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

(8:32 a.m.)

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

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

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

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

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

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

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

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

(No response.)

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

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

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

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

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

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

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

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

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

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

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

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

Clearly, the goal is not to measure

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

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

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

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

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

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

Again, this is another element that

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

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

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

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

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

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

Where does that strategic coordination

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

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

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

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

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

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

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

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

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

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

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

go with Andrea first because she's over there.

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

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

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

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

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

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

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

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

like something we can build into the MAP process.

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

CO-CHAIR TRAVIS: Okay, Marty.

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

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

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

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

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

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

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

things interact.

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

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

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

That's a great suggestion to kind of

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

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

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

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

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

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

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

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

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

CO-CHAIR TRAVIS: Allen.

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

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

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

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

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

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

the measure decisions?

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

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

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

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

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

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

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

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

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

MS. SHAHAB: Thanks, Cristie. PPS-Exempt Cancer Hospital Program is a voluntary data reporting program and the data is published on Hospital Compare.

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

program.

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

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

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

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

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

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

some insight into that at all.

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

DR. YOUNG: So --

(Simultaneous speaking.)

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

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

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

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

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

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

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

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

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

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

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

I would tell you that while you come

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

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

(Pause.)

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

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

(Pause.)

OPERATOR: There are no comments at this time.

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

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

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

MS. SHAHAB: Sure, Cristie. Number 2,

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

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

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

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

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

DR. POLLOCK: Right, that's what Zehra

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

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

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

(Simultaneous speaking.)

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

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

MS. RANSHOUS: Yes, ma'am.

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

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

forward with these staff recommendations?

(No response.)

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

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

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

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

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

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

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

MEMBER FULD NASSO: I think that's an

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

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

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

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

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

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

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

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

One reason is that as we mentioned

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR TRAVIS: Thank you, Tom.

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

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

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

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

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

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

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

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

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

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

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

maybe cutting off the wrong body part.

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

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

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

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

(Simultaneous speaking.)

DR. PHELAN: I guess why, yes.

MS. RANSHOUS: This is Christine --

(Simultaneous speaking.)

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

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

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

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

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

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

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

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

CO-CHAIR TRAVIS: Thank you. Mitch.

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

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

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

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

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

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

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

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

(Voting.)

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

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

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

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

will take the end-stage renal.

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

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

(Simultaneous speaking.)

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

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

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

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

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

(No audible response.)

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

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

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

(No audible response.)

MEMBER BENIN: I have a question just

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

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

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

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

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

DR. YOUNG: It's by facility.

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

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

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

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

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

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

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

that measure, or any other questions?

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

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

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

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

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

DR. PHELAN: Thank you.

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

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

CO-CHAIR WALTERS: So you support the measure?

MS. EVANS: Yes, I do support it.

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

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

OPERATOR: Lisa's line is open.

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

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

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

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

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

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

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

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

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

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

(No audible response.)

Seeing none, let's proceed to vote.

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

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

DR. YOUNG: It's an error.

MEMBER FOSTER: Thank you.

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

(Simultaneous speaking.)

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

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

(Voting.)

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

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

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

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

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

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

people?

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

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

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

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

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

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

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

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

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

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

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

Some of the data elements that are

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

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

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

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

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

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

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

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

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

information for both data sources for this immunization measure.

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

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

Measures have numerators, denominators, exclusions, risk adjustment if

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

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

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

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

we're going to propose?

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

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

(Simultaneous speaking.)

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

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

CO-CHAIR WALTERS: Nancy.

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

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

CO-CHAIR WALTERS: Mitchell.

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

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

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

about here? I remain a little bit puzzled.

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

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

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

CO-CHAIR WALTERS: Allen.

MEMBER NISSENSON: I want to go back to --

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

(Simultaneous speaking.)

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

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

CO-CHAIR WALTERS: Dan, last comment.

DR. POLLOCK: Two comments.

CO-CHAIR WALTERS: Last comments.

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

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

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

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

(Voting.)

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

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

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

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

This one was picked because there was

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

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

CO-CHAIR WALTERS: Beth.

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

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

CO-CHAIR WALTERS: Sean.

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

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

out that this measure was continually important for safety monitoring.

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

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

(Simultaneous speaking).

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

facilities performing worse than expected.

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

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

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

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

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

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

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

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

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

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

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

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

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

Since the metric has been in place,

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

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

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

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

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

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

DR. MESSANA: Is this better?

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

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

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

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

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

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

percent of their patients with hypercalcemia?

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

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

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

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

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

MEMBER NISSENSON: Mine was to not support.

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

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

(Voting.)

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

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

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

MEMBER BENIN: Another programmatic question?

CO-CHAIR WALTERS: Sure.

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

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

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

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

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

(Simultaneous speaking.)

