia and sepsis, which --

11 CO-CHAIR TRAVIS: Thank you.

12 MS. RANSHOUS: Yes.

13 CO-CHAIR TRAVIS: Yes, no that's  
14 extremely helpful. So the hospital that's being  
15 measured is really looking at chemotherapy  
16 patients that got their chemotherapy at their  
17 facility. And so I just wanted to kind of make  
18 that clear, I wanted to be clear on it, that  
19 that's where they're receiving it, is at the  
20 hospital -- within a hospital.

21 Then if they go to the ED or have an  
22 inpatient admission with any of those conditions,

1       that's the numerator. So it's a little bit  
2       different than perhaps thinking about somebody  
3       going to a physician's office for chemotherapy.  
4       They're getting the chemotherapy in the hospital  
5       that is being measured here. So I just wanted to  
6       be sure we were kind of all on the same page  
7       relative to that piece. Sean.

8               DR. MORRISON: Yes, I think this is a  
9       critically important measure. I was thinking  
10      about this, actually, from one of the comments  
11      that was made about the end-stage renal disease  
12      program, as well. These are both critically  
13      important medications, have severe and  
14      predictable toxic side effects, and -- sorry,  
15      severe and predictable -- and effective  
16      treatments that are associated with them.

17             And if we're going to say an  
18      outpatient hospital, well, you're just a delivery  
19      model, that's it. We're going to give  
20      chemotherapy, and that's it, and you're on your  
21      own with your provider, well, that's one way of  
22      thinking about it.

1           I would say that if you are going to  
2       take the responsibility to give these  
3       medications, to have patients come in and see  
4       them, then you have a responsibility to take care  
5       of people all the way through the course of that  
6       event, and that you have responsibility of if  
7       they're going to their primary care provider to  
8       be treated for treatment-related side effects, to  
9       effectively communicate with them what the plan  
10      of care is for that. I think that's the  
11      responsibility of delivering these drugs.

12           I think it's -- not to be on a soap  
13      box, but if Dolores can do it, I can do it, too.  
14      I think it's the same with dialysis centers. I  
15      think to say that it's the responsibility of the  
16      nephrologist, it's the responsibility of the  
17      primary care physician to handle all of these  
18      things is incorrect. When patients go to the  
19      dialysis center, they look at that as their  
20      primary care. And so I think when patients go to  
21      an outpatient cancer center for the treatment of  
22      their cancer, they look at that as their site of



1 care and that we have a responsibility, as people  
2 working in hospitals, to take care of them.

3 CO-CHAIR TRAVIS: Thank you, Sean.

4 Ann Marie --- yes, well Mitch is next, but have  
5 you already said what you wanted to say, Mitch?

6 Thank you. Ron.

7 CO-CHAIR WALTERS: So yes, I strongly  
8 support it, like Sean does, for the same reasons,  
9 and with the same stipulations that we did  
10 earlier. I would make a bet that -- again,  
11 forget the self-contained institutions a second  
12 because that's a whole different issue.

13 As a system of care, I'd be willing to  
14 bet that no one has a report like this right now,  
15 and that feedback loop to the individual  
16 physicians about their potentially preventable  
17 visits to the ED or admissions doesn't exist for  
18 most hospitals. That's why the beauty of this is  
19 a pay-for-reporting. If it were -- I mean, I  
20 agree, attribution comes into play, when you  
21 really think like a systems person and you wonder  
22 who's going to take the hit financially for it.

1 But as a start, having that information go back  
2 as crosstalk between a given hospital and the  
3 attending physicians at that hospital which, yes,  
4 could be all over the place, can't help but  
5 improve patient care. This is exactly the kind  
6 of measure that we need to -- and in this  
7 particular program to improve care. I think it  
8 will.

9 CO-CHAIR TRAVIS: Thank you, Ron. Ann  
10 Marie, you put your card down. Okay, good, just  
11 wanted to be sure. Shelley.

12 MEMBER FULD NASSO: I think I'm going  
13 to pass because I think it's all been said.

14 CO-CHAIR TRAVIS: Okay, thank you very  
15 much. Nancy.

16 MEMBER FOSTER: Perhaps I wasn't  
17 clear. Let me be very specific here. We also  
18 support the use of this measure if it -- what we  
19 have right now are not specs for the measure, but  
20 a brief description of it. So we think A, that  
21 it's important that the NQF committee be able to  
22 take a look at it and make sure that the specs

1 live up to the description, which most often they  
2 do, but not always, and opine on that, and then  
3 wrestle to the ground some issues that are  
4 relevant in cancer care that I think will have to  
5 be addressed here to get accuracy in the measure  
6 and appropriateness of the measure.

7 Because it is not, say, uncommon, in  
8 my anecdotal, not data-driven experience here,  
9 for a hospital such as MD Anderson or a Johns  
10 Hopkins or another center with a major cancer  
11 care capability to develop a cancer treatment  
12 plan, maybe see that patient once or twice in  
13 their outpatient center, and then discharge that  
14 patient to a smaller hospital that is in that  
15 patient's hometown, where the hospital and its  
16 outpatient department or others are trying to  
17 execute on that plan.

18 Well who do you -- what's the  
19 attribution of the complications if they develop?  
20 I don't know the answer to that. I just want to  
21 make sure that the NQF panel has a chance to  
22 wrestle that one to the ground, along with the

1 issues that Mitch has already referenced around  
2 sociodemographics and whether they apply here or  
3 not.

4 I don't even know the answer to  
5 whether they apply or not, but I want to take a  
6 look at it because at least conceptually, it  
7 would make -- sorry, let me rephrase that. I  
8 don't want to necessarily take a look at it. I  
9 want the committee to take a look at that because  
10 conceptually, at least, there could be a link.  
11 That's my only issue is conditional support now,  
12 so that the NQF has a chance to do its job,  
13 period.

14 CO-CHAIR TRAVIS: -- that  
15 clarification. Andrea.

16 MEMBER BENIN: I can just try to  
17 clarify apropos Helen's question. My comments  
18 before weren't really in concern of unintended  
19 consequences, per se, that this would force  
20 patients to go to the wrong direction or  
21 whatever, although it certainly could, but I  
22 don't -- that wasn't really my concern, more that

1 are these really preventable things that are  
2 appropriate to be measured? I think that gets  
3 addressed by the idea that we think this metric  
4 needs more work/evaluation/measure specs, et  
5 cetera.

6 CO-CHAIR TRAVIS: So the review  
7 process, if I'm understanding you, Andrea --  
8 going through the endorsement process should  
9 address those concerns, assuming it's a robust --

10 (Simultaneous speaking.)

11 MEMBER BENIN: Maybe. The fact that  
12 we don't have measure specs, and it hasn't gone  
13 through anything, we have no idea right now what  
14 this really addresses. That, to me, is a little  
15 bizarre. It seems premature to have this here,  
16 but it is what it is.

17 CO-CHAIR TRAVIS: Okay, thank you.  
18 Marty.

19 MEMBER HATLIE: Just a quick comment.  
20 I really, really like this measure. There's a  
21 lot of work happening right now in patient and  
22 family engagement. A lot of it's being supported

1 by CMS in its different transformation programs,  
2 the Partnership for Patients, Transforming  
3 Clinical Practice, the QIOs.

4 We're all trying to figure out where  
5 we get the best value out of engaging patients,  
6 and it's kind of falling into three buckets. One  
7 is just the infrastructure. Do we have  
8 infrastructure to bring the voice of the patient  
9 into our organizations as we prioritize. One is  
10 activations, you know, how do we tell which  
11 patients can actually be partners in their care,  
12 which ones can't?

13 But the third piece is really  
14 relationships, how we manage the relationships  
15 with patients after discharge, so that we can  
16 avoid things like rehospitalization or coming  
17 back. If you call your doctor's office if you're  
18 having symptoms after chemo, do you get an  
19 answer, or do you say, you've got an appointment  
20 in a week, why don't you just wait until then?

21 It's stuff like that that really,  
22 there's not very much activity going on, yet

1       there's a lot of interest, but it's really,  
2       really new. This just fits in there really well,  
3       so I'm excited to see this, and I think it's on  
4       the right side of history. Thank you.

5                   CO-CHAIR TRAVIS: Thank you, Marty.  
6       Dolores.

7                   MS. MITCHELL: Well I think I was a  
8       little incoherent before, and I forgot that these  
9       were outpatient treatments, not inpatient, so  
10      scrap the thing I said about discharge planning.  
11      We talk a lot in the health policy world about  
12      not having silos. Here we are, the hospital  
13      group, talking about the hospital's  
14      responsibility. Nobody is tougher on the  
15      hospitals than I am, but it seems to me --  
16      there's no disagreement there, right? But fair  
17      is fair.

18                   If, in fact, we mean something -- and  
19      I think Marty started on the theme that I was  
20      incoherently trying to get to, is that what the  
21      patient wants, involving the patient's family, to  
22      be supportive, working with the patient to see

1       how much of responsibility the patient can assume  
2       -- it may be that it starts at the hospital level  
3       when you've gone in for your chemo and are  
4       talking about leaving, but certainly, it does not  
5       absolve all the others from participating.

6                       I don't know where that leaves me  
7       about how to vote on this one, but I think we  
8       need to get away from the silo idea and say, hey,  
9       we're all involved here, not just the hospitals.  
10      Sorry, Sean, I almost always agree with you, but  
11      you lost me on this one.

12                     CO-CHAIR TRAVIS:   Thank you, Dolores.  
13      And as is probably kind of clear as we've been  
14      talking about it, especially, Nancy, when you put  
15      forth your recommendation, this measure is not  
16      yet endorsed, so if we could -- and Nancy's  
17      recommendation was that it be conditional upon  
18      endorsement, with a few other caveats that were  
19      added to it because of the specific nature -- a  
20      few other conditions added to it for the specific  
21      nature of this, so, you know, with the -- all of  
22      those conditions would go to the consensus



1 development process, so that they could see what  
2 the MAP was concerned about or wanted to be sure  
3 to look at during the review process. Tom.

4 MEMBER LUTZOW: Yes. I'm not hospital  
5 either. I fund hospitals, and my concern is that  
6 by not adjusting, in this case, the exclusions  
7 correctly, there's a chance that we'll end up  
8 driving resources out of the inner city by not  
9 measuring correctly or adjusting correctly.  
10 That's the basis of the remark.

11 Marty brought up the concept here of  
12 patient activation. I'd like to extend that to  
13 this whole issue of patient accountability, where  
14 the patient could be a driver, and of course SES  
15 accentuates that a bit. The presence of mental  
16 health, behavioral issues among the SES  
17 population accentuates that a bit.

18 But there should be, perhaps, an  
19 adjustment, maybe an exclusion for a poor level  
20 or a failing level of patient accountability as a  
21 driver of poor measure performance. That's  
22 something I think that needs to be looked at.

1 The risk is we will see resources being driven  
2 out of the inner city as a result of that unless  
3 we account for it.

4 CO-CHAIR TRAVIS: Thank you, Tom. I  
5 don't see any other cards up. I guess that means  
6 it's time to move to a vote on this measure.  
7 Jean-Luc.

8 MR. TILLY: The polling is now open  
9 for admissions in emergency department visits for  
10 patients receiving outpatient chemotherapy,  
11 MUC15-951.

12 (Voting.)

13 MR. TILLY: We just need one more  
14 vote.

15 (Voting.)

16 MS. SHAHAB: Can you please vote  
17 again?

18 (Voting.)

19 MR. TILLY: The results are 32 percent  
20 support, 64 percent conditional support, 4  
21 percent do not support. The recommendation is  
22 conditional support.

1 MS. O'ROURKE: This would be the same  
2 conditions that we attached to this measure for  
3 the PCHQR program, but also some good discussion  
4 for some of the overarching themes about the  
5 report about truly engaging the patient and  
6 responsibility of the system.

7 CO-CHAIR TRAVIS: That's true. Plus,  
8 we all feel better about it anyway because we got  
9 to the same place with that robust discussion. I  
10 appreciate that. The next measure is risk  
11 standardized hospital visits within seven days  
12 after hospital outpatient surgery. Nancy, you  
13 pulled this measure, so you're first up.

14 MEMBER FOSTER: Thank you. I'm not on  
15 mute, am I? No, okay. I sort of hit both  
16 buttons at once. This, again, is a measure that  
17 we think would be responsive to sociodemographic  
18 factors, particularly noting that people who  
19 don't have a primary source of care are more  
20 likely to come back to the emergency department.  
21 We're glad to have them come back.

22 We'd love to make sure they don't have

1 to. That was our concern about this and wanted  
2 to make sure that we recommend this for  
3 conditional support, so that we get a look at  
4 that. I know it has recently been endorsed by  
5 the NQF, but I do not believe that they looked at  
6 the SDS factor for this, is my recollection of  
7 reading the materials. I'm curious as to why and  
8 really think this warrants that look.

9 MS. MARINELARENA: Nancy, you're  
10 correct. This just got endorsed through the  
11 surgery project. The endorsement was in  
12 September. This was submitted prior to the SDS  
13 trial period began, so they were not required to  
14 look at SDS in the risk adjustment model.

15 MEMBER FOSTER: I understand them not  
16 being required to do so, but I just can't imagine  
17 circumstances under which you couldn't  
18 conceptually agree that this may be one of those  
19 measures that is very responsive to  
20 sociodemographics and one that would need to be  
21 looked at before it's put into a program with  
22 required reporting for that very reason. Because

1       having those hospitals that serve impoverished  
2       communities look bad just because somebody got  
3       their measure in under the wire doesn't make a  
4       lot of sense to me.

5               DR. DRYE:  Hi, this is Elizabeth Drye,  
6       one of the developers, at Yale, of the measure.  
7       Just to clarify, although this wasn't formally in  
8       the SDS pilot, we did submit analysis with the --  
9       of rates and socioeconomic status to the  
10      committee, and it was discussed during review.  
11      It was actually commented on in the review  
12      process, too.  So it was very transparent, and  
13      we're happy to review it with you now if that  
14      would be helpful.

15             MS. MARINELARENA:  Yes, please.

16             DR. DRYE:  Mayur, do you want to do  
17      that, from Yale?

18             DR. DESAI:  Sure.  Good morning, this  
19      is Mayur Desai from Yale Center for Outcomes  
20      Research and Evaluation with the measure  
21      development team.  So we, as part of the testing,  
22      looked at two variables that are typically used

1 in this setting.

2 One is the proportion of patients --  
3 at the patient level, whether the patient is  
4 African-American and also dual eligible, and the  
5 results, with and without adjustment for those  
6 variables, were nearly identical, with  
7 correlation coefficients of 0.99 in that range.

8 A second analysis that we did was we  
9 looked at the proportion of patients at a  
10 facility who are African-American and the  
11 proportion of patients who are dual eligible as  
12 proxies for sociodemographic status. Those two  
13 also showed comparable results. So we felt at  
14 this time it wasn't necessary or important to  
15 control for those variables. Also, we would just  
16 point out that CMS is fully participating in the  
17 SDS trial, and currently, the Office of the  
18 Assistant Secretary for Planning and Evaluation  
19 is doing research in this area and is going to be  
20 issuing a report in October of 2016, next year.  
21 Based on their analysis, we will adjust the  
22 measures accordingly.

1 CO-CHAIR TRAVIS: Thank you. Nancy,  
2 any thoughts about that from your perspective?

3 MEMBER FOSTER: I'm pretty sure  
4 everyone heard me yesterday on the issue of  
5 adjustment by race, so I won't repeat myself.  
6 And additionally, dual eligibility is maybe a  
7 proxy for poverty, but less robust than adjusting  
8 by census track or zip code or other factors.

9 We're really looking at a series of  
10 factors that affect the community and the  
11 availability of additional resources in the  
12 community. That's where we think the impact  
13 comes from. Defining that community is really  
14 important as we go forward. Dual eligibility,  
15 depending on what state you're in, what the  
16 coverage of your Medicaid population is, it  
17 varies enormously. So there's a lot of noise in  
18 that particular set of measures or particular  
19 adjustment.

20 CO-CHAIR TRAVIS: Thank you. Is that  
21 David? Okay, thank you.

22 MEMBER ENGLER: Thank you very much.

1 I agree with Nancy that the community-based  
2 factors are incredibly important in this metric  
3 and have been proven to be important in other  
4 similar metrics on returns. Having said that,  
5 with that not being done, we would suggest  
6 strongly that SDS adjustment be looked at. The  
7 other part then turns to a question that I have  
8 of the developers is what was the final result of  
9 the receiver/operator curve on predictability of  
10 this measure with and without the risk adjustment  
11 for race or SDS factors?

12 DR. YOUNG: Elizabeth, are you still

13 --

14 DR. DESAI: I'm sorry. This is Mayur  
15 Desai again. Could you repeat the question?

16 MEMBER ENGLER: Thank you very much,  
17 I will. My question goes to the  
18 receiver/operator curve of this adjustment  
19 factor. So what did you find when you looked at  
20 the model, in terms of its predictability?

21 DR. DESAI: Thank you. We're just  
22 trying to look that up right now. I don't have



1       that handy at the moment.

2               DR. DRYE: We do have it, but you  
3 might want to go on and we'll get back to you,  
4 we're just pulling it out.

5               DR. DESAI: We're pulling up the  
6 documentation right now. I'm sorry for the  
7 delay.

8               CO-CHAIR TRAVIS: That's okay. We'll  
9 come back to David's question in a moment. Sean.

10              DR. MORRISON: I actually had a  
11 comment with Dolores about this. I struggle with  
12 this all the time. It's interesting that this is  
13 coming from the Yale group because one of the  
14 reasons that we, as a country, spend so much on  
15 healthcare is we spend so little on social  
16 services.

17              And I really struggle with who is  
18 responsible when we start talking about  
19 socioeconomic status and who are we going to hold  
20 accountable for that. Because if we don't hold  
21 the hospitals accountable for it, there is no  
22 safety net in this country to take care of those

1 people in the community. Is it right to hold  
2 hospitals responsible for that? I don't know,  
3 but that's where we're spending the money, and  
4 that's the path we are going down. So I am  
5 completely schizophrenic on this, but on this  
6 particular issue, again, if we're doing an  
7 outpatient operation, I do think it's our  
8 responsibility to ensure that our patients are  
9 well taken care of in the post-operative period.

10 That may not be fair on the hospitals  
11 and the surgical sites that are doing that, and I  
12 recognize that. But until we, as a country,  
13 decide that we're going to start spending money  
14 on other forms of social support, this is the  
15 only place where we can ensure that those  
16 patients get the care that they need by putting  
17 that responsibility on their shoulders.

18 And I would argue it's not perfect.  
19 It's not what I would like it to be, as the Yale  
20 group has shown. It's not what other countries  
21 do, but it's what we do, and that's why I would  
22 support these types of measures.

1 CO-CHAIR TRAVIS: Thank you, Sean.  
2 Donna.

3 MEMBER SLOSBURG: I just have a  
4 different concern about this measure. I agree  
5 with everything everybody has said up to this  
6 point. However, my concern goes to the  
7 reliability of this measure. It's a claims-based  
8 measure, and the reliability does not cover the  
9 entire seven days because of the three-day rule.  
10 We've had this discussion with Yale previously,  
11 and I know that they've made some adjustments. I  
12 don't know if everybody is -- is everybody  
13 familiar with the three-day rule?

14 Nancy, you're going to probably have  
15 to speak to this. I'll do my best. I'm not a  
16 coding person. Basically, the three-day payment  
17 window requires that outpatient services provided  
18 by a hospital or any Part B entity wholly owned  
19 or wholly operated by a hospital, so an HOPD,  
20 must be billed with the inpatient stay.

21 In addition, outpatient services  
22 provided by a hospital or any Part B entity, on

1 the first, second, and third calendar days  
2 preceding the date of beneficiary's inpatient  
3 admission, are also deemed related to the  
4 admission and must be billed with the inpatient  
5 stay.

6 So what that means, simply stated, is  
7 that the measure would only identify visits  
8 occurring on Days 4, 5, 6, and 7, following the  
9 index hospital outpatient visit. Index claims  
10 for 0, 1, 2, and 3 would not be created and,  
11 therefore, would not be counted. I do know that  
12 an attempt -- the measure is using physician  
13 claims for place of service in attempt to fill  
14 the three-day gap for the missing hospital  
15 outpatient claims. However, there's been a long  
16 history of inaccuracy for point-of-service  
17 physician claims. I had a lot of statistics, but  
18 I do want to bring up that point because I think  
19 it's a relevant one.

20 CO-CHAIR TRAVIS: Would the developer  
21 like to respond to those comments?

22 DR. DRYE: Sure. Hi, it's Elizabeth

1 Drye again. So that's true, it's definitely a  
2 challenge of this measure that it uses claims to  
3 identify the cases eligible for the measure, and  
4 also the outcomes to deal with the three-day  
5 payment rule. We have looked at that really  
6 closely. We do use physician claims.

7 We have a couple -- we tested that  
8 approach in an analogous measure. We have a  
9 measure of seven-day visits that is the same  
10 outcome following colonoscopies for hospital  
11 outpatient departments and ambulatory surgery  
12 centers. That went through national testing.  
13 Every facility got all of their patient-level  
14 data, plus they got a measure score  
15 confidentially this past summer.

16 We took a lot of detailed, case-level  
17 information from providers on where our  
18 claims-based analysis -- how it did or didn't  
19 line up with their actual patient experience. We  
20 identified some additional ways -- overall, we  
21 had, I think, a really great outcome from the dry  
22 run.

1           There was good acceptance of the  
2           measure, and the algorithm worked well, but we  
3           have identified a couple ways to tighten it up  
4           even further. Those we are building into the  
5           colonoscopy measure before it's used in public  
6           reporting. We're doing that right now. Then we  
7           will apply those, as well, to the surgery  
8           measure.

9           We're using every piece of claims  
10          information we can. We will be likely excluding  
11          a few more cases where it's not as clear, but in  
12          terms of the reliability in the coding and  
13          billing, we're not relying on anything that  
14          shouldn't be correct. These are things that  
15          really should be correct in the claims, so we  
16          have to rely on that. I would just say when we  
17          ran the colonoscopy dry run, there were  
18          definitely some facilities that learned the way  
19          they were coding was not aligned with what  
20          Medicare requires, and that was a piece of what  
21          they learned from the process, itself.

22          So there's nothing that is perfect.

1 It's not going to be 100 percent, but we think  
2 we're very, very close to that, and we're going  
3 to be doing better based on what we learned from  
4 the colonoscopy measure. This issue was also  
5 just vetted extensively at every stage through  
6 rulemaking and through NQF review, so I think we  
7 learned a ton from input from Donna and others.

8 CO-CHAIR TRAVIS: Okay, thank you.  
9 Brock.

10 MEMBER SLABACH: I'd like to kind of  
11 follow up on what Sean was saying, and I believe  
12 that my take would be that hospitals are dealing  
13 with the social impacts of the problems that  
14 we're talking about here. We're seeing large  
15 amounts of uncompensated care, and 60 percent of  
16 the emergency visits around the United States are  
17 low acuity, meaning they're basically clinic  
18 visits, because they're all mostly in health  
19 professional shortage areas, and there's not the  
20 resources to be able to respond effectively to  
21 the issues that we're talking about, the social  
22 determinants.

1           That's why the social determinants are  
2           so critically important to be able to then not  
3           create a reporting problem for these facilities  
4           that are dealing with these kinds of severe  
5           problems that lead the public to an impression  
6           that they're having problems in these areas, not  
7           because of anything that their responsible for  
8           necessarily, directly, but because of the  
9           socioeconomic issues that are in the community.

10           This is a reporting issue, and  
11           potentially a reimbursement issue if this moves  
12           into one of the reporting programs that have  
13           financial impacts directly. I think that we are  
14           dealing with that. I want to make the case that  
15           that's not -- that we are dealing with it, it's  
16           just that this is a reporting problem.

17           CO-CHAIR TRAVIS: Thank you. Tom.

18           MEMBER LUTZOW: Yes. I'd like to  
19           follow up on something Sean said, too. I think  
20           one of the real limitations of the national  
21           performance measurement initiative across the  
22           board is its limited reach into coordinating



1 social services with medical. It has the ability  
2 to do that in part because CMS funds 60 percent  
3 of Medicaid, and Medicaid covers waiver services,  
4 group home, adult family home, a host of other  
5 daycare programs and so on. It does have the  
6 ability to extend its reach in part. Some of  
7 those services are funded by sources  
8 non-governmental, United Way would be an example.

9           Despite that, where there is  
10 opportunity to extend the national performance  
11 program, it should. Group homes are in a great  
12 position to help with re-admission prevention.  
13 They're in a great position to help with  
14 medication adherence and a host of other things,  
15 even reducing no shows to primary care.