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

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

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

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

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

MEMBER FOSTER: It is a hospitalization

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

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

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

CO-CHAIR WALTERS: Yes, Pierre.

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

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

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

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

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

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

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

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

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

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

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

MEMBER NISSENSON: Four --

CO-CHAIR WALTERS: You said 5 and 6.

MEMBER NISSENSON: Four, five --

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

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

(Simultaneous speaking)

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

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

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

MEMBER FOSTER: Yes, thank you.

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

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

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

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

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

quite a poor measure as it's written now.

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

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

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

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

MS. MARINELARENA: Six and seven are endorsed.

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

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

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

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

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

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

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

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

PARTICIPANT: A what?

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

for maintenance in 2016, but they are currently endorsed.

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

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

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

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

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

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

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

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

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

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

CO-CHAIR WALTERS: Allen.

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

articulated.

CO-CHAIR WALTERS: Thank you. Mitchell.

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

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

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

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

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

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

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

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

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

CO-CHAIR WALTERS: Ann Marie.

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

the program is the mortality measure.

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

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

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

specific one.

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

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

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

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

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

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

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

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

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

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

CO-CHAIR WALTERS: Jack.

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

you wondered what the ratio was about.

CO-CHAIR WALTERS: Okay, Pierre.

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

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

There are a couple issues, also, that

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

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

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

that impact re-admission.

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

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

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

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

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

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

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

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

CO-CHAIR WALTERS: Sean.

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

CO-CHAIR WALTERS: Allen.

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

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

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

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

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

All of the clarity around the new risk

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

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

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

(Simultaneous speaking.)

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

NQF endorsement?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

on the phone?

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

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

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

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

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

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

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

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

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

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

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

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

measure?

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

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

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

CO-CHAIR TRAVIS: Andrea.

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

than the reporting.

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

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

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

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

MS. MITCHELL: Were hospitalized.

MEMBER FOSTER: Who were hospitalized.

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

MEMBER FOSTER: (Simultaneous speaking.)

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

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

MS. MITCHELL: Hospital outpatient departments.

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

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

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

Lots of questions about is it

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

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

consequence in this scenario?

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR TRAVIS: Thank you.

MS. RANSHOUS: Yes.

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

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

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

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

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

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

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

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

CO-CHAIR TRAVIS: Thank you, Sean. Ann Marie --- yes, well Mitch is next, but have you already said what you wanted to say, Mitch? Thank you. Ron.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Voting.)

MR. TILLY: We just need one more vote.

(Voting.)

MS. SHAHAB: Can you please vote again?

(Voting.)

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

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

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

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

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

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

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

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

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

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

MS. MARINELARENA: Yes, please.

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

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

in this setting.

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

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

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

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

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

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

MEMBER ENGLER: Thank you very much.

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

DR. YOUNG: Elizabeth, are you still --

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

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

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

that handy at the moment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So there's nothing that is perfect.

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

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

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

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

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

CO-CHAIR TRAVIS: Thank you. Tom.

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

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

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

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

it's a missing piece to the puzzle.

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

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

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

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

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

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

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

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

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

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

MEMBER ENGLER: That's correct --

(Simultaneous speaking.)

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

We compared the measure scores for all

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

MEMBER ENGLER: Thank you very much.

CO-CHAIR TRAVIS: Thank you all. Okay, well why don't we take a vote, and then we'll see what happens, and then we'll see what we have to do. Oh, yes you may.

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

CO-CHAIR TRAVIS: Shek.

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

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

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

(Simultaneous speaking.)

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

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

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

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

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

CO-CHAIR TRAVIS: Michael.

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

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

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

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

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

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

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

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

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

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

CO-CHAIR TRAVIS: Okay, thank you so

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

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

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

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

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

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

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

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

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

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

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

(Voting.)

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

(Voting.)

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

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

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

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

(Whereupon, the above-entitled meeting

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

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

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

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

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

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

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

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

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

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

CO-CHAIR WALTERS: Sean.

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

MS. CASSEL: Thank you, Sean.

(Applause.)

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

(Simultaneous speaking.)

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

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

MS. CASSEL: I might actually grab a

little lunch.

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

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

MS. MARINELARENA: I'll take over.

CO-CHAIR TRAVIS: Thank you, Melissa.

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

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

CO-CHAIR TRAVIS: Okay, thank you,

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

(No audible response.)

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

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

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

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

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

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

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

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

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

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

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

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

Commission for a while.

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

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

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

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

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

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

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

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

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

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

I think this is just a high -- it has

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

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

MS. MITCHELL: Who is the measure

steward?

MS. MARINELARENA: Joint Commission.

MS. MITCHELL: I'm sorry, what?

MS. MARINELARENA: The Joint Commission.

MS. MITCHELL: What drug commission?

MS. MARINELARENA: The Joint Commission.

(Simultaneous speaking.)

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

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

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

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

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

CO-CHAIR TRAVIS: Yes, we can.

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

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

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

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

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

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

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

DR. CAMPBELL: This sample is not from

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

(Simultaneous speaking.)

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

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

hospitals. These data were collected --

MS. MITCHELL: What is that?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. PHELAN: Just going on the same --

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR TRAVIS: Michael.

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

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

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

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

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

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

MEMBER ENGLER: Thank you. I don't want to reiterate what's already been said, but I will for a couple of reasons. I brought this up about two years ago as a measure gap area. Psychiatric care and the lack of real good measures in it is phenomenal to me as to why they're not there. Second of all, if you look at the re-admission data, you will find that reasons for re-admissions predominantly are psychiatric care. It's not only affecting inpatient psych care, but it's also affecting the re-admission penalties. Unless we can get to continuous care for patients that have psychiatric disorders, in particular drug and alcohol, which is a large portion of the patients that my hospital serve, until we can come to really good agreement and get some measures out there, we're not going to be able to address this gap.

I think this is a great first step. Sorry it's a check the box, but you've got to start somewhere. I would really encourage the developers -- and I thank Joint Commission for

coming up with this -- I would encourage more and more development on this because this stuff really matters. It really matters.

CO-CHAIR TRAVIS: Thank you, David. I think what we're going to do is go to Jack, Sean, and then Ann Marie, and then I think that hopefully, by that time, we'll be ready for a vote. Jack.

DR. FOWLER: I actually have to go. I think the choice about -- there's no question that everybody thinks this is a good -- they want a measure. I think it's a bit of a gesture, myself, and I think the group has to decide whether that's worth doing. I would probably vote no, but it's going to pass, and that's fine.

CO-CHAIR TRAVIS: Thank you, Jack, and thank you for bringing up this discussion point. Sean.

DR. MORRISON: Thanks for leaving, Jack, when I'm going to counter that. Actually, what I would say is slightly different. When we look at people hospitalized with serious mental

illness, schizophrenia, poorly treated depression, we tend not to focus on the comorbid illnesses that accompany that. We sort of give everybody a pass on tobacco and smoking cessation.

We say that drug and alcohol abuse are just part of the disease. Actually, even though it is a process measure, and even though it's a checkbox, it serves as a lightbulb measure to say we shouldn't be forgetting about these just because they have serious mental illness. We see this with diabetes in the setting of serious mental illness, as well. We just sort of say schizophrenia's the problem. I do think this sort of points a spotlight on the fact that this is an area of importance. It may be a checkbox, but the fact that we're not actually thinking about it on discharge, if this actually shines a light on the fact that we should think about it, that's a really good first step.

CO-CHAIR TRAVIS: Thank you. I didn't see Wei's card, so we'll go to Ann Marie, and

then Wei, and then hopefully we'll be at a time when we can vote. Use your microphone.

DR. SULLIVAN: -- would agree with what everyone's saying, especially in terms of the measure development, that unfortunately, there isn't anything out there that's a lot more robust at this point in time than what we have, but it's a very serious problem. You're absolutely right.

The mental health field has had trouble with this, paying attention to comorbidities, whether they're medical comorbidities, substance abuse comorbidities, tobacco, etc. I think it does shine the light. It does force people to do it. Just one fact. When we looked at avoidable admissions -- Medicaid avoidable admissions in New York State, half of those avoidable admissions -- half had substance abuse and mental health problems admitted to medical units. I think that's also where the development has to go.

We're sitting here in -- inpatient

psych, we need a lot there, too, but we also need it on the medical side, to your point, the screening for substance abuse, getting the right referrals out for substance abuse, for mental health issues. Because the huge cost in the healthcare system on the medical side has all these psychiatric and substance abuse comorbidities. I just think that's the other place to go, and I'll stop at that.

CO-CHAIR TRAVIS: Thank you. Wei.

MEMBER YING: My comment actually is more to CMS. If we do support this measure, and everyone already raised -- I wouldn't say concern, but comment that this is not a perfect measure, there may be other measures coming up. If we do support it and it becomes part of the program, please keep the program consistent for some time. This reporting program hasn't been out for long time, but just during its short life span, it has already gone through major change. A lot of measures -- I would say at least a third, if not half of the measure has been pulled

from the initial report. It's very hard for us to develop a program -- we actually developed a program with inpatient psych unit hospital facilities in our network based on the initial report, and then we have to pull it out, redesign it. This is not a perfect measure, but a measure step forward. Great, but then leave it for some time for us to work on it.

CO-CHAIR TRAVIS: Very good point. I guess I'm a sucker, but these last two cards really do need to be the last two cards, if you all don't mind. Nancy, final comment from you?