16           But what is missing is extending the  
17 national performance measurement program where it  
18 can be extended into Medicaid, and also into  
19 private funding through at least national  
20 guidance. There's more weight to that. NQF  
21 could be a leader in offering performance  
22 guidance to non-medical providers, and I think

1 it's a missing piece to the puzzle.

2 CO-CHAIR TRAVIS: Thank you very much  
3 for helping us recognize that kind of gap in how  
4 this working. Anyone else? Nancy? Oh, okay.  
5 Kelly.

6 MS. TRAUTNER: Hi. I just wanted to  
7 sort of follow up on what both Sean and Tom were  
8 just saying. I think this is easier to wrap our  
9 arms around for those of who like to dig through  
10 IRS filings and looking at the community benefits  
11 Schedule H form that hospitals file. I think in  
12 2009, hospitals spent about 20 percent of their  
13 community benefits expenditures on community  
14 health improvement activities, and those did not  
15 extend to Medicaid losses or bad debt  
16 expenditures.

17 I think as the system continues to  
18 expand and embrace the concept of population  
19 health, and while we kind of flesh out what that  
20 exactly means, depending on where you sit in the  
21 system, I think it's very important to continue  
22 to have that as a central piece in the

1 conversation about quality measurement and  
2 everything that we're talking about, with respect  
3 to the healthcare system.

4 CO-CHAIR TRAVIS: Thank you. I think  
5 if you all -- the developers had a chance to pull  
6 the information that David asked about earlier --  
7 - and David, you might want to repeat your  
8 question.

9 MEMBER ENGLER: Thank you. I was  
10 asking about the predictive nature of the model,  
11 in terms of how predictive it was --- it's a sort  
12 of open ended --

13 DR. DESAI: Yes, thank you. I just  
14 wanted to respond about that question about the  
15 state statistics. The model had, in our  
16 development, testing and validation, had a C  
17 statistic of 0.71.

18 I would just note that we also looked  
19 at -- and this adjusted for age, a range of  
20 comorbidities -- 24 comorbidities, in addition to  
21 the complexity of the surgery, as determined by  
22 the work RBUs and a measure of body system, which

1 are analytic approaches consistent with the  
2 literature and with the NSQIP program. We did  
3 look at the addition of the sociodemographic  
4 variables related to race and dual eligibility.

5 We did not report, in our  
6 documentation -- we're looking through that -- we  
7 didn't report a C statistic with those two  
8 variables added, but I would just note that when  
9 we did add those two variables, the correlation  
10 in the facility results were at the 0.99 level,  
11 so the C statistic is unlikely to have changed  
12 with the addition of those two variables.

13 MEMBER ENGLER: That's correct --

14 (Simultaneous speaking.)

15 DR. DRYE: This is Elizabeth. Let me  
16 just add -- because that's kind of something we  
17 throw around, the correlation was .99. More  
18 specifically, what we did was we estimated the  
19 measure score with the full model that Mayur laid  
20 out for every facility, then we re-estimated the  
21 measure score with the SDS adjustment in it.

22 We compared the measure scores for all

1 the facilities and they basically didn't change.  
2 So that is a correlation between the measure  
3 scores of those 4,000 plus hospital outpatient  
4 departments that was so high. Hence, we  
5 concluded it really doesn't make a difference in  
6 the measure score, after adjusting for all of  
7 these other factors.

8 MEMBER ENGLER: Thank you very much.

9 CO-CHAIR TRAVIS: Thank you all.

10 Okay, well why don't we take a vote, and then  
11 we'll see what happens, and then we'll see what  
12 we have to do. Oh, yes you may.

13 MS. HASKELL: I just want to express  
14 an opinion, which is I think this is a really,  
15 really important measure. The vast majority of  
16 our surgeries are done on an outpatient basis,  
17 and we really don't have a way of tracking those.  
18 The providers don't have a way of tracking them.  
19 I just can't imagine not having -- not approving  
20 something like this if we've got it because it's  
21 sort of the Wild West right now.

22 CO-CHAIR TRAVIS: Shek.

1                   MEMBER MEHTA: All right, I don't want  
2 to take up too much time, but in the --

3                   CO-CHAIR TRAVIS: Do not apologize.  
4 I meant to come to you all. I never did come to  
5 you all, so thank you, Shek.

6                   MEMBER MEHTA: That's fine. For the  
7 conditional support option is there a way to  
8 address the time frame that, I guess, Donna was  
9 talking about, in terms of the delay? I don't  
10 know --

11                   (Simultaneous speaking.)

12                   CO-CHAIR TRAVIS: It seemed to me that  
13 would be a change in the measure specifications  
14 itself. Therefore -- I'll look to NQF staff, but  
15 it seems like it would be a different measure.  
16 We're really to vote on the measure as it looks  
17 here.

18                   MEMBER MEHTA: In that case, for the  
19 option of conditional support, is it to do more  
20 comprehensive SDS analysis or assessment?

21                   CO-CHAIR TRAVIS: Any feedback on how  
22 the SDS might be impacted?

1 DR. AMIN: The recommendation would be  
2 conditional on looking at some of these  
3 additional factors beyond what the surgery  
4 committee looked at. I would say -- I would just  
5 reiterate that this measure was just looked at by  
6 the surgery endorsement maintenance committee.  
7 While it was not part of the SDS trial, the  
8 measure developers did provide sufficient --  
9 significant information, which was provided in  
10 your discussion guide, about what they looked at.

11 Nancy's point about the robustness of  
12 the variables that they looked at is another  
13 question, but the SDS question was looked at  
14 pretty significantly already. We would need  
15 specific guidance on what you would want the  
16 standing committee to look at, in addition to  
17 what was already looked at. I think Nancy made  
18 some points around additional variables, but --  
19 we want to -- right. Thank you.

20 CO-CHAIR TRAVIS: Michael.

21 DR. PHELAN: I guess going back to  
22 Shek's point about the -- it's not a different

1 measure, but it goes back to Donna's point about  
2 the lack of data on the first three days, which  
3 is kind of shocking to me, but not really because  
4 I think this problem has come up in other  
5 measures before, where it's some kind of billing  
6 problem. Could CMS maybe re-answer or give me a  
7 little bit more clarity of what the difficulty  
8 is, and is it insurmountable? What I'm hearing  
9 is it may be insurmountable, but is it something  
10 that could be looked at to capture those first  
11 three days?

12 Because to me, those first three days  
13 may be an important number of patients who are  
14 coming back in to be re-admitted. So is the  
15 issue completely insurmountable, or is something  
16 with some mathematical analysis and some pulling  
17 of data, it can be retrieved? Because it seems  
18 to me like that would be a pretty important  
19 cohort not to be dropped out of your first three  
20 days.

21 So it's not a seven day, it's really  
22 day 4 through 7. The measure should be a little



1 bit more specific. If it's insurmountable, then  
2 we can accept the measure as it is, but I think  
3 what Shek is getting at is, is there a way to  
4 make this dependent on whether someone can look  
5 at -- whether we can start to try to capture  
6 those first three days? Did I get that  
7 correctly? Okay.

8 MS. HASKELL: I thought they addressed  
9 that with the physician billing.

10 DR. DRYE: Right. This is Elizabeth,  
11 at Yale. Sorry, I probably wasn't as clear in  
12 defining this before. We do address it. It's  
13 all of those days because we are able to look at  
14 the physician claims that are filed as outpatient  
15 surgical claims and cross-check them a couple  
16 different ways to make sure that they are indeed  
17 outpatient surgeries.

18 Then we can link them to patients who  
19 have inpatient claims that have incorporated,  
20 according to the three-day payment window, the  
21 facility portion of the bill. We are able to  
22 capture visits on any of those days. As I

1 mentioned, we tested that algorithm with real  
2 data going to thousands of facilities during the  
3 colonoscopy measure dry run this past summer, and  
4 we've refined it even a little bit further. So  
5 yes, we've already worked around that problem.

6 CO-CHAIR TRAVIS: Okay. So I guess  
7 I've got three of you all who probably -- okay, I  
8 had written down Brock first, but are you going  
9 to let somebody else say it, or are you going to  
10 say it?

11 MEMBER SLABACH: No I just wanted to  
12 ask a question about the SDS adjustment because I  
13 understand that there may not be any differential  
14 on a national basis, but I'm trying to figure out  
15 how this applies to institution-specific  
16 information.

17 So if I'm in my small hospital in  
18 southwest Mississippi, would this make a  
19 difference in my hospital, in terms of the  
20 adjustment? I would have to say that it would  
21 because I know my population versus maybe the  
22 national picture. I think there's two different

1 areas I wanted to kind of get an idea, and then  
2 maybe my -- catch up on knowledge about SDS.

3 (Simultaneous speaking.)

4 DR. DRYE: Hi, this is Elizabeth Drye,  
5 sorry. I'm just cutting you off, just say if you  
6 want me to stop elaborating. I just wanted to  
7 make two points because I think the SDS  
8 adjustment is hard to digest when you only have a  
9 few minutes to talk about it.

10 One point is that when we looked at  
11 the relationship of the scores, with and without  
12 adjustment, we were looking at each individual  
13 facility, and it gave each facility two scores,  
14 one with adjustment, one without adjustment.  
15 Comparing that across 4,000 hospitals, there was  
16 almost no difference. So we did look at the  
17 individual facility level and the extent to which  
18 facilities would be affected. We saw very, very  
19 little -- really no appreciable effect.

20 The other thing I just wanted to say  
21 in terms of -- maybe it was Taroon, if I'm just  
22 recognizing your voice -- point earlier, the

1 variables we use, Medicaid dual eligibility and  
2 race, those are patient-level variables we know  
3 are accurate for the patient. While we are doing  
4 work at Yale, and others are looking at how could  
5 we characterize community-level factors that may  
6 be affecting the rate of outcomes for some of  
7 these risk adjusted outcome measures, there  
8 really isn't anything that's as tightly tied to  
9 the patient, other than what we were able to use.

10 We think we started with the most  
11 powerful variables, even though there might be  
12 other variables we want to look at. Finally, I  
13 would just add in the setting of this particular  
14 measure, this is a cohort of patients who could  
15 have been operated on in ambulatory surgery  
16 centers. They are surgeries that are safe to do  
17 even at ASTs, and they're same-day surgeries. I  
18 think it's just probably a group that is slightly  
19 less vulnerable to the factors that we think  
20 about for very sick admitted patients who then  
21 get discharged home.

22 CO-CHAIR TRAVIS: Okay, thank you so

1 much, Elizabeth. We have a couple more cards,  
2 maybe three. I want to be sure we get to you,  
3 but I also want to be sure that we're not just  
4 being repetitive of our earlier discussion, which  
5 I think has been pretty robust. Because I think  
6 we need to get to the vote, and then see where we  
7 are. Then we could focus our discussions around  
8 what the results of the vote are.

9 If anybody wants to put down their  
10 card, given that suggestion, that would be fine.  
11 But if you keep your card up, please try to make  
12 a statement that is not repetitive in nature, but  
13 is additive to helping us make a decision on this  
14 vote. I would really appreciate that because we  
15 don't want to rehash everything that we've just  
16 spent the last hour, practically, talking about.

17 DR. AMIN: Cristie, could I just also  
18 add one thing to that? I just want to reiterate  
19 the importance of the fact -- just sort of  
20 delineate the endorsement process and the  
21 selection process. Obviously, a lot of these  
22 technical questions are important for people to

1 put out on the table. I would just encourage  
2 you, if there's still outstanding questions, to  
3 direct them to the surgery standing committee  
4 that recently reviewed this.

5 There's extensive information in your  
6 discussion guide on their discussions. I know  
7 many of these questions around reliability  
8 testing and risk adjustment are important, but  
9 clearly, given the volume of information that we  
10 need to get through, and the way that committee  
11 is really constituted, I would really recommend  
12 suggesting that the endorsement committee review  
13 any of these technical questions that you still  
14 have outstanding.

15 CO-CHAIR TRAVIS: Okay, thank you. We  
16 can't go through all the technical issues in this  
17 setting because we're not really equipped, and  
18 it's not in our scope. I think that's part of  
19 what I'm hearing from Taroon. Okay, Donna.

20 MEMBER SLOSBURG: Just to be brief, I  
21 appreciate all the work that Yale has done, but I  
22 do want to continue to comment that community

1 service claims are still an issue. I'm not going  
2 to go into a lot of detail because you all are  
3 asking me to be brief, but I do think that if  
4 we're going to publicly report something, I think  
5 we need to be sure that the measure is reflecting  
6 what data we're collecting.