MEMBER FOSTER: Just one clarification because I want to make sure people knew that for psychiatric hospitals, they already have a screening measure in place, especially for those that are Joint Commission accredited. It's not about getting the initial screening. This measure addresses referral going forward. But in all sensibility, one might think about this measure for non-psychiatric hospitals.

CO-CHAIR TRAVIS: Very good point.

MEMBER FOSTER: It might be more there.

CO-CHAIR TRAVIS: Thank you for that. Did I see any other cards up? David, is yours still up?

Thank you. I'm sure there'll be a time when that will be a very important discussion for us to have. I think we will move on to taking a vote.

MR. TILLY: The polling is now open for substance abuse core measure set, Sub 3, alcohol and other drug use disordered treatment provided or offered at discharge, and Sub 3(a), alcohol and other drug use disorder treatment at discharge, MUC15-1065.

(Voting.)

The results are 71 percent support, 25 percent conditional support, 4 percent do not support. The recommendation is support.

CO-CHAIR TRAVIS: All right, thank you all for that good discussion. We'll now move to the second measure in this calendar, which is 30-day all cause unplanned re-admission following

psychiatric hospitalization in an inpatient treatment facility, and this was pulled by Nancy, so I'll turn it over to Nancy first.

MEMBER FOSTER: I know you will all be surprised. I'm going to recommend that this re-admission measure be especially evaluated for its sociodemographic impact. In this case, let me be a little bit more explicit.

I think that in addition to just the general factors in the community that may exist, one really has to look at the source of ongoing treatment for psychiatric disorders/mental health disorders in the community, whether it's through the HRSA data on shortage areas or some other data.

Because if you're discharging patients who've been hospitalized in an inpatient facility and there is a lack of resources in the community, the chance that they'll come back to the acute-care hospital or the psychiatric facility go up enormously.

As states and communities dismantle

their support for ongoing treatment of mental health disorders, the pattern here varies across the country, but it varies not with -- just with the typical sociodemographic factors that one might think of. It varies with accessibility of other services. So I encourage the NQF to make sure that the committee thinks about that as they are assessing this measure. Otherwise, I would support the conditional support.

CO-CHAIR TRAVIS: Okay, conditional support with a look at the ongoing treatment for psychiatric disorders in the community as part of the SDS review when this measure comes in.

MS. MITCHELL: Just a word question. Nancy, is there such thing as a planned psychiatric re-admission?

CO-CHAIR TRAVIS: Or Ann Marie.

DR. SULLIVAN: Nowadays, that's very, very rare -- very rare. Twenty years ago, maybe, but right now, very rare that it's a planned admission. Unfortunately, no.

CO-CHAIR TRAVIS: This is the measure,

as it's been -- I'm going to let our friends from CMS talk about that.

DR. MEYYUR: Yes, there are planned admissions, but they're very few. We did discuss that with the technical expert panel when we developed the measure. Kyle may be able to expand more on that.

MEMBER FOSTER: Just jump in here. This is all cause re-admission with, obviously, appropriate exclusions. One might be planned to be admitted to an acute-care facility for ongoing treatment of a medical problem that you wouldn't want counted in here, if you will, against the hospital.

CO-CHAIR TRAVIS: I think we have the developer on the phone, if we want to get your input and insights into this issue, please.

DR. CAMPBELL: Yes. This is Kyle Campbell from Health Services Advisory Group. As CMS just mentioned, it is rare. I'm going to turn it over to my colleague, Karen Pace, who worked on the algorithm.

DR. PACE: Hello, this is Karen. Just as an example of what might be a planned re-admission, we started with the Yale algorithm for the hospital-wide re-admission measures and followed that process, and also consulted with the technical expert panel. Probably the best example is plan to come back for electroconvulsive therapy was probably the example that resonates with most people, in terms of planned re-admissions, but agreed, and the data bore out, it doesn't happen very often. The mention about re-admission for -- moving a patient for a medical treatment, if the patient moves from an IPF to an acute care hospital, for example, for medical treatment that the IPF might not be able to provide there, that would be considered a transfer and would not be counted as a re-admission.

CO-CHAIR TRAVIS: Okay, thank you very much. David.

MEMBER ENGLER: Thank you. We offered comments in support of this measure with the

proviso -- and we've published some data on this -- that the adjustments really look at community-based support. It amounts to -- and don't quote me right now, but I think it amounts to about 40 percent of the variance that you see in this measure can be avoided if you have good community support with those two provisions. I just wanted to mention that again. Thank you.

CO-CHAIR TRAVIS: Thank you. Not seeing any other cards, I think we're ready to move to a vote.