7 So whether it's to keep digging and  
8 finding a way to get those 0, 1, 2, and 3  
9 patients, or whether it's to change the name of  
10 the measure because it's really not an all cause  
11 seven-day measure if you're not collecting all  
12 those patients. Thank you.

13 CO-CHAIR TRAVIS: Thank you, Donna.  
14 I appreciate that. Why don't we move to a vote  
15 on this measure?

16 MR. TILLY: The polling is now open  
17 for risk standardized hospital visits within  
18 seven days after hospital outpatient surgery,  
19 MUC15-982.

20 (Voting.)

21 MS. SHAHAB: We still need a few more  
22 votes, please.

1 (Voting.)

2 MR. TILLY: The results are 64 percent  
3 support, 20 percent conditional support, 16  
4 percent do not support. The recommendation is  
5 support.

6 CO-CHAIR TRAVIS: Okay. Thank you  
7 very much for working our way through that. I  
8 really appreciate everybody's comments, and I  
9 think it was helpful, so thank you very much. We  
10 did decide we're going to have a working lunch.  
11 We do get to eat. And so, what time, from you  
12 all's perspective --

13 MS. SHAHAB: We could take a 30-minute  
14 lunch instead.

15 CO-CHAIR TRAVIS: Yes, why don't we do  
16 a 30-minute lunch, so 12:40, because I do know  
17 that we have several people who do have a hard  
18 stop at 3:00, and some who have to leave before  
19 that. Thank you all for your patience, if we can  
20 come back at 12:40, and we will do inpatient  
21 psych at that time. Thank you.

22 (Whereupon, the above-entitled meeting



1       went off the record at 12:08 p.m. and went back  
2       on the record at 12:31 p.m.)

3                   CO-CHAIR TRAVIS:  We're almost all  
4       back.  There's some people in the back of the  
5       room, but I think for the first part of this,  
6       they can hear what we're going to be talking  
7       about.  Chris has joined us, and I think I will  
8       turn it over to you, Chris.

9                   MS. CASSEL:  Thank you Cristie, and  
10      thank you, Ron.  I just want to interrupt the  
11      important work of this group to just tell you,  
12      personally, an announcement that now has gone out  
13      on the press that I will be stepping down from my  
14      role at NQF in March, not for any bad reason, for  
15      a very good reason, which is that Kaiser  
16      Permanente is starting a new medical school, its  
17      own medical school, to be very innovative, very  
18      dedicated to physicians learning how to practice  
19      in teams and systems, using data, understanding  
20      quality.

21                   They've asked me to come and help lead  
22      that effort and help get it started.  For those

1 of you who know me, know that I have had a long  
2 career in academic medicine before I came to NQF  
3 and ABIM.

4 It was just irresistible to take this  
5 opportunity to start from scratch with a  
6 system-based, not a university-based, but a  
7 system-based medical school really focused on  
8 training top-notch clinicians and clinician  
9 leaders. But it's bittersweet because NQF is a  
10 wonderful and central and important organization,  
11 and my work here has been so rewarding, and we're  
12 doing so well. We're incredibly busy with both  
13 government-funded work, more than ever in our  
14 history, lots of it both central to federal  
15 policy, such as what you're working on, and also  
16 new areas in measurement science that are really  
17 breaking new ground around attribution,  
18 comparability, intended use, and other areas like  
19 that.

20 We also have a growing portfolio of  
21 foundation-funded work, including tomorrow, we're  
22 announcing a new grant from the Gordon and Betty

1 Moore Foundation on standardizing and adding  
2 quality to patient decision support, so that  
3 patients have more information about all of the  
4 different decision supports that they use. So  
5 there's lots going on here.

6 It's a very bittersweet time for me to  
7 be leaving because I feel so connected to this  
8 organization and the such wonderful staff and all  
9 of your and our terrific board. But on the other  
10 hand, there couldn't be a better time to recruit  
11 a new leader because the organization and its  
12 work are just growing in importance, so valuing  
13 the volunteer contributors to NQF's work, and  
14 that is every single member of this working  
15 group, all of MAP, and all of our standing  
16 committees. We sent a personal note out to  
17 everybody, so I don't want to clog up your  
18 emails, but you'll get that, if you haven't  
19 already, from me. I just wanted to personally  
20 come and let you know about it. Hi, Pierre. I'm  
21 happy, Cristie or Ron, to take any quick  
22 questions. I know you've got a busy afternoon.

1 This is coming down to the home stretch here, so  
2 I don't want to hold you up too long.

3 CO-CHAIR WALTERS: Sean.

4 DR. MORRISON: Chris, I just wanted to  
5 say congratulations. As somebody who trained  
6 with you as a medical student, not to age either  
7 of us, had you as my chair, Kaiser could not have  
8 picked a better person. This is really good for  
9 American healthcare, so congratulations, and  
10 thanks for everything you've done at NQF.

11 MS. CASSEL: Thank you, Sean.

12 (Applause.)

13 Okay, I'm going to let everybody get  
14 back to work.

15 (Simultaneous speaking.)

16 DR. PHELAN: Just to let you know,  
17 Sean graduated last year -- finished his  
18 residency last year.

19 CO-CHAIR TRAVIS: Thank you so much,  
20 Chris, and thank you for joining us and giving  
21 the news to us personally.

22 MS. CASSEL: I might actually grab a

1 little lunch.

2 CO-CHAIR TRAVIS: Please do. You've  
3 earned it. Thank you all for coming back a  
4 little bit earlier than we anticipated from lunch  
5 because, as I indicated before, we're going to  
6 start losing some people, and we want as many  
7 brains around this table as possible for the  
8 decisions that we still have left to make, which  
9 are around inpatient psych and ambulatory  
10 surgery.

11 As I indicated earlier today, we're  
12 going to put inpatient psych first to accommodate  
13 our lead discussants, but we also have a very  
14 tight time frame for ambulatory surgery because  
15 some of our lead discussants will have to leave  
16 no later than between 2:30 and 3:00. I think we  
17 can get through this work within those time  
18 frames. The first one we're going to talk about  
19 is inpatient psychiatric facilities quality  
20 reporting system. I'm going to turn it over to  
21 Erin, if she's here, to open up with an overview,  
22 or somebody will do the overview.

1 MS. MARINELARENA: I'll take over.

2 CO-CHAIR TRAVIS: Thank you, Melissa.

3 MS. MARINELARENA: Again, another  
4 quick overview on the psychiatric program. This  
5 is a pay for reporting program, so payment is not  
6 going to be -- it's pay for reporting, so we keep  
7 that clear as we're discussing the measures. The  
8 incentive structure for this program is inpatient  
9 psychiatric hospitals or psychiatric units that  
10 do not report data on the required measures will  
11 receive a 2 percent reduction in their annual  
12 federal payment.

13 The goals of this program are to  
14 provide consumers with quality information to  
15 help inform their decisions about their  
16 healthcare options, to improve the quality of  
17 inpatient psychiatric care by ensuring providers  
18 are aware of and reporting on best practices, and  
19 lastly, to establish a system for collecting and  
20 providing quality data for inpatient psychiatric  
21 hospitals or psychiatric units.

22 CO-CHAIR TRAVIS: Okay, thank you,

1 Melissa. We'd like to take some public comment  
2 now. Is there any in the room?

3 (No audible response.)

4 Seeing none, Operator, could you  
5 please see if there's any public comment on the  
6 line?

7 OPERATOR: Yes, ma'am. At this time,  
8 if you would like to make a comment, please press  
9 star, then the No. 1. There are no comments at  
10 this time.

11 CO-CHAIR TRAVIS: Okay, thank you very  
12 much, Operator. We have two measures that are on  
13 this calendar. The first one is substance use  
14 core measure set for alcohol and other drug use  
15 disorder treatment provided or offered at  
16 discharge.

17 I'm going to let you read the rest of  
18 what it says here. The second one is 30-day all  
19 cause unplanned re-admission. It's a 30-day all  
20 cause unplanned re-admission measure. The second  
21 measure has been pulled by Nancy Foster, and we  
22 will get to that in a moment, but the first

1 measure has not been pulled at this time and,  
2 therefore, still sits on the consent calendar.  
3 The staff's preliminary analysis and  
4 recommendation is support for this measure. Just  
5 one last call if anybody wants to remove this  
6 measure off the consent calendar. Jack.

7 DR. FOWLER: I don't agree with that.

8 CO-CHAIR TRAVIS: Okay, so you want to  
9 pull it? Yes, that's fine. Well, Jack, since  
10 we're on this measure, we'll go back to you.  
11 Please help us understand why you wanted to pull  
12 the measure.

13 DR. FOWLER: Sure. This is a measure  
14 where the rate at which people are offered  
15 entrance into either an alcohol or a drug abuse  
16 support program when they're discharged, in the  
17 event that they have been diagnosed -- they are  
18 labeled as having either an alcohol or drug  
19 problem.

20 The thing I don't like about this is  
21 this is some provider checking boxes. All you've  
22 got to do is say yes, we suggested he go into a



1 drug program, or we said you go into an alcohol  
2 program, and if I didn't check the box that he  
3 has a substance problem, then it wouldn't count,  
4 and it wouldn't matter because he wouldn't be in  
5 the denominator. I just think quality measures  
6 that are totally under the control of a provider  
7 who's getting evaluated checking boxes is pretty  
8 worthless. I wouldn't think a place was better  
9 because they had a better score in this, so I  
10 wouldn't want to recommend that anybody be  
11 exposed to this information. That's it.

12 CO-CHAIR TRAVIS: Okay, thank you for  
13 that. Ann Marie and Dolores are our other two  
14 lead discussants. Jack's a lead discussant, as  
15 well. Ann Marie, would you like to talk about  
16 this measure?

17 DR. SULLIVAN: I would support the  
18 measure. I agree it's not, in some ways, the  
19 strongest, but it's part of three -- as far as I  
20 understand, there are two pieces that are already  
21 in place. This is the third. These indicators  
22 have been around with ORYX and the Joint

1 Commission for a while.

2 I think they're attempting -- they're  
3 only process measures; that's true. But they're  
4 attempting to address the very serious issue of  
5 comorbidity of substance abuse and alcohol in  
6 individuals who are in inpatient psychiatric  
7 facilities. I believe that it's already required  
8 that you do an alcohol screening, and also that  
9 you do a brief intervention for alcohol. That's  
10 usually a kind of harm reduction or motivational  
11 interviewing brief intervention. Now they would  
12 be adding this third one, which is are you  
13 actually either providing treatment or referring  
14 somebody for treatment at the point of discharge  
15 if you have discovered that they have an alcohol  
16 problem, and then done some brief intervention?

17 There are two measures. One is just  
18 that you've basically referred and people may  
19 have refused. That's all in one. The second  
20 group are those who you referred, but have not  
21 refused. You're kind of, at least, dealing with  
22 this issue where people say I referred you, but

1 the guy said I don't want to go, and then you  
2 don't have to worry about it anymore.

3 You are segregating off a measure that  
4 says -- and assuming that -- again, I think with  
5 every measure, you have to assume that the  
6 providers are in it because they want to do it,  
7 and they're not just checking boxes. But if  
8 they're in it because they really want to do it,  
9 they would have two groups. They would be able  
10 to follow a rate of those who were legitimately  
11 given referrals and/or treatment on site --  
12 because sometimes you can take a drug, for  
13 example, for alcohol abuse -- and what that  
14 number would look like for your service, and then  
15 two, what it would look like for those who you  
16 offered it to, but refused.

17 I think tracking that's a good point  
18 because you can say that theoretically, people  
19 would be checking the box that people accepted  
20 treatment meant that they felt there was some  
21 degree of motivation to follow up. You offer it  
22 to 100 people, maybe 20 of them say yes, I'll go

1 or have treatment, and the other 80 just refuse,  
2 then they're probably not doing it right.

3 I do think the measure actually gets  
4 at a critical issue, in terms of looking at how  
5 we refer people and those people who refuse.  
6 It's a process measure. It's not an outcome  
7 measure. The fourth wing of this, which is the  
8 ORIX indicators do, does begin to look at what  
9 happened to that referral. That's not in here  
10 yet, but probably, my guess is, it might come at  
11 a later point. I do think it has a value in  
12 making sure that providers are really paying  
13 attention to substance abuse issues which, in the  
14 past, to tell you the truth, they have not been  
15 paying as much attention to as they should have.  
16 While it's not the best of all indicators, I  
17 would support it because I think it builds on the  
18 first two, which are already out there, and gets  
19 the psychiatric inpatient units to pay more  
20 attention.

21 CO-CHAIR TRAVIS: Thank you, Ann  
22 Marie. Dolores, any comments?

1 MS. MITCHELL: I think I'm somewhere  
2 between the two of my co-religionists over here,  
3 in that I found the measure to be tepid, at best.  
4 Just to say anybody who said no, they don't  
5 matter, but they matter most, not least, it seems  
6 to me.

7 Even if it's not as severe as opioid  
8 over use, which is approaching crisis proportions  
9 in this country, if it isn't, in fact, already  
10 there, drug use and deaths from drug over use are  
11 really a very serious problem that has been  
12 growing substantially over the past couple of  
13 years. It seems to me that simply saying if they  
14 refuse, that's the end of that is much in the way  
15 of a necessary approach to a terrible social  
16 problem. I don't know. Do we have some kind of  
17 a conditional support option in which the  
18 condition would be to ask the developers to beef  
19 it up or bulk it up or get started on other  
20 measures that support it that are more vigorous  
21 and all-inclusive in their coverage?

22 I think this is just a high -- it has

1 ripple effects not only on the lives of the  
2 people who are involved, but as everybody knows  
3 who's in this business, anybody with any of these  
4 problems also spends significantly more money and  
5 uses significantly more resources on the medical  
6 side, so it's a double whammy, in a way. As I  
7 say, if we can do something for conditional  
8 support, that's where I would end up voting, so  
9 you'll have to tell me because I don't know  
10 whether we've got that option.

11 CO-CHAIR TRAVIS: I'm going to look to  
12 NQF staff to help us kind of tease that out. It  
13 would seem to me that if we're looking at a  
14 change in the specifications that it would be a  
15 different measure and not the measure that is  
16 before us today. I think we could, if that is  
17 what we wanted, in our notes, indicate that we  
18 would encourage the developer to move in that  
19 direction. So we can send the note, but I think  
20 we've got to deal specifically with the measure  
21 in front of us today.

22 MS. MITCHELL: Who is the measure

1 steward?

2 MS. MARINELARENA: Joint Commission.

3 MS. MITCHELL: I'm sorry, what?

4 MS. MARINELARENA: The Joint  
5 Commission.

6 MS. MITCHELL: What drug commission?

7 MS. MARINELARENA: The Joint  
8 Commission.

9 (Simultaneous speaking.)

10 MS. MITCHELL: The quality of the  
11 discussion is rapidly deteriorating.

12 CO-CHAIR TRAVIS: I know. We better  
13 hurry up on these measures.

14 MS. MITCHELL: I take it there's no  
15 spokesman for the developer of this measure?

16 CO-CHAIR TRAVIS: We can see if -- is  
17 a developer on the line for this particular  
18 measure?

19 DR. CAMPBELL: Yes, this is Kyle  
20 Campbell with Health Services Advisory Group.  
21 Can you hear me okay?

22 CO-CHAIR TRAVIS: Yes, we can.

1 DR. CAMPBELL: Okay. Yes, I think  
2 there's been some important points made in the  
3 discussion. We think that this is a very good  
4 place to start, in terms of a measure related to  
5 alcohol and other drug use disorder treatment in  
6 the IPF setting. A couple of statistics that  
7 I'll bring to your attention. In the Joint  
8 Commission's testing data, they did an analysis  
9 of data from 2010, with approximately 9,000  
10 records, and they found that the compliance rate  
11 of this measure was only 3.5 percent.

12 That would indicate quite a large room  
13 for improvement on this particular measure. We  
14 did look specifically about the cohort of  
15 inpatient psychiatric facility patients, and we  
16 found that in using the 2013 Medicare  
17 administrative claims data, about 2.9 percent of  
18 patients had alcohol-related primary diagnoses,  
19 and an additional 16 percent, about 26,000  
20 admissions, had alcohol-related diagnoses as a  
21 secondary diagnosis. So we think that this is a  
22 very important place to start for this population



1       that's at high risk. As was mentioned, this  
2       measure does incorporate not just alcohol, but  
3       drug substance use. The president recently  
4       issued a memo concerning the importance of  
5       substance abuse in America.

6               So we feel like from an importance  
7       perspective, it's a good place to start. We  
8       recognize that it could certainly go further, but  
9       this was the measure that was currently endorsed  
10      and available that addressed this construct.

11             MS. MITCHELL: Whose compliance were  
12      you talking about with that 3 percent, the  
13      hospital's compliance or the patient's  
14      compliance?

15             DR. CAMPBELL: Yes, the hospital.  
16      That was the overall rate of the measure for the  
17      hospitals that were evaluated.

18             MS. MITCHELL: Are you saying that  
19      only 3 percent of the psychiatric hospitals ask  
20      people or offer program support for their alcohol  
21      or drug problems?

22             DR. CAMPBELL: This sample is not from

1 the inpatient psychiatric facilities. This was a  
2 sample of other hospitals, and it was based on  
3 approximately 9,000 records.

4 (Simultaneous speaking.)

5 MS. MITCHELL: I just want to clarify  
6 where that 3 percent -- what is being measured by  
7 that 3 percent? Are you saying that all patients  
8 who are in a hospital, not just a psychiatric  
9 hospital, but any hospital that has an inpatient  
10 psychiatric unit, I assume you mean, no? Nancy  
11 Foster, my guru on such matters, shakes her head,  
12 so that means anybody who comes into an  
13 inpatient, and only 3 percent of them are queried  
14 about and offered assistance for what appears to  
15 be an issue with either drugs or alcohol, is that  
16 right?

17 DR. CAMPBELL: Right. In the sample,  
18 just to describe it for you, eight of the  
19 hospitals that participated were VA hospitals,  
20 and six participating were referred to as SBIRT  
21 hospitals, which are screening, brief  
22 intervention, and referral to treatment program

1 hospitals. These data were collected --

2 MS. MITCHELL: What is that?

3 DR. CAMPBELL: To be honest, I can't  
4 answer that specific question, but that's part of  
5 (Simultaneous speaking).

6 MS. MITCHELL: Even Nancy doesn't know  
7 the answer to that.

8 PARTICIPANT: They were involved in a  
9 study for that screening and brief intervention  
10 treatment.

11 DR. CAMPBELL: Right. They were  
12 hospitals that were involved in a specific study  
13 for screening, brief intervention, referral and  
14 treatment. As was mentioned, those other  
15 measures that are related to this measure in the  
16 set, they were hospitals that were part of that  
17 group.

18 MS. MITCHELL: Well, whatever the  
19 group, or whatever that set of initials implies  
20 about these institutions, this being a  
21 nomenclature with which I am totally unfamiliar  
22 as, apparently, is everybody in this room, that's

1 an appalling number, that 3 percent -- really  
2 bad. So anything that we could do to -- not to  
3 encourage, but to mandate that people start  
4 asking those obvious questions --

5 MS. HASKELL: Does the measure exclude  
6 people who don't accept the referral?

7 DR. CAMPBELL: The numerator for the  
8 measure is the number of patients who received or  
9 refused, at discharge, a prescription for  
10 medication or treatment. If they refused, they  
11 would be counted in the numerator as numerator  
12 compliant. The second part of the measure, which  
13 is reported as a separate rate, is the number of  
14 patients who received a prescription at discharge  
15 for medication for treatment of alcohol or other  
16 drug use dependence or a referral for addiction  
17 treatment.

18 CO-CHAIR TRAVIS: Okay, thank you. I  
19 know this is going to be a little bit difficult  
20 for us to kind of work through because it's  
21 unfamiliar territory, I think, to a lot of us  
22 sitting here. But this is an endorsed measure.

1 We need to at least think about the process that  
2 it went through for the endorsement.

3 Some of these highly technical  
4 questions, I am assuming, unless someone on staff  
5 tells me differently, have been addressed at that  
6 level. But still, it is before us to see if we  
7 feel comfortable that it comes into this program.  
8 So I want to be sure that we address the issues  
9 enough to feel comfortable voting on it, but not  
10 so much that we have to get down into everything  
11 that probably was adjudicated during the  
12 endorsement process.

13 MS. MITCHELL: Cristie, don't I  
14 remember that we used to do -- in the process of  
15 going through these measures, that when we saw a  
16 gap, that we identified it as a measures gap and  
17 put it into a final report, saying let's get out  
18 there and beat the bushes and find some groups  
19 that are willing to put together some stronger,  
20 better, more comprehensive measures?

21 CO-CHAIR TRAVIS: Yes, and this didn't  
22 -- my comments were not to imply that we can't

1 carry a message forward from this group that we  
2 think stronger and better measures are needed in  
3 this area.

4 MS. MITCHELL: Yes, this is not a gap.  
5 This is a chasm.

6 CO-CHAIR TRAVIS: No, thank you for  
7 that clarification, Dolores. Would you like to  
8 say something, Erin?

9 MS. O'ROURKE: Sure. I think  
10 piggybacking on what Dolores was just saying,  
11 that we heard very clearly at the fall web  
12 meeting that this is a big gap area, and I think  
13 building on that theme today. I can't tell you  
14 how to vote, if it's a support or a conditional  
15 support, but either way, we can capture, in the  
16 rationale and in the accompanying report, that  
17 outcomes for this area are a huge gap, and a  
18 process measure could be an important start, and  
19 the MAP would recommend the quick development and  
20 adaptation of an outcome measure.

21 DR. PHELAN: Just going on the same --

22 CO-CHAIR TRAVIS: I feel like I'm kind

1 of losing a little control here. For those of  
2 you who know me, I am a control freak, so you  
3 don't want to see me morph into that in the last  
4 hour of this meeting, trust me. Thank you so  
5 much, Michael, I appreciate that. Nancy, I think  
6 you were next.

7 MEMBER FOSTER: At the time I raised  
8 my card, it was to associate myself with the  
9 remarks from the woman from Massachusetts. This  
10 is a baby step forward in measurement in this  
11 area, but it really -- we really need stronger  
12 measures, as Erin has just outlined. I want to  
13 remind folks that we're talking about a patient  
14 population in inpatient psychiatric facilities  
15 that are not just hospitalized for drug abuse or  
16 substance disorders. We're talking about people  
17 with schizophrenia and severe mental health  
18 problems, where perhaps this or tobacco cessation  
19 is not the major concern when they are actually  
20 discharged, but their overall mental health.

21 So how we get to the right measures  
22 and really are measuring that which is important

1 for patients who are hospitalized in a  
2 psychiatric facility -- and there are fewer and  
3 fewer of those these days -- is really the key  
4 question I think we're trying to put on the  
5 table. I really don't have heartache over this  
6 particular measure, but I'm not really passionate  
7 about it, either.

8 CO-CHAIR TRAVIS: Thank you, Nancy.  
9 I know Greg has to leave in a few minutes, so I  
10 wanted to be sure -- I hope you all don't mind.  
11 I'm going to take him a little bit out of order.  
12 If you have any comments, Greg, that you would  
13 like to make.

14 DR. ALEXANDER: I just wondered, in  
15 looking at this description, it's 18 years of age  
16 and older. I just wonder what the justification  
17 for that was because high school students have  
18 major issues with this, and I just wondered if  
19 we're not missing -- if there isn't a gap there?  
20 Because high school students, you start earlier  
21 intervention, and perhaps you have better  
22 outcomes in the end, and why they're not part of



1 this, or if there are other measures that take  
2 that into account?

3 CO-CHAIR WALTERS: The committee made  
4 that same recommendation, but they had to deal  
5 with the measure that was written, which was 18  
6 and above. So that was recognized last year by  
7 the steering committee.

8 CO-CHAIR TRAVIS: So common  
9 identification of a gap around this measure.  
10 Thank you very much for that, Greg. Ron.

11 CO-CHAIR WALTERS: We've got a chance  
12 to talk about an outcome measure in just a  
13 second, and I don't generally like process  
14 measures, but again, as Nancy said, this is an  
15 area that could use a lot of development. We  
16 know that. I'd rather keep a process measure, as  
17 we continue to work towards more relevant outcome  
18 measures, rather than discard it. I also am  
19 impressed, actually, that it is the Joint  
20 Commission that's the steward, and it is a part  
21 of their ORIX measures. So as we get into the  
22 Inpatient Psychiatric Quality Reporting Program

1 more developed, this is -- if we lost this  
2 measure, there's not an easily fillable measure  
3 to take its place. As everybody mentioned, this  
4 is a big process step that there still exists to  
5 be a huge gap in. Someone asked how -- I think  
6 it was Dolores said how can we improve on the use  
7 of this measure?