MR. TILLY: Polling is now open for 30-day all cause unplanned re-admission following psychiatric hospitalization in an inpatient psychiatric facility, MUC15-1082.

(Voting.)

The results are 43 percent support, 52 percent conditional support, 4 percent do not support. The recommendation is conditional support.

MS. O'ROURKE: I would say the conditions we heard are that this is a measure

that needs particular attention paid to the impact of SDS factors, and we'll make that recommendation to the standing committee when they evaluate this measure for NQF endorsement, with a particular attention given to the fact that there needs to be consideration of ongoing treatment options for mental health disorders in the community.

CO-CHAIR TRAVIS: Great. Now I'll turn it over to Ron.

CO-CHAIR WALTERS: We're on the last program. I will turn it over first to Jean-Luc to give an overview of the ASC program.

MR. TILLY: The Ambulatory Surgical Centers Quality Reporting Program is a pay for reporting program, where that data is currently reported to CMS and is expected to be publicly reported in the near future. ASCs that don't report data receive a 2 percent reduction in their annual payment update. The measures in this program are designed to promote high-quality care for Medicare beneficiaries and help

establish a system for collecting quality data that will eventually be reported to consumers. The only measure under consideration for ASCQR is the toxic anterior segment syndrome outcome measures. This measure has not been submitted for NQF endorsement.

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

(No audible response.)

Seeing none, would the operator check to see if there's any public comments on the phone?

OPERATOR: Yes, sir. At this time, if you have a comment, please press star, then the No. 1. There are no comments at this time.

CO-CHAIR WALTERS: Thank you very much. There is one measure which was proposed on the MUC list. Staff recommendation was do not support. That led to it being pulled by Donna Slosburg, who will now initiate her reason for pulling it.

MEMBER SLOSBURG: I'm pulling this

measure because I think there's some misunderstanding that may have impacted the analysis. I want to try to correct those misunderstandings. Toxic anterior segment syndrome is an outcome measure that assesses the number of anterior segment surgery patients diagnosed with TASS within two days of surgery.

It includes cataract surgery, as well as glaucoma surgery, as well as other surgeries on the cornea and iris. I'm sure you all are aware, but cataract surgeries are the No. 1 commonly performed procedure for Medicare patients. The number is in the millions, and that number is expected to grow. It's an acute sterile inflammation of the anterior segment of the eye that occurs following surgery.

It develops between 12 and 48 hours after surgery. Studies in the literature have reported TASS rates of 1.8 to 2.1 percent. The measure was developed to fill MAP-identified gaps in complications and surgical care quality. It's a complication that can result in significant

anterior segment sequelae and ocular morbidity. With intense topical corticosteroid treatment, most cases resolve over a period of weeks to months, with the cornea eventually clearing. However, there are severe cases that may result in permanent damage, and additional surgical procedures may be required. While there are many potential causes, by far the most common modifiable risk factor for TASS are related to instrument cleaning and sterilization processes.

Because most cases of TASS are tied to issues with instrument cleaning and sterilization processes, when TASS is diagnosed in an ASC patient, the surgeon is strongly motivated to make the center aware of this complication to prevent TASS in other patients. This assures the measure outcome can be captured by the ambulatory surgery center with a high degree of certainty. Sorry, I just want to make sure because there's a lot of misunderstanding.

Eye professionals agree that measure efforts should be focused on the prevention of

TASS. The American Society of Cataract and Refractive Surgery and the American Society of Ophthalmic Registered Nurses have published recommended practices for cleaning and sterilization of intraocular surgical instruments aimed at the prevention of TASS, and these practices were developed with guidance from the Association of Operating Nurses, the CDC, and the FDA, in recognition that while product manufacturer issues may rarely result in TASS, preventing TASS by appropriate management of intraocular surgical instruments is a challenge that must be repeated with each cycle of cleaning and sterilization.

The measure is a fully developed and pilot tested facility measure. Reliability and validity testing have been conducted, and the results have been shared with CMS. This measure has the support of the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgery, the Outpatient Ophthalmic Surgery Society, and the Society for Excellence

in Eye Care.

Inclusion of this measure in the program will oblige surgery centers to maintain meticulous adherence to best practices. Based on the experience of ambulatory surgery centers that participate in an outpatient ophthalmic surgery centers benchmarking project, measurement reporting and benchmarking of TASS rates has the potential to reduce and sustain the occurrence of TASS to near zero. The measure presents an important opportunity in quality improvement to essentially eliminate a preventable complication, and I am asking the workgroup to please support this measure.

CO-CHAIR WALTERS: Did anybody catch any behind this? Karen.

MEMBER ROTH: I'm Karen Roth. I represent purchasers and as, of course, everyone in this room is concerned about the care of the patient, I think that this is a very important measure because TASS does have the potential to cause blindness, and it does appear that there

are preventive actions that can be taken to keep this from happening.

The one thing that I don't understand is why NQF decided not to support this measure. I'd just like to ask for clarification of that. Also, I think that there's probably a reason why CMS wanted to include it in the MUC list, so I'd like to get some clarification from them why they thought that this was important.

CO-CHAIR WALTERS: The process is not foolproof. That's about the best answer.

MS. O'ROURKE: I can give you a little bit of our thinking. We had found some studies from the FDA that attributed TASS, in large instances, to the device manufacturer, rather than the ASC, so some concerns about attribution.

CO-CHAIR WALTERS: Karen.

MEMBER ROTH: Well, based on some of the findings that Donna mentioned, and some other things that I learned from various sources, whether they were from insurance companies that cover these surgeries and things like this, it

almost invariably was attributed to the ambulatory surgery care center. The other thing that concerned me, though, was that they said that a lot of times, TASS is mistakenly diagnosed as endophthalmitis.

Endophthalmitis is actually a bacterial infection that's treated with antibiotics. However, if it's misdiagnosed, then the TASS is not going to respond to the antibiotics. It responds to steroids. That is an issue. There seems to be a need, also, to sort of make sure that this is diagnosed properly, as well. The other thing that I read was that NQF mentioned in the notes that they thought that the cataract measure and the transfer admission measure from an outpatient facility would capture this. Given that TASS develops within 12 to 48 hours, the cataract measure appears to assess vision at 90 days. It doesn't quite address the issue.

The other thing is the transfer admission measure, it measures a patient that was

transferred or admitted right after they were discharged from the ambulatory surgery care center, so it wouldn't give time for the TASS to develop. I saw some deficits there, as well. Those are my comments. I would also like to understand why CMS thought it was important to include this metric.

CO-CHAIR WALTERS: Karen, could you clarify who the measure developer is?

MEMBER SLOSBURG: I should have said that.

DR. PHELAN: If I'm not mistaken, wasn't there an ophthalmology and ENT TEP that just finished their evaluative process in the last six months at NQF? Why wasn't this measure submitted during that TEP?

MEMBER SLOSBURG: It closed on March 27th, and we had not completed testing and development to submit it at that time.

CO-CHAIR WALTERS: Helen.

MS. HASKELL: I just wanted to say I think this seems to me like an important measure.

If 1.8 to 2.1 percent of cataract surgery patients are developing this clearly devastating complication, it's something that we need to be measuring. I think the fact that devices are involved, which happens in a lot of other instances, as well, it doesn't mean that we shouldn't be capturing it. It's about the only way you're going to capture it, and then go back and deal with the device.

CO-CHAIR WALTERS: Brock.

MEMBER SLABACH: The measure is not endorsed by NQF, is it? It said it was never submitted on the sheet that I have. So is it going to be submitted, and will it go through the process of endorsement?

MEMBER SLOSBURG: We can take it back to our technical expert committee. That's what we've done in the past.

CO-CHAIR WALTERS: Sean. I think that's -- we'll probably take care of that in just a second on the vote anyway. Sean.

DR. MORRISON: Yes, I am incredibly

uncomfortable endorsing something that has not gone through the NQF endorsement process. We are not the scientists. There's no reliability and validity measures. Let's make this go through the process -- I'm sorry, it's a long day. Let's take the time to have this go through the appropriate endorsement process.

CO-CHAIR WALTERS: Marty, did you -- okay. Yes, Jeff.

MEMBER JACOBS: I just wanted to agree that there's probably not a lot of experts about eyeball surgery at this table and seems like measures like this need to go through NQF endorsement before this panel of experts here weighs in on whether or not it's a good hospital measure.

CO-CHAIR WALTERS: Donna, as the measure developer, you cannot vote on this measure. I don't think there's anybody else who has comments on that, but we do have to restrict what you say. Are there any more questions or comments? Yes.

MR. CLIFT: I'm Joe Clift. I'm the measures lead for the HAC reduction program, and I also support the outpatient and ambulatory surgery center program. There was a few reasons why CMS was particularly interested in this measure.

The first reason, as Donna said, is that the number of anterior segment surgeries is in the millions each year, so the 2 percent incidence has a high number of patients that could be impacted. These also occurs in clusters, so as Donna said -- also, you might have one patient with TASS, and there might be a bunch of others that follow, so it's something to really focus on.

It's a process of care measure. It's something that should not occur in the ambulatory surgery center, so identifying ways to improve cleaning processes, care processes, etc., can get this down to zero. When we looked at past data on the number of -- specifically, I looked at the 2012, which is an all payer dataset, but teasing

out the ICD-9 for TASS was almost 60 percent of TASS diagnoses were from Medicare and Medicaid patients. So it does have the potential to impact this population, something that we were very interested in. With the number of independent eye surgery centers that are opening up, it is a -- could potentially be for a large volume impact, so that was our main reasons for supporting this measure on this MUC list.