8 One way is not going to be to get rid  
9 of the measure. It's going to actually be to do  
10 everything we can to enhance and to enforce the  
11 use of the measure. I'm sorry, Jack, that it is  
12 a checkbox, but there are plans to make it more  
13 tied in to electronic health records and so on.

14 CO-CHAIR TRAVIS: Michael.

15 DR. PHELAN: I guess I want to  
16 reiterate or establish the huge gap area in this.  
17 This is such a small Inpatient Psychiatric  
18 Quality Reporting Program compared to the  
19 outpatient world, compared to the emergency  
20 medicine world, compared to inpatient, where  
21 someone -- I think the report, they said only 3  
22 percent of patients who are admitted to a

1 hospital were actually getting -- so I think from  
2 this committee, recognizing that this is a gap  
3 area that needs a serious look at what measures  
4 are out there, what measures can be developed,  
5 and really push -- because this is a big area  
6 that -- I've been on the committing for a couple  
7 years, and we keep reiterating. We never get any  
8 feedback from when is someone going to step up to  
9 the plate and say this is -- and it's epidemic.

10 The heroin epidemic is -- a simple  
11 measure like how often are heroin addicts getting  
12 appropriate community resources to them, I think  
13 people would be shocked that that does not happen  
14 as often as it should. Having this as kind of a  
15 stamp on the table or a fist on the table to say  
16 we really want to get some measures around this  
17 because it's important to the patients, and it's  
18 important to their families.

19 I don't think there's a lot of measure  
20 development that I'm hearing in the last couple  
21 years around this area. I think if we're going  
22 to focus or put some attention on some gap areas,

1       this one would be one that really needs it. This  
2       measure, it's a process measure. It's a first  
3       step. It is such a small, narrow portion of the  
4       people that potentially are affected nationwide,  
5       and there is nothing out there that I've seen on  
6       the horizon or hear in meetings to say this is  
7       what we have to develop -- seven outpatient  
8       measures, seven inpatient measures, whatever  
9       there is out there. But there needs to be a push  
10      from somewhere, and I think this committee can at  
11      least state that fact.

12               CO-CHAIR TRAVIS: Thank you for that,  
13      Michael. To kind of reiterate what Erin said, I  
14      think it's going to be very clear to the staff  
15      when they write up our comments and our thoughts  
16      around this that this is an area that people feel  
17      very strongly about. To your point, things need  
18      to start looking different because this isn't the  
19      first time that we've had this conversation,  
20      although I do think it may be one of the  
21      strongest times we've had this conversation, so  
22      thank you for that. David.

1                   MEMBER ENGLER: Thank you. I don't  
2                   want to reiterate what's already been said, but I  
3                   will for a couple of reasons. I brought this up  
4                   about two years ago as a measure gap area.  
5                   Psychiatric care and the lack of real good  
6                   measures in it is phenomenal to me as to why  
7                   they're not there. Second of all, if you look at  
8                   the re-admission data, you will find that reasons  
9                   for re-admissions predominantly are psychiatric  
10                  care. It's not only affecting inpatient psych  
11                  care, but it's also affecting the re-admission  
12                  penalties. Unless we can get to continuous care  
13                  for patients that have psychiatric disorders, in  
14                  particular drug and alcohol, which is a large  
15                  portion of the patients that my hospital serve,  
16                  until we can come to really good agreement and  
17                  get some measures out there, we're not going to  
18                  be able to address this gap.

19                  I think this is a great first step.  
20                  Sorry it's a check the box, but you've got to  
21                  start somewhere. I would really encourage the  
22                  developers -- and I thank Joint Commission for

1 coming up with this -- I would encourage more and  
2 more development on this because this stuff  
3 really matters. It really matters.

4 CO-CHAIR TRAVIS: Thank you, David.  
5 I think what we're going to do is go to Jack,  
6 Sean, and then Ann Marie, and then I think that  
7 hopefully, by that time, we'll be ready for a  
8 vote. Jack.

9 DR. FOWLER: I actually have to go.  
10 I think the choice about -- there's no question  
11 that everybody thinks this is a good -- they want  
12 a measure. I think it's a bit of a gesture,  
13 myself, and I think the group has to decide  
14 whether that's worth doing. I would probably  
15 vote no, but it's going to pass, and that's fine.

16 CO-CHAIR TRAVIS: Thank you, Jack, and  
17 thank you for bringing up this discussion point.  
18 Sean.

19 DR. MORRISON: Thanks for leaving,  
20 Jack, when I'm going to counter that. Actually,  
21 what I would say is slightly different. When we  
22 look at people hospitalized with serious mental

1 illness, schizophrenia, poorly treated  
2 depression, we tend not to focus on the comorbid  
3 illnesses that accompany that. We sort of give  
4 everybody a pass on tobacco and smoking  
5 cessation.

6 We say that drug and alcohol abuse are  
7 just part of the disease. Actually, even though  
8 it is a process measure, and even though it's a  
9 checkbox, it serves as a lightbulb measure to say  
10 we shouldn't be forgetting about these just  
11 because they have serious mental illness. We see  
12 this with diabetes in the setting of serious  
13 mental illness, as well. We just sort of say  
14 schizophrenia's the problem. I do think this  
15 sort of points a spotlight on the fact that this  
16 is an area of importance. It may be a checkbox,  
17 but the fact that we're not actually thinking  
18 about it on discharge, if this actually shines a  
19 light on the fact that we should think about it,  
20 that's a really good first step.

21 CO-CHAIR TRAVIS: Thank you. I didn't  
22 see Wei's card, so we'll go to Ann Marie, and

1       then Wei, and then hopefully we'll be at a time  
2       when we can vote. Use your microphone.

3               DR. SULLIVAN: -- would agree with  
4       what everyone's saying, especially in terms of  
5       the measure development, that unfortunately,  
6       there isn't anything out there that's a lot more  
7       robust at this point in time than what we have,  
8       but it's a very serious problem. You're  
9       absolutely right.

10              The mental health field has had  
11       trouble with this, paying attention to  
12       comorbidities, whether they're medical  
13       comorbidities, substance abuse comorbidities,  
14       tobacco, etc. I think it does shine the light.  
15       It does force people to do it. Just one fact.  
16       When we looked at avoidable admissions --  
17       Medicaid avoidable admissions in New York State,  
18       half of those avoidable admissions -- half had  
19       substance abuse and mental health problems  
20       admitted to medical units. I think that's also  
21       where the development has to go.

22              We're sitting here in -- inpatient



1 psych, we need a lot there, too, but we also need  
2 it on the medical side, to your point, the  
3 screening for substance abuse, getting the right  
4 referrals out for substance abuse, for mental  
5 health issues. Because the huge cost in the  
6 healthcare system on the medical side has all  
7 these psychiatric and substance abuse  
8 comorbidities. I just think that's the other  
9 place to go, and I'll stop at that.

10 CO-CHAIR TRAVIS: Thank you. Wei.

11 MEMBER YING: My comment actually is  
12 more to CMS. If we do support this measure, and  
13 everyone already raised -- I wouldn't say  
14 concern, but comment that this is not a perfect  
15 measure, there may be other measures coming up.  
16 If we do support it and it becomes part of the  
17 program, please keep the program consistent for  
18 some time. This reporting program hasn't been  
19 out for long time, but just during its short life  
20 span, it has already gone through major change.  
21 A lot of measures -- I would say at least a  
22 third, if not half of the measure has been pulled

1 from the initial report. It's very hard for us  
2 to develop a program -- we actually developed a  
3 program with inpatient psych unit hospital  
4 facilities in our network based on the initial  
5 report, and then we have to pull it out, redesign  
6 it. This is not a perfect measure, but a measure  
7 step forward. Great, but then leave it for some  
8 time for us to work on it.

9 CO-CHAIR TRAVIS: Very good point. I  
10 guess I'm a sucker, but these last two cards  
11 really do need to be the last two cards, if you  
12 all don't mind. Nancy, final comment from you?

13 MEMBER FOSTER: Just one clarification  
14 because I want to make sure people knew that for  
15 psychiatric hospitals, they already have a  
16 screening measure in place, especially for those  
17 that are Joint Commission accredited. It's not  
18 about getting the initial screening. This  
19 measure addresses referral going forward. But in  
20 all sensibility, one might think about this  
21 measure for non-psychiatric hospitals.

22 CO-CHAIR TRAVIS: Very good point.

1                   MEMBER FOSTER: It might be more there.

2                   CO-CHAIR TRAVIS: Thank you for that.

3 Did I see any other cards up? David, is yours  
4 still up?

5                   Thank you. I'm sure there'll be a  
6 time when that will be a very important  
7 discussion for us to have. I think we will move  
8 on to taking a vote.

9                   MR. TILLY: The polling is now open  
10 for substance abuse core measure set, Sub 3,  
11 alcohol and other drug use disordered treatment  
12 provided or offered at discharge, and Sub 3(a),  
13 alcohol and other drug use disorder treatment at  
14 discharge, MUC15-1065.

15                   (Voting.)

16                   The results are 71 percent support, 25  
17 percent conditional support, 4 percent do not  
18 support. The recommendation is support.

19                   CO-CHAIR TRAVIS: All right, thank you  
20 all for that good discussion. We'll now move to  
21 the second measure in this calendar, which is  
22 30-day all cause unplanned re-admission following

1 psychiatric hospitalization in an inpatient  
2 treatment facility, and this was pulled by Nancy,  
3 so I'll turn it over to Nancy first.

4 MEMBER FOSTER: I know you will all be  
5 surprised. I'm going to recommend that this  
6 re-admission measure be especially evaluated for  
7 its sociodemographic impact. In this case, let  
8 me be a little bit more explicit.

9 I think that in addition to just the  
10 general factors in the community that may exist,  
11 one really has to look at the source of ongoing  
12 treatment for psychiatric disorders/mental health  
13 disorders in the community, whether it's through  
14 the HRSA data on shortage areas or some other  
15 data.

16 Because if you're discharging patients  
17 who've been hospitalized in an inpatient facility  
18 and there is a lack of resources in the  
19 community, the chance that they'll come back to  
20 the acute-care hospital or the psychiatric  
21 facility go up enormously.

22 As states and communities dismantle

1       their support for ongoing treatment of mental  
2       health disorders, the pattern here varies across  
3       the country, but it varies not with -- just with  
4       the typical sociodemographic factors that one  
5       might think of. It varies with accessibility of  
6       other services. So I encourage the NQF to make  
7       sure that the committee thinks about that as they  
8       are assessing this measure. Otherwise, I would  
9       support the conditional support.

10               CO-CHAIR TRAVIS: Okay, conditional  
11       support with a look at the ongoing treatment for  
12       psychiatric disorders in the community as part of  
13       the SDS review when this measure comes in.

14               MS. MITCHELL: Just a word question.  
15       Nancy, is there such thing as a planned  
16       psychiatric re-admission?

17               CO-CHAIR TRAVIS: Or Ann Marie.

18               DR. SULLIVAN: Nowadays, that's very,  
19       very rare -- very rare. Twenty years ago, maybe,  
20       but right now, very rare that it's a planned  
21       admission. Unfortunately, no.

22               CO-CHAIR TRAVIS: This is the measure,

1 as it's been -- I'm going to let our friends from  
2 CMS talk about that.

3 DR. MEYYUR: Yes, there are planned  
4 admissions, but they're very few. We did discuss  
5 that with the technical expert panel when we  
6 developed the measure. Kyle may be able to  
7 expand more on that.

8 MEMBER FOSTER: Just jump in here.  
9 This is all cause re-admission with, obviously,  
10 appropriate exclusions. One might be planned to  
11 be admitted to an acute-care facility for ongoing  
12 treatment of a medical problem that you wouldn't  
13 want counted in here, if you will, against the  
14 hospital.

15 CO-CHAIR TRAVIS: I think we have the  
16 developer on the phone, if we want to get your  
17 input and insights into this issue, please.

18 DR. CAMPBELL: Yes. This is Kyle  
19 Campbell from Health Services Advisory Group. As  
20 CMS just mentioned, it is rare. I'm going to  
21 turn it over to my colleague, Karen Pace, who  
22 worked on the algorithm.

1 DR. PACE: Hello, this is Karen. Just  
2 as an example of what might be a planned  
3 re-admission, we started with the Yale algorithm  
4 for the hospital-wide re-admission measures and  
5 followed that process, and also consulted with  
6 the technical expert panel. Probably the best  
7 example is plan to come back for  
8 electroconvulsive therapy was probably the  
9 example that resonates with most people, in terms  
10 of planned re-admissions, but agreed, and the  
11 data bore out, it doesn't happen very often. The  
12 mention about re-admission for -- moving a  
13 patient for a medical treatment, if the patient  
14 moves from an IPF to an acute care hospital, for  
15 example, for medical treatment that the IPF might  
16 not be able to provide there, that would be  
17 considered a transfer and would not be counted as  
18 a re-admission.

19 CO-CHAIR TRAVIS: Okay, thank you very  
20 much. David.

21 MEMBER ENGLER: Thank you. We offered  
22 comments in support of this measure with the

1       proviso -- and we've published some data on this  
2       -- that the adjustments really look at  
3       community-based support. It amounts to -- and  
4       don't quote me right now, but I think it amounts  
5       to about 40 percent of the variance that you see  
6       in this measure can be avoided if you have good  
7       community support with those two provisions. I  
8       just wanted to mention that again. Thank you.

9               CO-CHAIR TRAVIS: Thank you. Not  
10       seeing any other cards, I think we're ready to  
11       move to a vote.

12              MR. TILLY: Polling is now open for  
13       30-day all cause unplanned re-admission following  
14       psychiatric hospitalization in an inpatient  
15       psychiatric facility, MUC15-1082.

16              (Voting.)

17              The results are 43 percent support, 52  
18       percent conditional support, 4 percent do not  
19       support. The recommendation is conditional  
20       support.

21              MS. O'ROURKE: I would say the  
22       conditions we heard are that this is a measure



1 that needs particular attention paid to the  
2 impact of SDS factors, and we'll make that  
3 recommendation to the standing committee when  
4 they evaluate this measure for NQF endorsement,  
5 with a particular attention given to the fact  
6 that there needs to be consideration of ongoing  
7 treatment options for mental health disorders in  
8 the community.

9 CO-CHAIR TRAVIS: Great. Now I'll  
10 turn it over to Ron.

11 CO-CHAIR WALTERS: We're on the last  
12 program. I will turn it over first to Jean-Luc  
13 to give an overview of the ASC program.

14 MR. TILLY: The Ambulatory Surgical  
15 Centers Quality Reporting Program is a pay for  
16 reporting program, where that data is currently  
17 reported to CMS and is expected to be publicly  
18 reported in the near future. ASCs that don't  
19 report data receive a 2 percent reduction in  
20 their annual payment update. The measures in  
21 this program are designed to promote high-quality  
22 care for Medicare beneficiaries and help

1 establish a system for collecting quality data  
2 that will eventually be reported to consumers.  
3 The only measure under consideration for ASCQR is  
4 the toxic anterior segment syndrome outcome  
5 measures. This measure has not been submitted  
6 for NQF endorsement.

7 CO-CHAIR WALTERS: Are there public  
8 comments in the room?

9 (No audible response.)

10 Seeing none, would the operator check  
11 to see if there's any public comments on the  
12 phone?

13 OPERATOR: Yes, sir. At this time, if  
14 you have a comment, please press star, then the  
15 No. 1. There are no comments at this time.

16 CO-CHAIR WALTERS: Thank you very  
17 much. There is one measure which was proposed on  
18 the MUC list. Staff recommendation was do not  
19 support. That led to it being pulled by Donna  
20 Slosburg, who will now initiate her reason for  
21 pulling it.

22 MEMBER SLOSBURG: I'm pulling this

1 measure because I think there's some  
2 misunderstanding that may have impacted the  
3 analysis. I want to try to correct those  
4 misunderstandings. Toxic anterior segment  
5 syndrome is an outcome measure that assesses the  
6 number of anterior segment surgery patients  
7 diagnosed with TASS within two days of surgery.

8 It includes cataract surgery, as well  
9 as glaucoma surgery, as well as other surgeries  
10 on the cornea and iris. I'm sure you all are  
11 aware, but cataract surgeries are the No. 1  
12 commonly performed procedure for Medicare  
13 patients. The number is in the millions, and  
14 that number is expected to grow. It's an acute  
15 sterile inflammation of the anterior segment of  
16 the eye that occurs following surgery.

17 It develops between 12 and 48 hours  
18 after surgery. Studies in the literature have  
19 reported TASS rates of 1.8 to 2.1 percent. The  
20 measure was developed to fill MAP-identified gaps  
21 in complications and surgical care quality. It's  
22 a complication that can result in significant

1 anterior segment sequelae and ocular morbidity.  
2 With intense topical corticosteroid treatment,  
3 most cases resolve over a period of weeks to  
4 months, with the cornea eventually clearing.  
5 However, there are severe cases that may result  
6 in permanent damage, and additional surgical  
7 procedures may be required. While there are many  
8 potential causes, by far the most common  
9 modifiable risk factor for TASS are related to  
10 instrument cleaning and sterilization processes.

11 Because most cases of TASS are tied to  
12 issues with instrument cleaning and sterilization  
13 processes, when TASS is diagnosed in an ASC  
14 patient, the surgeon is strongly motivated to  
15 make the center aware of this complication to  
16 prevent TASS in other patients. This assures the  
17 measure outcome can be captured by the ambulatory  
18 surgery center with a high degree of certainty.  
19 Sorry, I just want to make sure because there's a  
20 lot of misunderstanding.

21 Eye professionals agree that measure  
22 efforts should be focused on the prevention of

1 TASS. The American Society of Cataract and  
2 Refractive Surgery and the American Society of  
3 Ophthalmic Registered Nurses have published  
4 recommended practices for cleaning and  
5 sterilization of intraocular surgical instruments  
6 aimed at the prevention of TASS, and these  
7 practices were developed with guidance from the  
8 Association of Operating Nurses, the CDC, and the  
9 FDA, in recognition that while product  
10 manufacturer issues may rarely result in TASS,  
11 preventing TASS by appropriate management of  
12 intraocular surgical instruments is a challenge  
13 that must be repeated with each cycle of cleaning  
14 and sterilization.

15 The measure is a fully developed and  
16 pilot tested facility measure. Reliability and  
17 validity testing have been conducted, and the  
18 results have been shared with CMS. This measure  
19 has the support of the American Academy of  
20 Ophthalmology, the American Society of Cataract  
21 and Refractive Surgery, the Outpatient Ophthalmic  
22 Surgery Society, and the Society for Excellence

1 in Eye Care.

2 Inclusion of this measure in the  
3 program will oblige surgery centers to maintain  
4 meticulous adherence to best practices. Based on  
5 the experience of ambulatory surgery centers that  
6 participate in an outpatient ophthalmic surgery  
7 centers benchmarking project, measurement  
8 reporting and benchmarking of TASS rates has the  
9 potential to reduce and sustain the occurrence of  
10 TASS to near zero. The measure presents an  
11 important opportunity in quality improvement to  
12 essentially eliminate a preventable complication,  
13 and I am asking the workgroup to please support  
14 this measure.

15 CO-CHAIR WALTERS: Did anybody catch  
16 any behind this? Karen.

17 MEMBER ROTH: I'm Karen Roth. I  
18 represent purchasers and as, of course, everyone  
19 in this room is concerned about the care of the  
20 patient, I think that this is a very important  
21 measure because TASS does have the potential to  
22 cause blindness, and it does appear that there

1 are preventive actions that can be taken to keep  
2 this from happening.

3 The one thing that I don't understand  
4 is why NQF decided not to support this measure.  
5 I'd just like to ask for clarification of that.  
6 Also, I think that there's probably a reason why  
7 CMS wanted to include it in the MUC list, so I'd  
8 like to get some clarification from them why they  
9 thought that this was important.

10 CO-CHAIR WALTERS: The process is not  
11 foolproof. That's about the best answer.

12 MS. O'ROURKE: I can give you a little  
13 bit of our thinking. We had found some studies  
14 from the FDA that attributed TASS, in large  
15 instances, to the device manufacturer, rather  
16 than the ASC, so some concerns about attribution.

17 CO-CHAIR WALTERS: Karen.

18 MEMBER ROTH: Well, based on some of  
19 the findings that Donna mentioned, and some other  
20 things that I learned from various sources,  
21 whether they were from insurance companies that  
22 cover these surgeries and things like this, it

1 almost invariably was attributed to the  
2 ambulatory surgery care center. The other thing  
3 that concerned me, though, was that they said  
4 that a lot of times, TASS is mistakenly diagnosed  
5 as endophthalmitis.

6 Endophthalmitis is actually a  
7 bacterial infection that's treated with  
8 antibiotics. However, if it's misdiagnosed, then  
9 the TASS is not going to respond to the  
10 antibiotics. It responds to steroids. That is  
11 an issue. There seems to be a need, also, to  
12 sort of make sure that this is diagnosed  
13 properly, as well. The other thing that I read  
14 was that NQF mentioned in the notes that they  
15 thought that the cataract measure and the  
16 transfer admission measure from an outpatient  
17 facility would capture this. Given that TASS  
18 develops within 12 to 48 hours, the cataract  
19 measure appears to assess vision at 90 days. It  
20 doesn't quite address the issue.

21 The other thing is the transfer  
22 admission measure, it measures a patient that was



1 transferred or admitted right after they were  
2 discharged from the ambulatory surgery care  
3 center, so it wouldn't give time for the TASS to  
4 develop. I saw some deficits there, as well.  
5 Those are my comments. I would also like to  
6 understand why CMS thought it was important to  
7 include this metric.

8 CO-CHAIR WALTERS: Karen, could you  
9 clarify who the measure developer is?

10 MEMBER SLOSBURG: I should have said  
11 that.

12 DR. PHELAN: If I'm not mistaken,  
13 wasn't there an ophthalmology and ENT TEP that  
14 just finished their evaluative process in the  
15 last six months at NQF? Why wasn't this measure  
16 submitted during that TEP?

17 MEMBER SLOSBURG: It closed on March  
18 27th, and we had not completed testing and  
19 development to submit it at that time.

20 CO-CHAIR WALTERS: Helen.

21 MS. HASKELL: I just wanted to say I  
22 think this seems to me like an important measure.

1 If 1.8 to 2.1 percent of cataract surgery  
2 patients are developing this clearly devastating  
3 complication, it's something that we need to be  
4 measuring. I think the fact that devices are  
5 involved, which happens in a lot of other  
6 instances, as well, it doesn't mean that we  
7 shouldn't be capturing it. It's about the only  
8 way you're going to capture it, and then go back  
9 and deal with the device.

10 CO-CHAIR WALTERS: Brock.

11 MEMBER SLABACH: The measure is not  
12 endorsed by NQF, is it? It said it was never  
13 submitted on the sheet that I have. So is it  
14 going to be submitted, and will it go through the  
15 process of endorsement?

16 MEMBER SLOSBURG: We can take it back  
17 to our technical expert committee. That's what  
18 we've done in the past.

19 CO-CHAIR WALTERS: Sean. I think  
20 that's -- we'll probably take care of that in  
21 just a second on the vote anyway. Sean.

22 DR. MORRISON: Yes, I am incredibly

1 uncomfortable endorsing something that has not  
2 gone through the NQF endorsement process. We are  
3 not the scientists. There's no reliability and  
4 validity measures. Let's make this go through  
5 the process -- I'm sorry, it's a long day. Let's  
6 take the time to have this go through the  
7 appropriate endorsement process.

8 CO-CHAIR WALTERS: Marty, did you --  
9 okay. Yes, Jeff.

10 MEMBER JACOBS: I just wanted to agree  
11 that there's probably not a lot of experts about  
12 eyeball surgery at this table and seems like  
13 measures like this need to go through NQF  
14 endorsement before this panel of experts here  
15 weighs in on whether or not it's a good hospital  
16 measure.

17 CO-CHAIR WALTERS: Donna, as the  
18 measure developer, you cannot vote on this  
19 measure. I don't think there's anybody else who  
20 has comments on that, but we do have to restrict  
21 what you say. Are there any more questions or  
22 comments? Yes.

1 MR. CLIFT: I'm Joe Clift. I'm the  
2 measures lead for the HAC reduction program, and  
3 I also support the outpatient and ambulatory  
4 surgery center program. There was a few reasons  
5 why CMS was particularly interested in this  
6 measure.

7 The first reason, as Donna said, is  
8 that the number of anterior segment surgeries is  
9 in the millions each year, so the 2 percent  
10 incidence has a high number of patients that  
11 could be impacted. These also occurs in  
12 clusters, so as Donna said -- also, you might  
13 have one patient with TASS, and there might be a  
14 bunch of others that follow, so it's something to  
15 really focus on.

16 It's a process of care measure. It's  
17 something that should not occur in the ambulatory  
18 surgery center, so identifying ways to improve  
19 cleaning processes, care processes, etc., can get  
20 this down to zero. When we looked at past data  
21 on the number of -- specifically, I looked at the  
22 2012, which is an all payer dataset, but teasing

1 out the ICD-9 for TASS was almost 60 percent of  
2 TASS diagnoses were from Medicare and Medicaid  
3 patients. So it does have the potential to  
4 impact this population, something that we were  
5 very interested in. With the number of  
6 independent eye surgery centers that are opening  
7 up, it is a -- could potentially be for a large  
8 volume impact, so that was our main reasons for  
9 supporting this measure on this MUC list.

10 CO-CHAIR WALTERS: Brock, did you have  
11 another comment? Michael.

12 DR. PHELAN: I understand this is a  
13 gap, but I kind of agree with my colleague from  
14 Hopkins. This isn't the appropriate body to make  
15 that decision. It's where I get confused on I  
16 don't want to say conditional support because I  
17 want it to go through the NQF process, but I  
18 don't want the impression to be gotten if we say  
19 do not support until it goes through the NQF  
20 process.

21 It's always given me great  
22 consternation that we don't have the fourth

1 option, which would be await NQF, bring back to  
2 the MAP so we could review it then. Because it  
3 kind of gives a free pass on No. 2 for  
4 conditional support. It's just like yes, it's a  
5 great idea. Let's say in six months, after the  
6 data comes in and a technical expert panel  
7 reviews it and says serious issues with this,  
8 this is a problem due to gaming or people are  
9 calling things one thing, but it's really  
10 another. I always really struggle with where to  
11 put my vote on this because I really want it to  
12 go through the NQF process and then be brought  
13 back so I can hear what they actually said about  
14 it. That's my --

15 CO-CHAIR WALTERS: I think we actually  
16 did stick both of those on a measure yesterday,  
17 actually. We did.

18 MS. O'ROURKE: We can't guarantee  
19 things would come back to the MAP, but we could  
20 certainly put it as a condition to request that  
21 it come back to the MAP, but I do want to be  
22 clear. CMS is not obligated to do that.

1 CO-CHAIR WALTERS: Okay, ready for a  
2 vote? I knew you were going to have a comment.

3 MEMBER HATLIE: You're prescient. I'm  
4 just struck by the sense of urgency here that  
5 this is something that could harm a number of  
6 patients quickly, especially if there's a  
7 clustering and there's new players in the market  
8 where this could be at risk. I'm hoping that our  
9 conditions will express a sense of urgency, just  
10 not go into a two or three or four-year process.  
11 Is there something we can say to move it along if  
12 the imminent harm is as strong as it is?

13 CO-CHAIR WALTERS: Jeff.

14 MEMBER JACOBS: I wanted to agree with  
15 one comment to go about the problem with the  
16 three voting choices because there really should  
17 be a choice that says we're totally agnostic  
18 about a measure and have no opinion about it,  
19 whatsoever, until it undergoes evaluation through  
20 a scientific review.

21 That's something that we don't have  
22 the expertise about. There's surgical committees,

1 and there's medical committees, and there's  
2 cancer committees that actually look at the  
3 science of the measures. Any of the choices here  
4 say we either like it or we don't like it, but we  
5 should be able to say we can't really judge it at  
6 all until the scientists have looked at it. I  
7 think that was a very good point that was made.

8 CO-CHAIR WALTERS: There is an option  
9 that covers that. It's the bottom one, although  
10 it may not send the same message.

11 MEMBER JACOBS: But that has a little  
12 bit of a negative connotation. That's what was  
13 being brought up. That has a negative  
14 connotation. That doesn't say we don't support  
15 it because we're waiting on more information.  
16 That just means we don't support it. What we're  
17 saying is maybe in the future we should just have  
18 a choice that says we don't want to say whether  
19 or not we support it all until the scientists  
20 look at it.

21 CO-CHAIR WALTERS: With those  
22 comments, you get the opportunity to vote now.



1 Push the four button and see what happens.

2 MR. TILLY: The polling is open for  
3 toxic anterior segment syndrome, TASS outcome,  
4 MUC15-1047. The options are support, conditional  
5 support, and do not support. There is no fourth  
6 option.

7 (Voting.)

8 The results are 13 percent support, 65  
9 percent conditional support, 22 percent do not  
10 support. The recommendation is conditional  
11 support.

12 CO-CHAIR WALTERS: Erin.

13 MS. O'ROURKE: The conditions we heard  
14 are that this measure needs NQF review and  
15 endorsement and, ideally, for CMS to bring this  
16 back to the MAP so that MAP has a chance to weigh  
17 in after they have data from experts in the  
18 subject matter.

19 MEMBER HATLIE: Could we say something  
20 about urgency and an expedited process?

21 MS. O'ROURKE: Of course. We can  
22 recognize the importance and the urgency of this

1 issue.

2 CO-CHAIR TRAVIS: I think we know what  
3 to do.

4 CO-CHAIR WALTERS: There is an  
5 opportunity for public comment again. Are there  
6 any public comments in the room about anything?

7 CO-CHAIR TRAVIS: Well, on this list.

8 CO-CHAIR WALTERS: Operator, is there  
9 anybody on the phone with public comments about  
10 any of the programs we've talked about?

11 OPERATOR: Once again, to make a  
12 comment, please press star, then the No. 1.  
13 There are no comments at this time.

14 CO-CHAIR WALTERS: I would personally  
15 like to thank everybody for their involvement.  
16 The discussion, again, has been very rich. I  
17 hope everybody leaves feeling that they got an  
18 adequate chance to contribute and contribute  
19 significantly to the discussion and to the  
20 recommendations we give to CMS, so thank you  
21 again.

22 CO-CHAIR TRAVIS: I want to add my

1 thanks to everybody in the room. Please note the  
2 time. It's 1:37. Thank you all very much. We  
3 were able, I think, to give it the time it  
4 needed, but to still end early, so that's really  
5 a tribute to everybody in the room, so thank you  
6 for that. I want to add my personal thanks, and  
7 I'm sure Ron's, as well, to the staff.

8           They actually get the last words here.  
9 But before I hand it over to them, I do also want  
10 to thank, Pierre, you and your team and the  
11 developers that have been on the line. It's  
12 always helpful to have you here because it helps  
13 us be sure that we understand CMS, why measures  
14 were put here, some of the details of the  
15 measures that we need to go through, so thank you  
16 all so much, as well.

17           DR. YOUNG: Thank you for that, and  
18 thank you to all the committee members for all  
19 the input you've provided and time taken, and  
20 thank you, also, for putting me and my staff  
21 through our paces. As I mentioned, we start this  
22 training in the spring. I do want to thank,

1 particularly, my staff and our measure developers  
2 for all the support they've provided here. Thank  
3 you.

4 CO-CHAIR TRAVIS: Thank you, Pierre,  
5 and your team. I'm going to turn it over to  
6 Zehra.

7 MS. SHAHAB: I just wanted to do next  
8 steps, and I don't want to have the last word. I  
9 want everyone else to have the last word. I just  
10 wanted to run through the next steps really  
11 quickly. This is the same timeline you've seen,  
12 but on the next slide, you will see some  
13 important dates.

14 After this, we are going to be opening  
15 up for a member and public comment, which will  
16 start December 23rd from January 12th. This will  
17 include the Excel and a draft version of the  
18 report, as well, that we are going to write  
19 quickly after today, so starting tomorrow and  
20 later today. Then the coordinating committee is  
21 going to review the recommendations on January  
22 26th, so the chairs will be representing the

1       workgroup, and we would welcome all of you  
2       workgroup members to dial in and listen to our  
3       summary and description of the coordinating  
4       committee. The final spreadsheet of  
5       recommendations on all these individual measures  
6       under consideration is going to be released  
7       February 1.

8               The guidance for hospital and PAC/LTC  
9       programs will be released February 15th, and the  
10      final guidance for clinician and special programs  
11      will be March 15th. Those are just some upcoming  
12      dates to look forward to. I want to start, on  
13      behalf of the staff, and thank all of you for all  
14      of your hard work and rich discussions. We have  
15      gathered a lot, and we can't thank you enough. I  
16      want to make sure that Taroon and the rest of my  
17      team has a time to say more, as well.

18             MS. O'ROURKE: I'll jump in. Thank  
19      you, as Zehra said, to the committee for taking  
20      the time to participate in this meeting. We  
21      greatly value your input. This is my fifth time  
22      now, and it's remarkable to watch how the process

1 has grown and the input we've received over the  
2 years and how valuable it's been. A special  
3 thank you to Pierre and the CMS staff and the  
4 developers for their open participation and being  
5 willing to take so many questions and be such  
6 active, involved participants in this process.  
7 It really, I think, adds a richness. The more  
8 they are willing to participate, the better our  
9 recommendations can be. A special thank you to  
10 Ron and Cristie for their amazing leadership for  
11 the past few days and for setting a MAP hospital  
12 workgroup record of getting us out about an hour  
13 and a half early.

14 I know. I'm going to be double  
15 checking that. You might be getting frantic  
16 emails from me later to come back. We did not.  
17 Just joking. Thank you to everyone. We greatly  
18 appreciate everything you've done to make this a  
19 reality.

20 MS. MARINELARENA: I just want to  
21 thank everyone, as well. I feel spoiled because  
22 it was my first MAP. I feel that apparently,

1 we've come a long way, so I feel very lucky, and  
2 I'm thankful to all of you for all of your hard  
3 work, CMS, my co-workers, and we look forward to  
4 putting this report out and getting all the  
5 comments and finishing up this process so Pierre  
6 can get started with his spring training in  
7 April.

8 MS. SHAHAB: I also wanted to make  
9 sure that if any of you would want to say any  
10 closing remarks -- I know Cristie and Ron got a  
11 chance, as well, but if any of you would like to  
12 provide us feedback, improvements, any last  
13 words? You don't have to raise your cards. You  
14 can just speak up. Go ahead.

15 MEMBER HATLIE: Just a general comment  
16 about the base of our activity. One of the  
17 things that I'm noticing -- and it's a  
18 frustration I've had with this group because I  
19 feel like I'm at the end of a process where I  
20 wish patients were engaged in measure development  
21 more, but that is happening more and more.

22 I think PCORI gets a lot of the credit

1 for it, honestly. We're starting to see  
2 different metrics come out that are different  
3 from a crude metric for mortality, so days out of  
4 hospital, days not in the healthcare system,  
5 things like that that I think are attributable to  
6 engaging patients early on. For the measurement  
7 developers in the room, I just think that's a  
8 really great area to think about is pulling in  
9 people who suffer from the conditions or are  
10 acquainted with the conditions that you're  
11 developing measures from. I think that you'll  
12 find a lot of patients will be eager to be part  
13 of a process like that. Thank you for my soap  
14 box at the end of the day.

15 MS. SHAHAB: Thank you. Anyone else?  
16 Dolores, Nancy, anyone?

17 MEMBER FOSTER: Sure. Now that I'm  
18 called upon, thank you all. I think this process  
19 worked a lot more smoothly. I miss a little bit  
20 of the opportunity to really go back to what -- I  
21 can't even remember -- somebody else was  
22 commenting before that we need to, again, be able



1 to identify gaps that really are important in the  
2 care.

3 When we're so focused on the list in  
4 front of us, it's hard to think more broadly, but  
5 I think we're kind of missing that, and I hope we  
6 can talk about how we get to that point later on.  
7 I also would welcome -- as you craft the report,  
8 NQF staff, in your great skill, I think there are  
9 a number of themes that ran throughout the  
10 discussions of individual measures. Calling  
11 those out and helping us all to get better by  
12 thinking about what those themes are and how we  
13 can address them going forward would be really,  
14 really constructive for all of us. I'd love to  
15 hear the themes from the other workgroups, too.

16 MS. O'ROURKE: Please, if you do have  
17 additional suggestions for improvement or what  
18 worked well or what didn't, please feel free to  
19 email us at any time, so that we can keep getting  
20 better for next year.

21 (Whereupon, the above-entitled meeting  
22 went off the record at 1:43 p.m.)

A			
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