CO-CHAIR WALTERS: Brock, did you have another comment? Michael.

DR. PHELAN: I understand this is a gap, but I kind of agree with my colleague from Hopkins. This isn't the appropriate body to make that decision. It's where I get confused on I don't want to say conditional support because I want it to go through the NQF process, but I don't want the impression to be gotten if we say do not support until it goes through the NQF process.

It's always given me great consternation that we don't have the fourth

option, which would be await NQF, bring back to the MAP so we could review it then. Because it kind of gives a free pass on No. 2 for conditional support. It's just like yes, it's a great idea. Let's say in six months, after the data comes in and a technical expert panel reviews it and says serious issues with this, this is a problem due to gaming or people are calling things one thing, but it's really another. I always really struggle with where to put my vote on this because I really want it to go through the NQF process and then be brought back so I can hear what they actually said about it. That's my --

CO-CHAIR WALTERS: I think we actually did stick both of those on a measure yesterday, actually. We did.

MS. O'ROURKE: We can't guarantee things would come back to the MAP, but we could certainly put it as a condition to request that it come back to the MAP, but I do want to be clear. CMS is not obligated to do that.

CO-CHAIR WALTERS: Okay, ready for a vote? I knew you were going to have a comment.

MEMBER HATLIE: You're prescient. I'm just struck by the sense of urgency here that this is something that could harm a number of patients quickly, especially if there's a clustering and there's new players in the market where this could be at risk. I'm hoping that our conditions will express a sense of urgency, just not go into a two or three or four-year process. Is there something we can say to move it along if the imminent harm is as strong as it is?

CO-CHAIR WALTERS: Jeff.

MEMBER JACOBS: I wanted to agree with one comment to go about the problem with the three voting choices because there really should be a choice that says we're totally agnostic about a measure and have no opinion about it, whatsoever, until it undergoes evaluation through a scientific review.

That's something that we don't have the expertise about. There's surgical committees,

and there's medical committees, and there's cancer committees that actually look at the science of the measures. Any of the choices here say we either like it or we don't like it, but we should be able to say we can't really judge it at all until the scientists have looked at it. I think that was a very good point that was made.

CO-CHAIR WALTERS: There is an option that covers that. It's the bottom one, although it may not send the same message.

MEMBER JACOBS: But that has a little bit of a negative connotation. That's what was being brought up. That has a negative connotation. That doesn't say we don't support it because we're waiting on more information. That just means we don't support it. What we're saying is maybe in the future we should just have a choice that says we don't want to say whether or not we support it all until the scientists look at it.

CO-CHAIR WALTERS: With those comments, you get the opportunity to vote now.

Push the four button and see what happens.

MR. TILLY: The polling is open for toxic anterior segment syndrome, TASS outcome, MUC15-1047. The options are support, conditional support, and do not support. There is no fourth option.

(Voting.)

The results are 13 percent support, 65 percent conditional support, 22 percent do not support. The recommendation is conditional support.

CO-CHAIR WALTERS: Erin.

MS. O'ROURKE: The conditions we heard are that this measure needs NQF review and endorsement and, ideally, for CMS to bring this back to the MAP so that MAP has a chance to weigh in after they have data from experts in the subject matter.

MEMBER HATLIE: Could we say something about urgency and an expedited process?

MS. O'ROURKE: Of course. We can recognize the importance and the urgency of this

issue.

CO-CHAIR TRAVIS: I think we know what to do.

CO-CHAIR WALTERS: There is an opportunity for public comment again. Are there any public comments in the room about anything?

CO-CHAIR TRAVIS: Well, on this list.

CO-CHAIR WALTERS: Operator, is there anybody on the phone with public comments about any of the programs we've talked about?

OPERATOR: Once again, to make a comment, please press star, then the No. 1. There are no comments at this time.

CO-CHAIR WALTERS: I would personally like to thank everybody for their involvement. The discussion, again, has been very rich. I hope everybody leaves feeling that they got an adequate chance to contribute and contribute significantly to the discussion and to the recommendations we give to CMS, so thank you again.

CO-CHAIR TRAVIS: I want to add my

thanks to everybody in the room. Please note the time. It's 1:37. Thank you all very much. We were able, I think, to give it the time it needed, but to still end early, so that's really a tribute to everybody in the room, so thank you for that. I want to add my personal thanks, and I'm sure Ron's, as well, to the staff.

They actually get the last words here. But before I hand it over to them, I do also want to thank, Pierre, you and your team and the developers that have been on the line. It's always helpful to have you here because it helps us be sure that we understand CMS, why measures were put here, some of the details of the measures that we need to go through, so thank you all so much, as well.

DR. YOUNG: Thank you for that, and thank you to all the committee members for all the input you've provided and time taken, and thank you, also, for putting me and my staff through our paces. As I mentioned, we start this training in the spring. I do want to thank,

particularly, my staff and our measure developers for all the support they've provided here. Thank you.

CO-CHAIR TRAVIS: Thank you, Pierre, and your team. I'm going to turn it over to Zehra.

MS. SHAHAB: I just wanted to do next steps, and I don't want to have the last word. I want everyone else to have the last word. I just wanted to run through the next steps really quickly. This is the same timeline you've seen, but on the next slide, you will see some important dates.

After this, we are going to be opening up for a member and public comment, which will start December 23rd from January 12th. This will include the Excel and a draft version of the report, as well, that we are going to write quickly after today, so starting tomorrow and later today. Then the coordinating committee is going to review the recommendations on January 26th, so the chairs will be representing the

workgroup, and we would welcome all of you workgroup members to dial in and listen to our summary and description of the coordinating committee. The final spreadsheet of recommendations on all these individual measures under consideration is going to be released February 1.

The guidance for hospital and PAC/LTC programs will be released February 15th, and the final guidance for clinician and special programs will be March 15th. Those are just some upcoming dates to look forward to. I want to start, on behalf of the staff, and thank all of you for all of your hard work and rich discussions. We have gathered a lot, and we can't thank you enough. I want to make sure that Taroon and the rest of my team has a time to say more, as well.

MS. O'ROURKE: I'll jump in. Thank you, as Zehra said, to the committee for taking the time to participate in this meeting. We greatly value your input. This is my fifth time now, and it's remarkable to watch how the process

has grown and the input we've received over the years and how valuable it's been. A special thank you to Pierre and the CMS staff and the developers for their open participation and being willing to take so many questions and be such active, involved participants in this process. It really, I think, adds a richness. The more they are willing to participate, the better our recommendations can be. A special thank you to Ron and Cristie for their amazing leadership for the past few days and for setting a MAP hospital workgroup record of getting us out about an hour and a half early.

I know. I'm going to be double checking that. You might be getting frantic emails from me later to come back. We did not. Just joking. Thank you to everyone. We greatly appreciate everything you've done to make this a reality.

MS. MARINELARENA: I just want to thank everyone, as well. I feel spoiled because it was my first MAP. I feel that apparently,

we've come a long way, so I feel very lucky, and I'm thankful to all of you for all of your hard work, CMS, my co-workers, and we look forward to putting this report out and getting all the comments and finishing up this process so Pierre can get started with his spring training in April.

MS. SHAHAB: I also wanted to make sure that if any of you would want to say any closing remarks -- I know Cristie and Ron got a chance, as well, but if any of you would like to provide us feedback, improvements, any last words? You don't have to raise your cards. You can just speak up. Go ahead.

MEMBER HATLIE: Just a general comment about the base of our activity. One of the things that I'm noticing -- and it's a frustration I've had with this group because I feel like I'm at the end of a process where I wish patients were engaged in measure development more, but that is happening more and more.

I think PCORI gets a lot of the credit

for it, honestly. We're starting to see different metrics come out that are different from a crude metric for mortality, so days out of hospital, days not in the healthcare system, things like that that I think are attributable to engaging patients early on. For the measurement developers in the room, I just think that's a really great area to think about is pulling in people who suffer from the conditions or are acquainted with the conditions that you're developing measures from. I think that you'll find a lot of patients will be eager to be part of a process like that. Thank you for my soap box at the end of the day.

MS. SHAHAB: Thank you. Anyone else? Dolores, Nancy, anyone?

MEMBER FOSTER: Sure. Now that I'm called upon, thank you all. I think this process worked a lot more smoothly. I miss a little bit of the opportunity to really go back to what -- I can't even remember -- somebody else was commenting before that we need to, again, be able

to identify gaps that really are important in the care.

When we're so focused on the list in front of us, it's hard to think more broadly, but I think we're kind of missing that, and I hope we can talk about how we get to that point later on. I also would welcome -- as you craft the report, NQF staff, in your great skill, I think there are a number of themes that ran throughout the discussions of individual measures. Calling those out and helping us all to get better by thinking about what those themes are and how we can address them going forward would be really, really constructive for all of us. I'd love to hear the themes from the other workgroups, too.

MS. O'ROURKE: Please, if you do have additional suggestions for improvement or what worked well or what didn't, please feel free to email us at any time, so that we can keep getting better for next year.

(Whereupon, the above-entitled meeting went off the record at 1:43 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Applications Partnership Hospital Workgroup

Before: NQF

Date: 12-17-15

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter