NATIONAL QUALITY FORUM

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JOINT MEETING OF THE MEASURE APPLICATIONS PARTNERSHIP HOSPITAL AND PAC/LTC WORKGROUPS

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MONDAY
JANUARY 11, 2021

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The Joint Workgroups met via Video Teleconference, at 10:00 a.m. EST, Akin Demehin, Gerri Lamb, Kurt Merkelz, and Sean Morrison, Co-Chairs, presiding.

PAC/LTC WORKGROUP MEMBERS:
GERRI LAMB, PhD, RN, FAAN, Arizona State University, Chair
KURT MERKELZ, MD, CMD, Compassus, Chair
ALICE BELL, PT, DPT, American Physical Therapy Association
SEPIDEH CHEGINI, MD, SNP Alliance
DESIREE COLLINS BRADLEY
JILL COX, PhD, RN, APN-C, National Pressure Injury Panel
TZVETOMIR GRADEVSKI, National Partnership for Healthcare and Hospice Innovation
KURT HOPPE, MD, AAPM&R
JENNIFER KENNEDY, EdD, MA, BSN, RN, CHC, National Hospice and Palliative Care Organization
PAMELA ROBERTS, PhD, OTR/L, SCFES, FAOTA, CPHQ, FNAP, National Occupational Therapy Association
DEBRA SALIBA, MD, MPH, American Geriatrics Society
AARON TRIPP, LeadingAge
MARY VAN DE KAMP, MS/CCC-SLP Kindred Healthcare

HOSPITAL WORKGROUP MEMBERS:
AKIN DEMEHIN, MPH, American Hospital Association, Chair
R. SEAN MORRISON, MD, National Coalition for Hospice and Palliative Care
AMY CHIN, MS, Greater New York Hospital Association
JAN DONIS, RN UPMC Health Plan
TEJAL GANDHI, MD, MPH, CPPS, Press Ganey
FRANK GHINASSI, PhD, ABPP, National Association for Behavioral Healthcare
KELLY GIBSON, MD, Society for Maternal-Fetal Medicine
KAYCEE GLAVICH, Press Ganey
MARYELLEN GUINAN, JD, America's Essential Hospitals
MARTY HATLIE, JD, Project Patient Care
VILMA JOSEPH, MD, American Society of Anesthesiologists
ANNA LEGREID DOPP, Pharm.D., American Society of Health-System Pharmacists
JENNIFER LUNDBLAD, PhD, MBA Stratis Health
LISA McGIFFERT, Mothers Against Medical Error
ELIZABETH McKNIGHT, MS, Intermountain Health Care
DENISE MORSE, MBA, City of Hope
SANTOSH MUDIRAJ, MPH, Henry Ford Health System
SARAH NOLAN, PhD, MPA, Service Employees International Union
JANIS ORLOWSKI, MD, MACP, Association of American Medical Colleges
AISHA PITTMAN, MPH Premier Healthcare Alliance
KAREN SHEHADE, MBA, Medtronic
CRISTIE UPSHAW TRAVIS, MS, Memphis Business Group on Health
DEBBIE WHEELER, Molina Healthcare
JACKSON WILLIAMS, JD, MPA, Dialysis Patient Citizens
MIKE WOODRUFF, MD, Intermountain Health Care

INDIVIDUAL SUBJECT MATTER EXPERTS:
DANIEL ANDERSEN, PhD
TERRIE BLACK, DNP, APRN, ACNP-BC, ACNS-BS
SARAH LIVESAY, DNP, APRN, ACNP-BC, ACNS-BC
RIKKI MANGRUM, MLS
EUGENE NUCCIO, PhD
ANDREEA BALAN-COHEN, PhD
LINDSEY WISHAM, MBA

LIAISONS FROM THE RURAL HEALTH WORKGROUP
BROCK SLABACH, MPH, FACHE, National Rural Health Association
JESSE SPENCER, MD, Intermountain Healthcare

FEDERAL LIAISONS PRESENT:
MICHELLE SCHREIBER, MD, CMS
DAN BUDNITZ, MD, MPH, CDC
MIA DeSOTO, PhD, MHA, AHRQ
ANDREW GELLER, MD, CDC
ALAN LEVITT, MD, CMS
ELIZABETH PALENA HALL, MIS, MBA, RN, ONC
DANIEL POLLOCK, MD, CDC

NQF STAFF:
CHRIS QUERAM, MHSA, Interim President and CEO
SHERI WINSPER, RN, MSN, MHA, Senior Vice President, Quality Measurement
MICHAEL HAYNIE, Senior Managing Director, Quality Measurement
AMY MOYER, MS, Director, Quality Measurement
MATTHEW PICKERING, Pharm.D., RPh, Senior Director, Quality Measurement
UDARA PERERA, DrPH, MPH, Senior Manager, Quality Measurement
CHRIS DAWSON, MHA, CPHQ, CPPS, LSSBB, Project Manager
JANAKI PANCHAL, MSPH, Project Manager
BECKY PAYNE, MPH, Analyst

ALSO PRESENT:
ELIZABETH DRYE, MD, MS, Yale CORE
SHARON McCAULEY, MS, MBA, RDN, LDN, FADA, FAND, American Dietetic Association
COLLEEN McKIERNAN, MS, Lewin Group
KARTHIK MURUGIAH, MBBS, Yale CORE
JESSE ROACH, MD, American Society of Nephrology
LISA SUTER, MD, Yale CORE
ANGEL VALLADARES, MPH, Avalere Health

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10:01 a.m.

DR. PICKERING: Well, good morning, and welcome, everyone. I have 10:00 a.m. Eastern here. Welcome to today's meeting, which is the MAP Hospital Workgroup Meeting for PAC/LTC and also Hospital.

Today there is a joint meeting. This morning we'll have a joint session between both workgroups to talk about process and overview of the MAP process and evaluation.

But we also will be talking about some of the recent measures that have come through for MAP consideration, which are the COVID-19 measures. There is going to be a presentation for that today.

And just to note that we will then break off into separate workgroup rooms, or Zoom rooms, which there is links attached within the calendar invites as well as within the agendas that were distributed to you all.

So those will be separate workgroup

meeting rooms, Zoom rooms, but today this morning we will be having this joint meeting for the morning.

So my name is Matthew Pickering. I am the NQF Senior Director here and overseeing the MAP Hospital Workgroup. It's a pleasure to speak with you all today and working on this exciting work around some of the measures coming through this cycle for consideration within CMS programs.

I would also like to allow my colleague, Amy Moyer, to introduce herself as part of being PAC/LTC. Amy.

MS. MOYER: Good morning, everyone, and welcome. We appreciate you taking your Monday to spend with us.

I am Amy Moyer, the Director on the MAP PAC/LTC project here at NQF and I am really looking forward to today's meeting. Thank you all. I will turn it back to Matt.

DR. PICKERING: Great. Thanks. And, Becky, if you could go back to the housekeeping slides I'll just touch on that really quick.

Thank you.

Okay, just a few housekeeping items just to keep in mind before we get started. So we are using Zoom but we ask to mute your computer or if you are dialing through the phone to mute your line if you are not speaking just to prevent any background noise.

Ensure that your name is also displayed correctly in the box that shows on the platform, or if you are dialing in you might be able to indicate who you are as well if you are not able to put your name into the feature within the Zoom platform.

We encourage you to turn on your video. It is optional, but we are encouraging you to turn on your video, especially when you are talking.

It just allows increased engagement with folks. We'd love to see your face, as well, just to see everyone since we are all in a virtual environment.

You can do this by right-clicking on

"View" at the right upper hand side of the screen and go to "Speaker" or "Gallery" to do so.

You can use the raise a hand feature as well if you wish to provide any points or raise a question. There is also the chatbox as well and you indicate any questions you have within our chatbox which will be monitored as well.

And then for this meeting we will, again, be using Zoom, but for the voting procedures that will occur during our separate workgroup meetings in the afternoon we have the Poll Everywhere link which was also distributed within the calendar invite but also email communications as well.

We kindly ask that you do not distribute that Poll Everywhere link. This is only given to workgroup members for voting on the measures moving forward.

I am going to go to the agenda and just again a reminder that this is a joint meeting in the morning in which we are doing

welcome and introductions as well as disclosures of interest and reviewing the meeting objectives.

We will also have CMS Dr. Michelle Schreiber providing some opening remarks relating to the Meaningful Measures update and work there and then we'll have an overview of the pre-rulemaking approach as well as a presentation from CMS on COVID-19 measures, the measures that are coming through to review this cycle, and also an opportunity for the workgroups to have some question and answers.

We will then have lunch, about 30 minutes or so. From 12:30 to 1:00 we'll have that break for everyone to grab lunch and then reconvene.

We ask you to reconvene a little bit early through Zoom just to make sure that everybody is up and running right before 1 o'clock and then we'll proceed with the program measure reviews for our separate workgroups as well as providing opportunity for public comment, and then the summary of the day, next steps, and

then adjourning.

Next slide, please. So I would like to also allow others from the NQF staff to introduce themselves and also provide some opening remarks as well.

I kindly would like to introduce Chris Queram, who is our new Interim CEO here at NQF, as well as Sheri Winsper, who is our Senior Vice President of Quality Measurement here at NQF, to kindly introduce themselves and also provide some welcoming remarks. So I will turn it over to Chris.

MR. QUERAM: Thank you, Matt, I appreciate that. Welcome, everyone. I will add my thanks to those from Amy for all of you who are taking time from your busy schedules to join us today.

I want to also acknowledge that this has been an unprecedented period of time for the MAP and its workgroups.

It has required a considerable amount of flexibility on everybody's part to accomplish

the important work of the workgroup and to schedule this meeting today, so I very much appreciate it.

This is the tenth year that the National Quality Forum has served as the convener and the facilitator of the Measure Applications Partnership.

During that time we have successfully stewarded over one thousand measures since the initial convening in 2011. So we have a robust history of work to build on in our session today.

The NQF's work with the Measure Applications Partnership would not be possible without the strong support of our partners at CMS.

I would like to be sure to express our appreciation to Michelle and her many colleagues at the Agency for their continued confidence in the NQF as the convener and the facilitator of the MAP for all these years.

So, Matt, I will stop there and invite my colleague, Sheri, to add her remarks and look

forward to a very productive day with both workgroups. Thank you.

MS. WINSPER: Thank you, Chris, I really appreciate that. This is Sheri Winsper. I am the Senior Vice President for Quality Measurement at the National Quality Forum and we very much welcome all of you here today.

We are excited to finally get some of this kicked off and make some wonderful recommendations to CMS.

I wanted to just kind of provide a few remarks around I know that this year we obviously have some changes in the timing and the format this year, but our purpose really does remain the same as in any other year for MAP.

It's to provide CMS feedback from the lens of consumers and our provider stakeholder groups to inform the rulemaking process for CMS quality and performance programs.

We are definitely convening, as Chris mentioned, in the midst of a national healthcare crisis. Our nation's resources have been

stretched as we face the challenges that COVID has certainly presented to all of us.

And now with two viable vaccinations on the market, and I don't know by now maybe there is a third one, but we look forward to a future where we can prospectively overcome this crisis.

MAP will discuss the role that measurements and accountability should play related to COVID vaccination among other very critical measurement issues for our patients across the United States.

Thank you again to, I will echo Chris's thank you to CMS and our partners and colleagues for your preparation and your partnership on the Measure Applications Partnership as well.

CMS continues to set the right tone for these meetings and, again, they are here today to participate with you all as well. So, welcome, and thank you so much to the committee for all of your time.

As I know this takes a lot of time out of, particularly today, but also in preparation and looking at materials, and we very much value your expertise and your input. I will turn it back to you, Matt.

DR. PICKERING: Great. Thank you, Sheri, and thank you, Chris, as well, for those opening remarks. I will just echo our gratitude to you all for all of your time, we recognize this is a full day, and also the materials leading up to today and reviewing those.

We appreciate all of your input and engagement and participation. If you do have to step away please make sure to notify your respective workgroups. It just allows us to keep track of quorum.

As you know voting that goes on throughout these workgroup meetings does require a quorum, so, please, just let your respective workgroups know that you will have to step away at any point in time, understanding that other priorities exist for everyone here, so thank you

very much.

Next slide, please. I would like to now turn it over to Michael Haynie. She is our Senior Managing Director here within Quality Measurement here at NQF.

Michael Haynie, would you introduce yourself, please. Also, we'll be doing roll call and disclosures of interest for both of the workgroups. Michael.

MS. HAYNIE: Good morning, everyone. My name is Michael Haynie. I am the Senior Managing Director here at NQF. I am very pleased to be with you this morning.

Before we get started I did want to offer our co-chairs the opportunity to introduce themselves. So, Gerri and Kurt, would you like to begin?

PAC/LTC CHAIR LAMB: I'd be delighted to, Michael. I am Gerri Lamb. I am one of the co-chairs for the MAP Post-Acute Long-Term Care Group. Welcome, everybody, good morning.

I am assuming, Michael, we'll move

into other welcomes in a bit after we do the check-ins.

MS. HAYNIE: Correct.

PAC/LTC CHAIR MERKELZ: Yes. This is Kurt Merkelz. Good morning, everyone. I appreciate NQF, CMS for hosting and having our availability and look forward to the discussion. Thank you, everyone.

MS. HAYNIE: Thank you so much. All right, so what we are going to do we are going to do our sort of roll call and disclosures all together here, so please bear with me.

Before we begin I would just like to give everyone a very brief reminder, NQF is a non-partisan organization, so out of mutual respect for each other we kindly encourage that we make an effort to refrain from making comments, innuendos, or humor relating to, for example, race, gender, politics, or topics that otherwise might be considered inappropriate during the meeting.

We encourage discussions that are

open, constructive, and collaborative. So let's all be mindful of our language and opinions may be perceived by others.

We will combine our disclosure with the introductions and the disclosures of interest are going to be in two parts for each of the groups here today because we have two types of MAP members, organizational members and subject matter experts.

So I am going to start with our organizational members from PAC/LTC. Our organizational members represent the interests of a particular organization so we expect you to come to the table representing those interests.

Because of your status as an organizational representative we asked you only one question specific to you as an individual, so we ask you to disclose if you have an interest of $10,000 or more in an entity that is related to the work of this committee.

So now let's start going around our virtual table, it's a very large virtual table

this morning, beginning with our organizational members only, please.

I will call on anyone in the meeting who is an organizational member. So when I call your organization's name please unmute your line, state your name, state your role at your organization and anything you wish to disclose.

If you don't have anything to disclose please just after stating your name and title add you have nothing to disclose so we can then make sure we get that documented.

So beginning here, the AMDA Society for Post-Acute and Long-Term Care Medicine.

(No audible response.)

MS. HAYNIE: All right, and if you are having trouble with mute just raise your hand and some staff can help you out and we'll come back to that. American Academy of Physical Medicine and Rehabilitation.

PAC/LTC MEMBER HOPPE: Good morning. My name is Kurt Hoppe and I am Past President of the American Academy of PM&R and I have nothing

to disclose.

MS. HAYNIE: Thank you. American Geriatric Society.

PAC/LTC MEMBER SALIBA: Good morning. My name is Debra Saliba and I have nothing to disclose.

MS. HAYNIE: Thank you. American Occupational Therapy Association.

PAC/LTC MEMBER ROBERTS: Hi. This is Pam Roberts and I am a member of the Quality Advisory Committee for AOTA and I have nothing to disclose.

MS. HAYNIE: Thank you. American Physical Therapy Association.

PAC/LTC MEMBER BELL: Hello. My name is Alice Bell. I am a Senior Payment Specialist with the American Physical Therapy Association and a physical therapist and I have nothing to disclose.

MS. HAYNIE: Thank you. ATW Health Solutions.

PAC/LTC MEMBER COLLINS BRADLEY: Good

morning. Desiree Collins Bradley, Patient Engagement Network Lead for the organization and I have nothing to disclose.

MS. HAYNIE: Thank you. Kindred Health Care.

(No audible response.)

MS. HAYNIE: LeadingAge.

PAC/LTC MEMBER TRIPP: Good morning. I am Aaron Tripp, Vice President of Financing and Reimbursement Policy at LeadingAge and I have nothing to disclose.

MS. HAYNIE: Thank you. National Hospice and Palliative Care Organization.

PAC/LTC MEMBER KENNEDY: Hi. I am Jennifer Kennedy. I am the Senior Director for Quality and Regulatory and I have nothing to disclose.

MS. HAYNIE: Thank you. National Partnership for Healthcare and Hospice Innovation.

PAC/LTC MEMBER GRADEVSKI: Hi. This is Tzvetomir Gradevski, Policy Director with

NPHI. I have nothing to disclose.

MS. HAYNIE: Thank you. National Pressure Injury Advisory Panel.

PAC/LTC MEMBER COX: Yes. Hi. My name is Jill Cox. I am a board member of the NPIAP and I have nothing to disclose as well.

MS. HAYNIE: Thank you. National Transitions of Care Coalition.

(No audible response.)

MS. HAYNIE: SNP Alliance.

PAC/LTC MEMBER CHEGINI: Good morning. This is Dr. Sepideh Chegini and I have nothing to disclose.

MS. HAYNIE: All right. And just checking on mute issues, do we have anyone from AMDA?

(No audible response.)

MS. HAYNIE: Kindred Health Care.

(No audible response.)

MS. HAYNIE: All right. So now what we will do is we will move on to our disclosures for our subject matter experts. So because

subject matter experts sit as individuals we asked you to complete a much more detailed form regarding your professional activities.

When you disclose there is no need to review your whole resume. Instead, we are interested in your disclosure of activities that are related to the subject matter of the workgroup's work.

We are especially interested in any disclosure of grants, consulting, or speaking arrangements, but only if relevant to the workgroup's work.

Just a few reminders, you do sit on this group as an individual. You do not represent the interest of your employer or anyone who may have nominated you for this committee.

I also want to mention that we are not only interested in your disclosures of activities where you were paid. You may, in fact, have participated as a volunteer on a committee where work is relevant to the measures reviewed by MAP. We are looking for you to disclose these types of

activities as well.

Finally, just because you disclose does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency.

Please tell us your name, what organization you are with, and if you have anything to disclose. And, again, if you don't please just say you have no disclosures so we can keep moving along.

So let's begin with our co-chairs. Gerri, would you be willing to go first here?

PAC/LTC CHAIR LAMB: I am Gerri Lamb and I do consulting work and research related to care coordination which is somewhat related to the measures we are going to be reviewing today.

MS. HAYNIE: Okay. Thank you, Gerri. And, Kurt.

PAC/LTC CHAIR MERKELZ: Yes. Good morning, again. Kurt Merkelz. I am the Chief Medical Officer for Compassus Healthcare. I also sit on the Quality Committee for the American

Academy of Hospice and Palliative Medicine. I have nothing to disclose.

MS. HAYNIE: Thank you, Kurt. All right, moving along. Dan Andersen.

DR. ANDERSEN: Hi, everybody. My day job is at the RELI Group. I guess new to disclose is beginning in this January I start serving as a project manager on a CMS contract that our role is actually doing content review, QA, and things like through the PAC QRP pages, that includes SNF, LTCH, and IRF, so -- wait. Yes, SNF, LTCH, and IRF.

So I just wanted to disclose that. Our work is not measure development related, but --

MS. HAYNIE: Okay. Thank you, Dan. Terrie Black.

DR. BLACK: Good morning. I am Terrie Black. I am a Clinical Assistant Professor of Nursing at the University of Massachusetts and I also am a per diem surveyor for Joint Commission and I have nothing additional to disclose.

MS. HAYNIE: Thank you. Sarah Livesay.

DR. LIVESAY: Hi. This is Sarah Livesay. My day job is as the Assistant Dean for Specialty Education at Rush University. I am an acute care nurse practitioner by training and I have nothing to disclose.

MS. HAYNIE: All right. Paul Molehasin. Paul, are you with us?

(No audible response.)

MS. MOYER: This is Amy. I believe Paul is in clinic this morning, but he will join us later.

MS. HAYNIE: Okay, great. Thanks, Amy. Rikki Mangrum.

DR. MANGRUM: Yes, good morning. This is Rikki Mangrum. I am a Principle Researcher at American Institutes for Research.

I would disclose that I am also the chair of the Quality Measures Committee for AMDO, which is the Society for Post-Acute and Long-Term Care Medicine.

MS. HAYNIE: Thank you. Eugene Nuccio.

DR. NUCCIO: Nuccio.

MS. HAYNIE: Nuccio. My apologies.

DR. NUCCIO: Not a problem. I am a retired professor at the University of Colorado Anschutz Medical Campus in the Division of Healthcare Policy and Research.

My specialty area is in home health. I have sat on several NQF committees, including the committee, the panel that worked on a sociodemographic inclusion and risk models and I am currently a member of the NQF Scientific Methods Panel, so I have reviewed many of these measures as part of that panel.

MS. HAYNIE: Thank you. All right. Now we would like to move on to invite our federal government participants. So these are the non-voting liaisons from these institutions for the workgroup.

So do we have the liaison to PAC/LTC here from the CDC?

DR. GELLER: Good morning. This is Andrew Geller from the Division of Healthcare and Quality Promotion at CDC.

MS. HAYNIE: Thank you. And the liaison from CMS?

DR. LEVITT: Yes. Hi. This is Alan Levitt. I am the medical officer in the Division of Chronic and Post-Acute Care and I have nothing to disclose.

MS. HAYNIE: Thank you. And our liaison from ONC?

MS. PALENA HALL: Hi, there. Good morning. I am Liz Palena Hall, a nurse informaticist in our Office of Policy at ONC.

MS. HAYNIE: All right. Excellent.

MS. VAN DE KAMP: Excuse me. Can I jump in? Can you hear me?

MS. HAYNIE: Yes.

MS. VAN DE KAMP: Hi. I'm sorry. This is Mary Van De Kamp from Kindred. For some reason I was unable to unmute and I gave my announcement about three times, so I apologize.

I am the Chief Clinical Officer for Kindred Healthcare in our KRS Division. I am a speech pathologist. I have nothing to disclose. Sorry I was unable to get in earlier.

MS. HAYNIE: Thank you so much. And, again, I hope you did this, but if it happens to anyone else raise your hand and staff can chat with you --

(Simultaneous speaking.)

PAC/LTC MEMBER VAN DE KAMP: Okay, perfect. All right. Thank you. I panicked instead of thinking through it. Thank you.

MS. HAYNIE: No worries. Thank you for your persistence. All right, so now we are going to go back and do that whole drill again on the Hospital side.

So to begin with do our Hospital co-chairs want to provide any welcome to start here?

HOSP CHAIR MORRISON: Sure. Good morning, everybody. This is Sean Morrison. I am one of the Hospital co-chairs and just wanted to welcome everybody to today's meeting and thank

CMS for all the work they have done in preparation as well as the NQF staff.

HOSP CHAIR DEMEHIN: And I am Akin Demehin. I am the other Hospital workgroup co-chair, Director of Policy with the American Hospital Association.

I just want to extend my thank you to all of you, especially those of you working in hospitals and healthcare systems at an incredibly busy time for making a full day for you to participate in this important meeting.

And, of course, thank you to CMS for your continued collaboration in preparation for this meeting and we would be nowhere without the tremendous work of the NQF staff.

So I'm looking forward to today's discussion.

MS. HAYNIE: All right. Thank you so much. So, again, we'll begin with organizational members.

Remember, you are representing an organization, there is just one question, we ask

you to disclose if you have an interest of $10,000 or more.

So let's go around our virtual table here. America's Essential Hospitals.

HOSP MEMBER GUINAN: Hi, everyone. Maryellen Guinan, Principle Policy Analyst at America's Essential Hospitals and I have nothing to disclose.

MS. HAYNIE: Thank you. American Case Management Association.

(No audible response.)

MS. HAYNIE: All right, we'll move back. Remember, raise your hand if you're having trouble getting off of mute and we'll help you figure it out. American Society of Anesthesiologists.

HOSP MEMBER JOSEPH: Hi. I am Vilma Joseph. I am Vice Chair of the Committee on Performance and Outcomes Measurement and I have nothing to disclose.

MS. HAYNIE: Thank you. American Society of Health-System Pharmacists.

HOSP MEMBER LEGREID DOPP: Hi. Good morning. My name is Anna Legreid Dopp. I am the Senior Director of Clinical Guidelines and Quality Improvement at the American Society of Health-System Pharmacists and I have nothing to disclose.

MS. HAYNIE: Great. Thank you. Association of American Medical Colleges.

HOSP MEMBER ORLOWSKI: Good morning. I am Dr. Janis Orlowski. I am the Chief Healthcare Officer at the Association. I am also a practicing nephrologist. I have nothing to disclose.

MS. HAYNIE: Thank you. City of Hope.

HOSP MEMBER MORSE: Good morning. My name is Denise Morse. I am the Director of Quality and Value Analytics at City of Hope and I have nothing to disclose.

MS. HAYNIE: Thank you. Dialysis Patient Citizens.

HOSP MEMBER WILLIAMS: Good morning. This is Jackson Williams, Vice President of

Public Policy. I have nothing to disclose.

MS. HAYNIE: Thank you. Greater New York Hospital Association.

HOSP MEMBER CHIN: Hi. This is Amy Chin. I am a Senior Director of Health Economics and Outcomes Research with the Greater New York Hospital Association and I have nothing to disclose.

MS. HAYNIE: Thank you. Henry Ford Health System.

HOSP MEMBER MUDIRAJ: Hi. This is Santosh Mudiraj. I am the Quality Manager for Performance Improvement and Data Analytics and I have nothing to disclose.

MS. HAYNIE: Thank you. Intermountain Healthcare.

(No audible response.)

MS. HAYNIE: All right, we'll move back around to Intermountain. Medtronic.

HOSP MEMBER SHEHADE: Hi, it's Karen Shehade. I work at Medtronic and as a for-profit company I do have stock and will refrain from any

topics that may pose any kind of conflict of interest.

MS. HAYNIE: Thank you. Memphis Business Group on Health.

HOSP MEMBER TRAVIS: Hi. This is Cristie Travis. I am the CEO of the Memphis Business Group on Health working with self-insured employers across the State of Tennessee and I have nothing to disclose.

MS. HAYNIE: Thank you. Molina Healthcare.

HOSP MEMBER WHEELER: It's Debbie Wheeler. I am the VP of Quality for Molina Healthcare. I have a disclosure, just in terms of I have stock in Molina, but I don't know if that is a real conflict or not so I just say it out loud.

MS. HAYNIE: Okay. Thank you for your transparency. Mothers Against Medical Error.

HOSP MEMBER MCGIFFERT: Hi. This is Lisa McGiffert. I am a Patient Safety Activist with Mothers Against Medical Error and I have

nothing to disclose. I am based in Austin, Texas.

MS. HAYNIE: Thank you. National Association for Behavioral Healthcare.

HOSP MEMBER GHINASSI: Good morning. Frank Ghinassi. I am a member of the Board of Directors with the National Association for Behavioral Healthcare and also the chair of their Quality Committee and I have nothing to disclose.

MS. HAYNIE: Thank you. Premier Healthcare Alliance.

HOSP MEMBER PITTMAN: Good morning. I am Aisha Pittman, the Vice President of Policy at Premier, and I have nothing to disclose.

MS. HAYNIE: Thank you. Press Ganey.

HOSP MEMBER GANDHI: Hi. I am Tajal Gandhi, Chief Safety and Transformation Officer at Press Ganey and I do have equity in the company so I will disclose that, but nothing else to disclose.

Also, I have to leave a little bit early so my colleague, Kaycee Glavich, is on with

me so I will let her introduce herself as well.

MS. HAYNIE: Thank you, Ms. Tajal.

HOSP MEMBER GLAVICH: Hi. This is Kaycee Glavich. I am the Director of Policy at Press Ganey and I have nothing to disclose.

MS. HAYNIE: Thank you. Project Patient Care.

HOSP MEMBER HATLIE: Good morning. I am Marty Hatlie. I am the President and CEO of Project Patient Care and I have nothing to disclose.

MS. HAYNIE: Thank you. Service Employees International Union.

HOSP MEMBER NOLAN: Hi. I am Sarah Nolan. I am the Director of Health Policy at SEIU and I have nothing to disclose.

MS. HAYNIE: Thank you. Society for Maternal Fetal Medicine.

HOSP MEMBER GIBSON: Hi. This is Kelly Gibson. I am a maternal fetal medicine specialist in Cleveland, Ohio, and sit on the Patient Safety and Quality Committee for SMFM. I

have nothing to disclose.

MS. HAYNIE: Thank you. Stratis Health.

HOSP MEMBER LUNDBLAD: Good morning, everyone. I am Jennifer Lundblad, President and CEO at Stratis Health, and I have nothing to disclose.

MS. HAYNIE: Thank you. UPMC Health Plan.

HOSP MEMBER DONIS: Hi. Good morning, everyone. My name is Jan Donis. I am the Senior Director for Hospital and Physician Quality Performance at the system level, not just the health plan.

I am replacing Amy Helwig who has served on this committee in the past.

MS. HAYNIE: Thank you. All right, just a quick loop back to the American Case Management Association.

(No audible response.)

MS. HAYNIE: And to Intermountain.

HOSP MEMBER WOODRUFF: Hi. Good

morning. It's Mike Woodruff, Interim Chief Patient Experience and Quality Officer for Intermountain. Nothing to disclose.

I do have to step away for a bit and my colleague Elizabeth McKnight will be substituting for me, so I will introduce Elizabeth.

MS. HAYNIE: Elizabeth, are you able to get off of mute?

HOSP MEMBER MCKNIGHT: Hi. Yes. I am Elizabeth McKnight. I work in the Office of Patient Experience with Mike Woodruff and I have nothing to disclose.

MS. HAYNIE: All right. Thank you so much. Okay, so now we'll continue. We'll move on to our individual subject matter experts. A reminder, just the same as last time, you sit as individuals.

There are more detailed disclosures here, and I won't read the entire piece again. Let's start with our co-chairs. So, Akin.

HOSP CHAIR DEMEHIN: Sure. So as I

mentioned earlier I am a Director of Policy for the American Hospital Association primarily focused on quality measurement programs that affect our member hospitals and health systems. I have nothing to disclose.

MS. HAYNIE: Thank you. And, Sean.

HOSP CHAIR MORRISON: Yes. Hi, everybody. Sean Morrison. I direct the National Palliative Care Research Center and am the Assistant Chair for Geriatrics and Palliative Medicine for the Mount Sinai Health System in New York and I have nothing to disclose.

MS. HAYNIE: Thank you. Andreea Balan-Cohen.

DR. BALAN-COHEN: Good morning. I am Andreea Balan-Cohen, healthcare economy is my training. I am Vice President at IMPACT. My disclosure today is that IMPACT has some projects developing measures for CMS. This is my third year on the committee. That's it.

HOSP MEMBER HAYNIE: Thank you. Lindsey Wisham.

DR. WISHAM: Yes. Good morning. I am a Senior Director at Telligen over quality measurement and my employer does have CMS contracts, nothing that pertains to the measures we will be reviewing today.

I would also like to disclose I am the patient representative on the MACRA measure development plan TEP.

MS. HAYNIE: Thank you. All right. And now to our federal government participants who are non-voting liaisons. Could we have the liaison from AHRQ, please.

DR. DESOTO: Yes. Good morning and Happy New Year. I am Mia DeSoto from the Agency for Healthcare Research and Quality and I lead the Quality Indicator Program. Thank you.

MS. HAYNIE: Do we have the liaison from the CDC?

DR. POLLOCK: Yes. Daniel Pollock. I lead the unit at CDC responsible for the National Healthcare Safety Network and HSM.

MS. HAYNIE: Thank you. And the

liaison from CMS?

DR. SCHREIBER: Michelle Schreiber from CMS. I have nothing to disclose.

MS. HAYNIE: Thank you. All right. Well, thank you all for bearing with me. That concludes our roll call and disclosures of interest. I will turn it back over to Matt.

DR. PICKERING: Great. Thank you, Michael. And, lastly, I just wanted to recognize two additional individuals for our separate workgroup meetings.

From the Rural Health Workgroup we have two liaisons that will be with us. On the PAC/LTC side it's Brock Slabach. Brock, are you on the line?

MR. SLABACH: Good morning. Yes, I'm here.

DR. PICKERING: Great. Would you just mind introducing yourself?

MR. SLABACH: Sure. Oh, I'm sorry. I'm Brock Slabach, senior vice president at the National Rural Health Association and

headquartered in Leawood, Kansas. And I have nothing to disclose today, here representing the Rural Measures Application Partnership Workgroup.

DR. PICKERING: Thank you so much, Brock, and happy to have you today. And then for the Hospital side, the Rural Health Liaison will be Jesse Spencer. Jesse, are you on and would like to introduce yourself?

DR. SPENCER: Yes, hi. Good morning. Also representing the Rural Workgroup. My name is Jesse Spencer. I'm a rural physician in Utah, actually work with Intermountain Healthcare and am the medical director of Family Medicine at this point.

DR. PICKERING: Okay, thank you, Jesse. Both individuals will be providing input based on the Rural Health meeting we had last week. Gosh, it seems like forever ago that we had last week. They both were very much involved with the proceedings that happened during that meeting and all of the measures that we'll be reviewing today. So if there's any point in time

you want the rural perspective, both individuals will be able to provide that. So thank you both very much for your time. But they will not have any voting privileges during these meetings. Next slide, please.

Can you go to 10, Becky? Thank you. Okay, and now I'd like to introduce Michelle Schreiber. Dr. Michelle Schreiber is the deputy director for Quality and Value at the Centers for Medicare and Medicaid Services. And she's here to provide some opening remarks as well as meaningful measure update in all the great work that they've been doing over there. So, Dr. Schreiber, I'll turn it over to you, and we have your slides lined up.

DR. SCHREIBER: Thank you very much. Let me do a sound check. Matt, can you hear me okay?

DR. PICKERING: Coming through beautifully.

DR. SCHREIBER: Wonderful. Thank you and good morning to everybody. As Matt said, I'm

Michelle Schreiber. I am the deputy director of the Center for Clinical Standards and Quality at CMS and also the director for the Quality Measures and Value-based Incentives Group there. This is my third year of the MAP. It's hard to believe. And it's nice to see so many people that I've gotten to know over the past couple of years, so thank you.

Welcome to the MAP 2020 that, of course, is in 2021. We've obviously had some challenges with scheduling and we've compressed this into a very short time. We thank everybody, especially the NQF, quite honestly, for their flexibility in being willing to make these changes and are deeply appreciative to everybody for their involvement.

This has been an extraordinary year. I think that goes without saying. At the MAP last year, I don't think any of us would have thought in our wildest imagination that we would have had a year like we have had, with a massive pandemic that is global that has taxed health

care to, I don't want to say its limits because I don't think health care knows its limits, but it certainly has been extraordinarily taxing but has revealed the resiliency and the dedication of health care. And to everybody who works in it in any way, shape or form, on behalf of CMS, really, thank you to each and every one of you.

As you know, the Measures Application Partnership is a partnership but it's a formalized process that's mandated in statute 1890 and 1890A of the Social Security Act, if you want to know, paid through from CMS, whereby you as an independent group of expert individuals convened by the National Quality Forum make recommendations to us at CMS about measures that you believe are appropriate or perhaps less appropriate to be used in the various CMS value-based incentive programs.

These programs are used both for public reporting and they're used for payment as well as you are all very familiar with. This is an independent process and we really treasure

your expert opinion, and really have made many changes over the years based on the input from the MAP, so thank you.

We have many people on the line today both from CMS, our contractors. They are experts. We are not here to slay your opinion. We are here to answer questions and to provide clarifications for you. And so we enjoy that opportunity and look forward to working with each of you today. I'd like to thank a few others as well in addition to those who are on the phone from CMS. Our federal partners, I know we have Dan Pollock, I've heard, but Dan Budnitz also who will be speaking on the COVID vaccines. And our other federal partners such as AHRQ who are on the line.

Thank you, certainly, to the NQF. Our personal welcome to Chris Queram who took over what is it even a week ago, two weeks ago, Chris, as the interim CEO of the National Quality Forum and he has just stepped right in, and it's very exciting to have you in that role. And,

obviously, to all of you, Sheri and others, at NQF who have worked very hard in putting the MAP meetings together and in convening all of the consensus-based meetings that you do. And, of course, to each and every one of you on the phone. I've had the privilege of getting to know many of you in the last couple of years, thank you all for your participation.

And last but not least, certainly, to everybody who has worked on the front lines to your organizations who represent them, please go back and say a special thank you to all of those providers at the front lines who have been taking care of COVID patients. It has been extraordinary, it has been heroic, and thank you for everybody's efforts.

What I wanted to do today is just outline some of the goals of CMS when it comes to quality measurement, just to ensure that this committee has an understanding of where we're going in the future and also to seek your input on these slides. So we have been having

listening sessions on the CMS Quality Action Plan and value stakeholder engagement and input and, really, I'm looking forward to this being more of a conversation than it is me talking. And so I'm going to pause at many of the slides and just seek feedback.

And if there's not an opportunity that there's something that you have wanted to note, just please drop me an email. NQF certainly knows how to reach me, or put something in the chat and we will make note of it. But we look forward to hearing your input on the CMS Quality Action Plan. So thank you, and without ado, can we have the next slide, please?

This was a disclaimer to the presentations that we had done, but this may contain references to statutes and regulations but this really doesn't necessarily, this isn't actually rule writing. This is, you know, an open conversation about where CMS may be going directionally. Next slide.

I think our vision is your vision and

the vision of many who have frameworks around quality measures, and that's really to use the most impactful quality measures to improve outcome, health outcomes, and to deliver value by empowering patients to make informed care choices, while at the same time I hope you recognize there have been significant efforts to reduce burden to clinicians. Next slide, please.

What I'm going to talk about are the four goals and there's a fifth one embedded here. I'll be curious to see if you think we should call it out explicitly, but the goals of the CMS Quality Action Plan. Let me just back up for a moment because many of you are familiar with the HHS Quality Roadmap, and last year, HHS actually convened a group of external stakeholders to talk kind of about the state of what we'll call the quality measurement enterprise.

And there are opinions all over about the quality measurement enterprise from we shouldn't have any measures because they haven't done anything, to we need to have lots more

measures because, you know, I'm a specific provider and there isn't a measure that is relevant to me. It's clear that there is a lack of alignment in the quality measurement space. It's clear that there is work yet to be done. And HHS put forward a Roadmap that had three essential recommendations. One was around measurement itself, to review measures to try and align measures and reduce measures that are less impactful or that aren't working.

A few is around data, data structures and data interoperability to make data as widely available as possible. And third is governance. Should there be an independent governance body for the quality measurement enterprise of the country? And so with that background they published their HHS Roadmap, I believe it was in May. With that background, CMS has been working for years, if not decades, actually, in quality measurement and has developed the quality value-based incentive programs that have led the way for public transparency and the link to payment,

either penalty or payment, for organizations so that performance is tied to payment.

We think these programs have been extremely valuable and actually have noted significant increases in quality as well as reductions in costs over the years. The CMS Quality Action program is really an outgrowth of the work that CMS has been doing for a long time, including the first phase of meaningful measures which started in 2016, went public in 2017, and we're in the process of putting meaningful measures 2.0 together. And in each of MAP meetings we've actually talked about meaningful measures.

The goals then of the CMS Quality Action Plan are to use the most impactful measures -- and I see we have an error in that first line there, we'll have to fix the typing -- to improve and streamline quality measurement, and that includes alignment. The second is to leverage these measures to drive value and outcomes improvement. The third is to make

measures as efficient as possible, and we believe that much of that is through the transition to digital measures and then using advanced analytic systems so that we can even look at measures differently.

The fourth is to ensure that measures are patient-centered. And that could be measures that are specific around patient-centered care such as shared decision making or ensuring that there are goals of care that are being met. And also patient reported outcomes so that we are sure that we are always hearing the voice of the patient. And the fifth one, which we have actually woven through all of these is to try and shine a spotlight on disparities so that we can close those gaps and provide equitable care for all. Next slide.

Most of you remember Meaningful Measures 1.0 which had six different domains of care and 17 specific focus areas. We've actually used this at CMS to look at all of our measures in all of our programs and retire some measures

that didn't quite fit within the framework of meaningful measures. We've looked for duplicative measures. We've looked for those that, you know, are more one-off measures and certainly those that are topped out. And we have over a period of time, through a preformalized process, made advances in aligning measures and in reducing the number of measures that we have. The next slide. Thanks.

Through the Meaningful Measures 1.0 framework, which was part of the Patients Over Paperwork at CMS, we really have made significant improvements with a 15 percent reduction in the overall number of measures that are used in the CMS Medicare Fee-for-Service program. We've gone down from 534 to 460 unique measures in the Fee-for-Service program. So I know there's a lot of talk out there, there are thousands of measures used. There aren't. This is the actual number, and we continue to reduce that so that we get to a more parsimonious list.

Overall, the measures portfolio is

also shifting in that we have by percentages fewer measures that are process measures and more measures that our outcome measures. Although I will say as I've said almost all the time, there are important process measures, there are important structural measures as a matter of fact. And so although we are shifting towards more outcome measures, we will not eliminate process nor structural measures either. This streamlining of measures has an estimated millions of dollars of savings and millions of burden hours that we have also saved as well. Next slide.

Meaningful Measures 2.0, which is currently what we are working on and have sought public comment on and introduced at last year's CMS Quality Conference, has seven different domains. We eliminated the specific focus areas and we're hoping that through simplicity we can be highlighting the most important areas of measurement. So person-centered care, and if you'll notice the patient is at the top as the

true North, person-centered care is the true North and it's also our foundation in the voice of the patient.

The other domains include patient safety, and I have to tell you I'll be curious what you all have to say. We debated if that should just say safety or if that should say healthcare safety. Tejal knows that debate. I specifically had asked her to weigh in on it because we know that it's not just patient safety but it's worker safety, workforce safety, facility safety, but we intentionally left it as patient safety because that's what's fundamentally important.

Chronic conditions, seamless communication including interoperability, affordability and efficiency, wellness and prevention, and behavioral health and substance use disorders is one that we added because we recognized just how important this is. Transitions of care, we put in both seamless communication and chronic conditions, although

we've heard some feedback that maybe we need to call that out a little bit more explicitly. And the goals I'll talk about in the next few slides, but utilizing measures of high value, aligning them, prioritizing them, transforming them to digital, ensuring that we're hearing the voice of the patient, and we'll talk later about social and economic determinants.

Let me pause for just a moment and ask the group, on this house diagram would you like to see anything differently? Did we not capture some key domain, or would you reword it differently? So maybe we can just spend a couple of moments and you can either chat or raise your hand. Matt, if you wouldn't mind facilitating and see if there are any comments from the group on the box, the house.

DR. PICKERING: Thanks, Michelle. So you can chat, send a chat, or you can chime in and take yourself off mute if you'd like to provide any input.

HOSP MEMBER HATLIE: Well, this is

Marty Hatlie. I'd like to comment on Michelle's comment about patient safety. I think that that term now strikes me in 2021 as sort of an interim term that's changing. CMS, I think, helped inform the dialogue several years ago by shifting from patient to person in a lot of your planning documents. And that resonates with me because I think workers are persons too. The persons in the system, I think, all have safety interests.

And so when I look at the word patient safety and now even though I've spent my career sort of wrapped around that term, it feels too narrow, perspectively, because it really is about person safety. And it's not just patients. It's residents of long-term care facilities. It's words for which patient is not precisely the right word, even though it's the word that's out there. So I think person safety could be something that we should consider going forward.

DR. SCHREIBER: And I see a number of comments by the way -- I'm sorry, Lisa.

HOSP MEMBER MCGIFFERT: That's okay.

DR. SCHREIBER: I just see a number of comments. I'm trying to read the chat while I'm looking at people and having the conversation around healthcare equity. I will say there was a lot of debate about healthcare equity. Should it have been, should it be sort of one of those foundations like we have voice of the patient, we put healthcare equity as a foundation? Should it be within the box? I'm curious what people say. We wove it into each of these, but if you think that we should call it out more explicitly, I'd like to hear that feedback as well. And I'm sorry, Lisa. I didn't mean to interrupt you.

HOSP MEMBER MCGIFFERT: Oh, that's okay. It's kind of hard to know how to raise your hand. Yes, somebody has one. I tried to find that symbol and I couldn't. Oh, there it is. I would just take the position that I think patient safety is an important phrase. I think healthcare provider safety, worker safety is important too. Certainly, long-term care resident safety is important. But I see those as

coming under a different category or a subcategory perhaps for long-term care.

But if we want to add something for worker safety, which I think is totally valid, I think it should be a separate category. I think the strategies are different and the, you know, what the activities you have to do are really different for that group.

DR. PICKERING: And, Gerri? Gerri, did you have your hand raised?

PAC/LTC CHAIR LAMB: I did. I wanted to comment on the seamless communication, Michelle, and would encourage CMS to consider using care coordination as the broader umbrella for seamless communication and transitions of care. I think our work in the CDP suggests that they're not the same, and care coordination gives us a much fuller process.

DR. SCHREIBER: Thanks. I think, Matt, we'll take one more comment and then I'll move forward.

DR. PICKERING: That sounds good.

Thank you, Michelle. And I have Tejal?

HOSP MEMBER GHANDI: Hi there. Hi, Michelle. I thought I would just comment about the patient safety topic as well. I mean I think I had told you that we had our National Steering Committee for Patient Safety that really debated this issue of do you say safety and patient safety and workforce safety, and what do you say? And there was concern that if we didn't say patient safety it would, first of all, confuse people because we've been talking patient safety for 20 years. And it is, to Marty's point, I think a term that it will be transitioning to that broader safety, but we weren't sure if we were quite there yet to do it.

Now, that being said, I also agree that workforce safety, really, more and more is, you know, we know is critical that's in the -- we say that worker safety is a precondition to patient safety and actually to doing any of the things that we're talking about on this slide. We need to have, you know, a safe workforce. So

I almost see that as like a foundational element underneath all of this. In order to achieve person-centered care, patient safety, all that stuff, we need that workforce that's supported, maybe highlighted separately but still mentioned.

DR. SCHREIBER: Great. Well, thank you all. I recognize we don't have a huge amount of time and I will try very hard to run on time. Matt, how about if we advance to the next slide, please?

DR. PICKERING: That sounds good. And, Michelle, I'll just note too that we'll be able to save and capture everyone's input in the chat. So if you're not able to participate on the call, please provide it in the chat and we can definitely share accordingly.

DR. SCHREIBER: Great, thanks. Let me go through again and highlight the goals of the CMS Action Plan and then I'll pause after I do some of these goals so that we can open the conversation again. The first is using meaningful measures to streamline quality

measurement and a lot of this has to do with alignment, alignment, alignment, reducing the number. You've heard about our efforts to date of decreasing the number of measures.

I think we are in the process of doing that. We've made significant headway and we will continue. Although I have to tell you we don't have some golden magic number of the number of measures there should be either at all or in the CMS programs. I know, you know, again there are opposite ends of the spectrum from no measures or two measures to more measures. We think it's the right number of measures that are covering the right key domains.

There's been a lot of alignment work that is going on. Within CMS there's an alignment committee between all of the centers of CMS, so these are the Medicare Fee-for-Service programs for the most that you see, but there are programs for Medicare C and D. There's obviously the CMMI innovation models. There's Medicaid that has to be taken into consideration, and so

we're working hard within CMS to bring alignment. We are also working with our VA and DOD federal partners to bring alignment more across the federal workspace. As a matter of fact, I was on the phone this morning with the VA and DOD. We have frequent meetings to try and do that as well.

And many of you actually are participating and know the work of the Core Quality Measures Collaborative which is sponsored by NQF, CMS and AHIP, America's Health Insurance Plans -- thank you to them -- which has just developed key, a measure set. These are all ambulatory at the moment. There's eight in development. There's two more being worked on that are actually sets of key measures that we have agreed to use across all payers. So the more we can get to an all-payer point of view, I think the better. So lots of efforts going on in this direction. Next slide, Matt, please.

Obviously, we want to take those measures and the measurement enterprise and use

them within whatever programs. Some of them are public reporting. Some of them are just confidential feedback. Some of them are pay for performance, but use them in our programs. And we're trying to modernize the programs across CMS and I think you've seen the evidence of that. You've seen the transition from MIPS to MIPS value-based pathways which are smaller sets of related measures that are being developed in close collaboration with the specialty societies.

We have modernized the Hospital Stars program. And you probably saw in the recent legislation that passed, the Consolidated Appropriations Act, and I know the PAC and Long-Term Care folks will talk more about that, an expanded SNF value-based purchasing program so that it's not just one measure for post-acute care in SNFs, we have the mandate to include or the opportunity to include up to ten so that we'll have a more holistic program for nursing home value-based programs.

We also had been looking at, many of

you have heard this before, a hospital simplification model where we took all of the five programs of the hospitals and tried to unify them into a single, more simplified program so that remains a subject of conversation across CMS. So we are trying to use these measures appropriately and modernize the value-based programs as possible. Next slide.

I want to talk a little bit about the digital transition. Many of you have heard me speak of this before, but CMS at last year's Quality Conference, the administrator, herself, announced that CMS is going to transition to all digital quality measures. You'll see in the MUC list this year that 80 percent of our measures are indeed digital and we're making a significant and concerted attempt to move all measures to digital by 2025, actually accelerating that timeline.

Now I know that that's perhaps inspirational or aspirational, but we're making strides in that direction and you can see it from

this year's MAP. I say that because in the future, CMS probably won't accept as new measures into their programs measures that aren't digital. So those who are thinking of bringing new measures forward onto the MUC and MAP list, I will tell you that that is our point of view at this time. And please consider that actually in your deliberations or even as you're thinking in your mind of what measures should be brought forward.

Now, I have a very broad view of what a digital measure is. Obviously they're electronic clinical quality measures that come directly from electronic medical records, but there are also other digital means such as what do we do with information that may come from patient downloadable devices, such as what do we do with census information, such as what do we do with claims information, most of which is captured digitally.

And so it's a broad view of digital, but I think all of us need to become very

conversant in digital measures and ECQMs because that, we think, is a way of moving forward that will help ease the burden of measurement, perhaps not in the short run as these things have to be built, but in the long run so that this is all digital and we can have a seamless communication of information. Having digital measures also allows us to leverage whatever you want to call it, advanced learning, neuro networks, machine learning, artificial intelligence, but advanced analytics so that we can be looking at measures in a very different way.

Digital measures also allows CMS to provide much more rapid feedback and point of fact eventually in a real-time manner because we know that right now quality has been somewhat retrospective and we need to push that so that it is much more timely so that we can really be part of creating those learning healthcare systems that I think we all aspire to.

And on the next slide, empowering patients to make the best healthcare choices

through patient-directed quality measures, we spoke of this before. For public transparency, CMS, this year, introduced its updated Compare Sites making them easier for patients and consumers to understand. We've made a commitment to increase our patient-reported outcome measures by 50 percent. To be quite honest with you, when you don't have that many of them, 50 percent isn't quite as much as it sounds. But our goal is to increase reporting by patients and to include patients in everything that we do.

So we now include patients or have been for a while on all of our TEPs, but even as these MIPS value pathways are being developed, we've asked all the specialty societies who are working on this with us to ensure that they include patients and that we're looking at a patient-centered measure in all of them. And it may be a patient-reported outcome measure or it could be something related to goals of care or shared decision making to make sure that we are doing patient-reported outcomes.

And on the next slide I want to talk a little bit about disparities and equity, because even though it wasn't in the house slide, this is something that CMS takes very seriously and we've tried to weave it through all of the goals that we've had, although more and more I think we are going to call it out specifically in the slide with the house diagram. So thank you for your feedback on that.

We are, have already been providing confidential feedback largely to hospitals with some measures based on dual eligibility. We will be providing more and more of that over time, not only to hospitals but in other programs and envision at some point making those public as well. But that will take a while until I think all of us are used to seeing it and we're more sure of our data. We've been looking, obviously, with NQF over the past several years about what are some appropriate measures. Do we have appropriate measures for SES? And we probably don't have enough.

And we're also partnering with our Office of Minority Health looking at the HES score, which is a Health Equity Score, which actually assigns a score based on some of the local characteristics, geographic characteristics of the areas as well as characteristics of the practices. So we are looking very much at health equity. And I have a couple of other slides specific to health equity in a moment, but that's a separate topic that I want to get to.

Let me pause here and ask Matt if we can open up the conversation again on these four goals and these directions of CMS regarding quality measures. Would love to hear everybody's input. Thank you. And I'll assume if there's no comments you just all agree with us. Thank you so much.

DR. PICKERING: So Michelle, I'm just looking at the raised hands. Akin, do you have your hand raised? Would you like to provide comments to something?

HOSP CHAIR DEMEHIN: I do indeed have

my hand raised. Good morning, Michelle. It's great to see you.

DR. SCHREIBER: Hi, Akin.

HOSP CHAIR DEMEHIN: Thanks so much for the overview of CMS' activities. I wanted to dive just a little bit deeper on the notion of digital measures. You know, I think when, when we've thought about digital measures we often think of them mostly as ECQMs. This construct seems a little bit broader.

Are you drawing any distinctions between ECQMs and digital measures? A little bit of definition might help.

DR. SCHREIBER: Yeah. To be honest with you, we're trying to be as broad as we can, at least to start with, Akin, because we want to make sure that we can embrace everything that may fall under a digital kind of definition.

We will actually be introducing into some formal rule writing our definition of digital measures. And to be honest with you, we're still refining that.

I know NCQA also has a definition of digital measures. I think there are a few definitions of digital measures that are floating around out there. But ECQMs is actually a subset, a large subset of digital measures. And I think over time we'll probably get to a point where most of this is ECQMs, but I don't know that we're there yet, nor do I know that we will ever completely be there because there are these other digital data sources that I think we'll bundle under and include as well.

HOSP CHAIR DEMEHIN: I think it's actually good that you're, you're trying to think broadly about what digital measurement looks like. You know, it's always a balance between being broad enough to be inclusive, but specific enough so that people really know what you mean. But look forward to continuing the conversation about that. I'm glad you're thinking about it.

DR. SCHREIBER: Yeah, thanks. The other thing is that we're obviously partnering with ONC, too, on what digital quality measures

look like and what the capabilities are. So CMS has really been at the leading edge of translating quality measures into FIRE, FIRE API measures. We have standardized data elements for ECQMs. Actually on the CMS website we've worked on standardized elements.

We're building actually the FIRE servers within CMS that can take bulk data around this. So we've been at the leading edge of that.

You can imagine that some years going forward certification may include the necessity of delivering quality measures or collecting quality measures in a way that are interoperable. And so there's a lot of work that translates this interoperability as well.

HOSP CHAIR DEMEHIN: Thank you.

DR. PICKERING: And also -- sorry, Michelle. I also have Janis Orlowski. Janis, do you have a question or a comment?

HOSP MEMBER ORLOWSKI: I do, thank you. Good morning. Hi, Michelle. How are you?

DR. SCHREIBER: Hi, Janis.

HOSP MEMBER ORLOWSKI: You know, I first of all applaud the work that you're doing. And I think that many of these are the key areas.

One of the things that I'd like, I was wondering if you would delve in a little more, give us sort of your thoughts, is the diversity and equity gaps you were talking about.

You know, that we've been for years looking at how we can take a look at our sociodemographics, differences, how they can be measured in order to improve them. And we have recently spent a lot of time looking at equity gaps in quality and safety.

And so I was just wondering what, what direction. I think, and let me just say this, I think unless we come up with a standard, uniform SDS agreed-upon metric that we're all going to be measuring, that we're going to be floundering. And so I was wondering if you could make any comments or give us thoughts about what direction CMS is headed.

Thanks.

DR. SCHREIBER: Yeah, thanks, Janis, for your question. And I think you're right, we don't have clear SES measures, for one. For example, is it food insecurity? Is it transportation? Is it income? Is it race? What is it? I don't think we know. And there's certainly a lot of research that has yet to be done about that.

The things that we're looking at is, one, to start with this confidential feedback so that organizations and providers can at least look at their data. Based on duals, which is what we have, and I have a few slides about something different that I want to share with the group in a few minutes, but based on duals so that because I think step one is ensuring that hospitals in particular, because they're very used to looking at their data, but all facilities, all providers are actually looking at their information, ratified appropriately. And by appropriately I think that's up to the organization, but at least by duals. And as well

as other REL -- race, ethnicity, and language -- information that they may have.

I think there's a challenge at CMS and across the federal government in that we don't have as much information as people may assume that we have. And you know, part of that goes back to a number of years ago when Social Security stopped collecting that data on enrollment. And so we need a standardized way of even collecting the data to make sure that we have it.

Now I know a lot of organizations have it. And a lot of organizations put in a lot of work. I know when I worked at Henry Ford -- and hi to our Henry Ford colleagues -- we put in a tremendous amount of effort in collecting REL data. But I will tell you that CMS doesn't necessarily have that quota. So for us to provide that reporting is actually a little bit more difficult.

So I think A) it's giving people information; B) it's making sure that

organizations are looking at their data and then acting appropriately; and then C) again, we're working with the Office of Minority Health about what might be something like the HES score, the health equity score. Is that one that we can rally around or, frankly, are there others? I think there are broader conversations that we need about this.

HOSP MEMBER ORLOWSKI: Well I appreciate that. And my, you know, final two comments. A number of the larger vendor EHRs are starting to put in some kind of an SDS, you know, program.

DR. SCHREIBER: Yeah.

HOSP MEMBER ORLOWSKI: And that, you know, that's good but, you know, we can't have six of them out there. So you know, if there was some standardization, that would be good.

And the other thing, you know, since you know that I still practice part time, you know, physicians really have never been educated on Z codes. You know, I'm aware of them --

DR. SCHREIBER: Yeah.

HOSP MEMBER ORLOWSKI: -- because I'm the chief healthcare officer at the AAMC, not because I'm a practicing doctor. And I think that if we took a look and said, you know, what are the critical Z codes, you know, if there were two Z codes or three Z codes rather than the multitude that we have.

But as you said, let's take a look at the use of Z codes over, you know, a 6-month or 12-month period of time, educate physicians. I, you know, I could add a Z code to my care. What I can't do is I can't add 20 of them because I just don't understand their importance and, you know, whether we're doing them right.

So those are two, those are sort of two comments that I don't want to get so far ahead that we have all of these un-standard platforms out there.

DR. SCHREIBER: Yeah. It's a good point and you're absolutely right. Matt, what do you think, one more comment and then I'll move to

the next slides?

DR. PICKERING: That's good. Udara, do we have any other hands raised?

DR. PERERA: We do. We have Tejal. Go ahead, Tejal.

HOSP MEMBER GANDHI: Thank you. Michelle, I know you and I have talked about this but, you know, you mentioned the distinction of process measures versus outcome measures. And in this particular area I think that's an important thing to think about because, you know, we've been doing an initiative with over 200 health systems to segment patient experience and workforce engagement data by raising ethnicity at the starting point, and doing work with them to understand the quality of their race and ethnicity data, giving them strategies around improving the quality of that data.

And so I think, you know, when you think about process measures, most organizations, or many organizations, you know, will segment maybe a couple of clinical outcomes like diabetes

or hypertension. And then they sort of, you know, check the box, yes, we've done something here.

So I think sort of moving into process around data quality, making sure they have ways to -- and we can measure that relatively, in a relatively straightforward way -- so starting to push organizations to improve the quality of their data and pushing them to segment more than just those one or two clinical measures, but really across the board on many of their measures.

Like I measured experience engagement because -- many others as well -- that may be a way to try to accelerate progress here with the process measures side.

DR. SCHREIBER: Yep. So thank you. And I've seen a number of ones coming through the chat. So we'll look at -- we'll take all of those into consideration. So thank you.

Since we're speaking of equity, let's go into the next slides, if we may, Matt. And I

wanted to run something by the group and see what you all think of this. So I shared that we really don't have great data on race, ethnicity, and none on language. Next slide, please.

And you can actually see the data. So that when we looked in the National Academy of Medicine in ASPE actually that recommended stratifying data, when we look at providing confidential feedback we have limitations in the accuracy of the demographics. So that you can see the sensitivity and specificity is not bad when it comes to is a patient white or black, it's not perfect.

But when it comes to ethnicity we can see for the Latino/Hispanic population is terrible; Asian Pacific, not great; and American Indian population is even worse. So we have lots of room to go when it comes to making sure we have data that is correct. Next slide.

There are models out there. Many of you I'm sure are familiar with them -- RAND has one, RTI has another one -- where there is an

indirect estimation, in other words you impute race, ethnicity, and language. And you can see that the numbers get much better when you use one of these models.

We also recognize the sensitivity, the political sensitivity of telling people we're going to impute your race or your ethnicity. And really would like to bring forward the concept of using some of these models in providing confidential feedback that CMS would like to be able to share with organizations.

So getting to your -- some of your comments of being able to use more than dual eligibility in confidential feedback, but actually providing further information, how would this group feel about using some of these imputational models? You've seen that the data does get better. NQF and IOM have actually supported this. But we also recognize that we think it's a little bit sensitive to say that we're using imputational models for this as opposed to direct data collection. The next

slide.

So I think I've covered most of this already. But we haven't used this previously in risk-adjusted quality outcome measures. And are considering or at least having conversations about doing this through confidential feedback, and would really like the opinion of the group. So Matt, I will pause it there and you can open it up again.

DR. PERERA: We currently do not have any raised hands. Vilma just raised her hand. Go ahead. You're muted, Vilma.

HOSP MEMBER JOSEPH: Yes, thanks. Okay. Yeah. So I really think you should take more time and ask for direct information as opposed to using indirect estimates. It may be more labor-intensive, and it may seem more invasive, but I think if we allow people to get into the habit of providing the data they will do it like they supply, you know, their date of birth, or their Social Security Number. So I think if we just make it seem that it's expected,

that our patients will provide the data accurately.

DR. SCHREIBER: Thank you. All right. We're coming to a close for this section. Any other last comments that people would like to add something different to the CMS Action Plan, something you'd like to see us do differently, accelerate, not accelerate?

DR. PERERA: Akin has his hand raised.

HOSP CHAIR DEMEHIN: I do. So just reflecting a little bit on the notion of indirect estimation, Michelle, you know, I think I get why the indirect estimation approach has some appeal, because it does take the data that you have and try to leverage it and create a more comprehensive picture.

I do think that there is -- I think that there are some challenges with making some statistical guesses about the race and ethnicity of patients.

DR. SCHREIBER: Yep.

HOSP CHAIR DEMEHIN: And there's

something about it that doesn't sit entirely right. I do know that hospitals have been working through approaches for collecting race and ethnicity data in a more consistent fashion. And I think one of the, one of the challenges that we continue to face is figuring out at what point during care delivery it makes the most sense. How do you leverage patient encounters in the most effective way?

And I would say this applies not to just race and ethnicity, I think it applies to a broad range of social determinative health-related data. I don't have a simple and elegant solution for you at this point. I do think it's a conversation that we need to have as a field.

I think we also have to try to think of ways of getting creative about where we obtain the data. This is going to sound a little off the wall, so take it with a grain of salt. But you know, I do wonder to what extent when we enroll patients in Medicare and Medicare Advantage to what extent any of that data can

work its way into Medicare claims so that we're at least getting it at one point in time.

That may work for some kinds of data but not for others. But really thinking about how we can all work together to make sure that providers are collecting what they should but not more than they should, and that if there are sustained sources of data out there that we're using them to the best effect that we can.

I am really glad that you're looking at this issue because it is a very, very important one.

DR. SCHREIBER: So thank you. And I know that we're coming to time. We will -- obviously there's a larger community. I'll be thinking through this. But these are huge issues that we do have to be addressing.

Let me be very clear when I talk about the indirect estimation, that if we were to do anything it would only be confidential feedback reports to whomever, not public, because we recognize we are far from that. So I don't want

people to think that we're talking about using this in public reporting. It's really -- and it may even just be some pilot projects to say what does it look like and does it make sense?

But I agree with you, Akin, there are, there are things about it. I mean the data obviously looks like it's better, but there are things about it that, I don't know, don't necessarily feel right. So I think we need a lot more work around it. But these are models that are out there. And they're actually being fairly well used.

But we will definitely consider this conversation and continue the conversation. I wanted people to know that we are thinking seriously about it and thinking seriously about how we look at issues of disparities because, first of all, all of us knew this all along but, second of all, the COVID pandemic has certainly highlighted the absolute need for us to be addressing this issue. And we look forward to having the continued conversations.

But with that, I want to thank all of you for participating in this conversation this morning. Again, if you have comments, anything on the CMS Action Plan that you would like to see different or even just engage in the conversation around it, please don't hesitate to reach out to me personally or to any of the staff at CMS. And so many of you work with us at CMS in different ways.

And let me turn this back to NQF to continue the rest of the day, and thank NQF for moderating and for also giving me the opportunity to speak this morning. So thank you, and look forward to the rest of the day.

DR. PICKERING: Thank you very much, Michelle. Again, I do want to iterate that if you have a comment or question, please put it in the chatbox. We definitely will look at that as we -- as we move forward accordingly.

For the next portion of the agenda we're really going to be talking about the overview of the pre-rulemaking approach. And two

of my colleagues will be presenting this, both Janaki Panchal, who is the Manager of Quality Measurement, she's working on the PAC/LTC Workgroup; and also Udara Perera. She is our Senior Manager here at Quality Measurements, and she is working with us on the MAP Hospital Workgroup. So Janaki, you're starting out. I'll turn it over to you.

MS. PANCHAL: Great. Thank you so much, Matt. Hello, everyone. My name is Janaki Pancha, and I'm a manager on PAC/LTC MAP Workgroup here at NQF.

So we'll now take a look at the preliminary analyses of measures under consideration and walk through the preliminary analysis algorithm. Next slide, please. Thank you.

So before we go into the algorithm I want to highlight a few things about the preliminary analysis or the PA. Basically NQF staff conducted preliminary analysis of each measure under consideration. And the goals of

the preliminary analysis is for the NQF staff to flesh out each measure under consideration in some detail, and to create a succinct profile of each measure by really giving a brief rundown of the measure and a preliminary look at how it compares to the evaluation criteria. And the intention really is to facilitate -- help facilitate the MAP Workgroup discussion and serve as a starting point for these discussions.

In order for us to conduct the preliminary analysis, the NQF staff uses an algorithm which we'll look at on the next few slides. And this algorithm was developed from the MAP measure selection criteria to evaluate each measure in light of MAP's previous findings.

This algorithm was approved by the MAP Coordinating Committee, and it is an important aspect of the overall process. Next slide, please.

Looking at the algorithm now, I know there is a lot going on on this slide but we have several key components or criteria of the

preliminary analysis algorithm. Each criterion is listed in the first column in the next three slides.

And the definition of each component is in the middle column which just provides further clarity on what each of these assessment components are looking at. And then the outcome of each component is in the last column here on this slide. I won't read through everything, but we will briefly go over each one here.

So the first assessment criterion is the measure -- is if the measure addresses the critical quality objective are not adequately addressed by the measures the program sets.

And what this really means is listed in the middle column there for your reference. And for the outcome, if we say yes, the measure does meet this criterion, then the review continues. However, if we say no, then the measure will receive a do not support the recommendation as a decision category designation. And we will look at what each of

these decision categories mean in more detail in the next section.

And also MAP may provide a rationale for the decision to not support, or make suggestions on how to improve the MAP measure for a potential future support categorization.

The second criterion here is if the measure is evidence-based and is strongly linked to outcomes or is itself an outcome measure. So for this component, if the measure is a process or structural measure we are really looking to see if the measure has a strong scientific evidence base to demonstrate that when the measure is implemented it can lead to the desired outcomes.

And for an outcome measure we are looking to see if the measure has a scientific evidence base and has a rationale for how the outcome is influenced by health care processes or structures. Similar to the outcome of the previous criterion, if we say yes, then the review continues. If we say no, then the measure

will receive a do not support recommendation. And again, MAP may provide the rationale for the decision to not support or make suggestions on how to improve the measure for a potential future support categorization.

Now the next assessment criterion is if the measure addresses a quality challenge. So if we say yes, then similar to the previous two criteria, the review does continue. And if not, then we do not support the measure for implementation. But again, MAP may provide a rationale for that decision to not support, or make suggestions on how to improve the measure. Next slide please.

So for the next couple of criteria now the algorithm does change a little bit in the sense that we need to see past those first three assessment criteria first. So the fourth criterion is that the measure contributes efficient use of measurement resources and/or supports the alignment of measurement across programs.

If the answer is yes, then the review continues. However, if the answer is no, then the highest rating can be do not support with potential for mitigation. So if the committee does arrive at this decision category, then the committee would outline precisely what the measure developers should do to improve the overall -- to improve the measure overall for future support.

The next criterion is if the measure can be feasibly reported. The outcome is similar to the previous criterion. If it's yes, then the committee continues the review of the measure. And if no, the highest rating is do not support, with potential for mitigation, and again, provide how to potentially mitigate the measure along with any sort of rationale for how they arrived at that decision. Next slide, please.

So the next criterion here is that the measure is applicable to and appropriately specified for the program's intended care settings, levels of analysis, and population.

This generally means that the measure is NQF endorsed, and if it's not NQF endorsed the measure is fully developed and specifications are provided, and the measure testing demonstrates reliability and validity for the level of analysis, program, or settings for what's being considered.

So if the outcome is yes, then the measure can be supported or conditionally supported. If the outcome is no, then the highest rating can be conditional support, and MAP in this instance dictates what those conditions are and suggest how the measure can be improved.

And the last criterion is if the measure is in current use and there haven't been any negative unintended consequence situations, and that burdens don't outweigh the benefits, the outcome of this is that if there's no negative unintended consequences or implementation issues, then the measure can be supported or conditionally supported.

However, if there are implementation issues, then the highest rating should be conditional support and MAP can elect to provide a rationale at this point on how they think those challenges could be overcome, or anything else that the measure developers could do for that.

Before we move on to the next section, I will pause to see if there are any questions on the algorithm?

(No response.)

MS. PANCHAL: Okay. Hearing none, do we have any questions in the chat?

(No response.)

MS. PANCHAL: All right. So we'll move on to the next section now. Next slide, please. So we'll briefly take a look at MAP voting decision categories now. Next slide, please.

Okay. Each measure is assigned a decision category, and MAP workgroups must reach a decision about every measure under consideration. Again, I know there's a lot of information on this slide as well, but we'll

review what each category means and try to link it back to the evaluation criteria that we just looked at.

So as you can see on this slide, there are four decision categories that are listed in the first column on this slide in dark green. The first is support for rulemaking. The second is conditional support for rulemaking. Third is do not support for rulemaking with potential for mitigation. And the last one is do not support for rulemaking.

So the first category, support for rulemaking, means that MAP supports implementation and MAP has not identified any conditions that need to be met prior to implementation.

And then linking this back to our evaluation criteria, what this means is that the measure is fully developed and tested for the setting in which it's going to be applied. And that means that the measure meets the first six evaluation criteria that we saw on the previous

slide.

And if the measure is in current use, then it should also meet the last evaluation criteria which was about unintended consequences and burden.

The second decision category is conditional support for rulemaking. This means that, overall, MAP supports implementation of the measure as specified. However, MAP has identified certain conditions or other modifications that would ideally be addressed prior to implementation.

In terms of our evaluation criteria, what we are saying is that the measure meets the first three evaluation criteria. The designation of this category assumes that one of the criteria between assessments 4 through 7 has not been met. And ideally, those modifications would be made before the measure is proposed for use.

The next decision category is do not support the rulemaking with potential for mitigation. And for this category MAP does not

support implementation of the measure as it's specified, but MAP reviews with the importance of the measure and has suggested material changes to the measure specifications.

For this category, the measure meets the first three evaluation criteria, but the measure can't be supported as currently specified. And a designation of this category assumes that at least one of the criterion from assessments 4 through 7 is not met.

And the last decision category is do not support for rulemaking. And that simply means that MAP does not support the measure. And this is when the measure under consideration doesn't meet at least one or more of the first three measure evaluation categories.

So those are the four MAP decision categories. I will pause once again to see if there are any questions before we move on.

(No response.)

MS. PANCHAL: Hearing none, I'll turn it to Udara who will walk us through the MAP

voting process.

DR. PERERA: Thank you so much, Janaki. Next we'll talk about the voting process that we conduct on MAP. Next slide, please.

One of our key principles is that of quorum. And this is ubiquitous across the National Quality Forum. We require a certain percentage of the workgroup to be present.

For MAP, quorum is defined as 66 percent of the voting members that have to be present virtually for the meeting to commence. So since we're convening completely virtually this year, we need to have 66 percent of the committee present in order for us to be able to take any vote.

So once we establish that quorum is present, that process involves simply taking a roll call or an attendance. So at any given time we can determine if quorum is established at the beginning of the meeting. But if we feel that we've lost quorum, we can do a check before we actually conduct a vote.

So if we don't establish quorum, we'll then vote via an electronic ballot after the meeting. So we'll present a recording of the proceedings and then ask MAP members to vote once we've conducted our business without the vote during the meeting. But I am happy to announce that we do currently meet quorum for this meeting.

MAP has also established a consensus threshold. And that is greater than or equal to 60 percent of voting participants who must vote positively, and that a minimum of 60 percent of the quorum figure has to vote positively.

So one thing that I do want to point out is if for any reason you are conflicted on a measure, we invite you to please recuse yourself. And any abstentions do not count within our denominator. And as I mentioned before, every measure under consideration receives a decision category. Next slide, please.

So here is the stepwise process by which we conduct voting. We have five steps

within our voting procedure. First, our NQF staff will review the preliminary analysis for each measure under consideration using the MAP selection criteria and programmatic objectives.

Next, the co-chair will ask any clarifying questions or concerns from the workgroup, and measure developers will then respond to these clarifying questions or concerns that are related to specifications on the measure. And our NQF staff will respond to clarifying questions and concerns on the preliminary analysis.

For step three we vote on acceptance of the preliminary analysis decision category within the workgroups. So after clarifications have been resolved, the co-chair will then open up the vote on accepting a preliminary analysis assessment.

The vote will be framed as a simple yes or no vote to accept the result. If greater than or equal to 60 percent of the workgroup members vote to accept the preliminary analysis

assessment, then the preliminary analysis assessment will be the workgroup recommendation. But if less than 60 percent of the workgroup votes to accept the preliminary analysis assessment, then we open up the discussion for a full review of the measure. Next slide please.

Step four, that's the discussion and voting on the measure under consideration. First, the lead discussant will review and present their finding. And MAP Rural Health liaisons will add in a summary of their workgroup's discussion.

Then the co-chairs will open the discussion among the workgroup, and workgroup members should participate in the discussion to make their opinions known. However, we just ask that we refrain from repeating any points that have already been presented. There's nothing wrong with agreeing with them and saying that it makes sense, but just in the interests of time we want to keep the discussion moving forward.

And after the discussion is concluded,

the co-chairs will open up a vote on the measure that's under consideration. So co-chairs will summarize the major themes from the discussion, and chairs will determine which decision categories will be put to a vote first, based on where they think that consensus was emerging from the discussion.

Now if the co-chairs don't feel that there was a clear consensus position, then they'll start at the top. So the workgroup will take a vote on each potential decision category that we just went over one by one.

The first vote will be on support and conditional support, then do not support with potential mitigation, and then finally do not support. Next slide, please.

And our last step is tallying the votes. So if a decision category put forward by the co-chairs receives greater than or equal to 60 percent of the votes, the motion will pass and the measure receives that decision category. But if no decision category greater than or equal to

-- greater than 60 percent to overturn the preliminary analysis, then that PA decision will stand.

This will be marked by staff and noted for the Coordinating Committee's consideration in the case of the preliminary analysis standing. And those are our five steps for our voting procedure. I do want to pause here and see if there are any questions on our voting procedures.

DR. ANDERSEN: This is Dan Andersen. I have a question.

DR. PERERA: Go ahead.

DR. ANDERSEN: Yes. Can you say a little bit about -- I know you talked about the discussants providing their preliminary analysis -- but is there some guidance on what, you know, what aspects that includes? Is it a full kind of discussion of their impressions of the measure, from everything to reliability to exclusions, things like that, or is it just a bigger picture than that?

DR. PICKERING: Udara, I can take that

if you'd like. So Dan, this is Matt. Thank you for the question, and it's a great question.

So we are looking for MAP input related to how relevant this measure and how important this measure is for the program it's intended for use. Now with that, hand in hand there's reliability, validity types of testing to consider.

But those types of statistical types of assessments or even reviewing the actual testing itself is really reserved for NQF's consensus development process, which is our standing committees that review these measures, that are looking at those actual qualities of the measure against our evaluation criteria for endorsement.

With this workgroup we're really looking for based on what's been submitted to you all in our preliminary analysis, your review of that and assessment, and also with the public comments that have been received and included in those preliminary analyses, what are your -- what

are your opinions or viewpoints or your stakeholder perspective take on how appropriate this measure is to the program it's being submitted for?

And so there is an assessment of the evidence. There's an assessment of how -- what's the impact, the quality challenge, all of that to be considered.

So if you are having concerns related to testing, for example, if you really looked at this measure related to, you know, some testing around reliability and validity, there may be some different types of voting that you could have, such as conditional voting pending NQF support -- or NQF endorsement, excuse me, for example. And so that would be where the NQF, that measure would go through the NQF process and get evaluated on reliability and validity with our standing committees.

So it's not so much in the weeds, if you will, with reliability and validity testing so much. It's more how aligned is this measure

to the program it's being placed in.

DR. ANDERSEN: All right. That's great. Thank you.

DR. PERERA: Are there any other questions? Hearing none, we will move forward to the next slide please.

We're now going to give a brief overview of the role of the MAP Rural Health Workgroup on the pre-rulemaking process. Next slide please.

The MAP Rural Health Workgroup's charge is to provide a rural perspective on the measures that are under consideration to the other MAP workgroups and committees, and to help address priority rural health issues such as the challenge of low case volume.

And as you heard earlier today, the Rural liaison for the PAC/LTC Workgroup is Brock Slabach from the National Rural Health Association. And the Rural liaison for the Hospital Workgroup is Jesse Spencer from Intermountain Healthcare. Next slide please.

The Rural Health Workgroup reviews the measures under consideration and provides input to all three of the setting-specific workgroups. With the release of the MUC list we sent out the preliminary analyses for the measures for your review. The analyses were developed by our NQF staff, and they're intended to provide a succinct profile of each measure and to serve as a starting point for the discussions.

The Rural Health Workgroup also received these preliminary analyses, and they were able to provide us with input on the relative priority or utility of the measure under consideration in terms of access, cost, or quality issues that are encountered by rural residents.

They also provided input on data collection and/or reporting challenges for rural providers, in addition to any methodological problems of calculating performance for these smaller rural facilities. They also provided input on any potential unintended consequences of

inclusion within these specific programs, as well as gap areas in measurement that are relevant to both rural residents and rural providers for these specific programs. Next slide please.

The Rural Health Workgroup feedback for these setting-specific meetings will be provided to the relevant workgroups for their consideration today during the discussion and voting on the measures under consideration. A qualitative summary of the discussion that the Rural Health Workgroup had for each measure, as well as the quantitative result of the Rural Health Workgroup voting results are included in the measure preliminary analyses.

And we also have a Rural Health Liaison for each of these setting-specific meetings in order to try and summarize the discussions as well. I'd now like to pause for any questions on the Rural Health Workgroup.

(No response.)

DR. PERERA: And hearing none, I would now like to turn it over to -- did we have a

question on the phone?

MS. WINSPER: That's me, Udara. Sheri. That's my phone number.

DR. PERERA: Perfect timing, Sheri. I'd now like to turn it over to Sheri Winsper of NQF to provide some comments on the COVID-19 measures.

MS. WINSPER: Thank you, Udara. You did a really great job on presenting an overview of our process and helping everyone to answer their questions or follow through on that. So thank you.

We, as an organization, the National Quality Forum wanted to just be sure that we provide a little bit of perspective, or our perspective on the COVID-19 vaccine measures. And so my remarks will be brief, and then we'll turn it over to the CDC and CMS as well to provide a presentation as well.

Many of you may note, and we'll see in our preliminary analysis of these measures, that the preliminary analysis recommendation is a do

not support with potential for mitigation. And I just wanted to clarify NQF's perspective from two different issues when it comes to vaccines and then this measure.

We wanted to make sure that we really did maintain the integrity of the MAP selection criteria analysis and the algorithm that Udara just went over. And so we know that the specifications that currently are available for the COVID vaccine measure aren't quite as complete as I know our colleagues at HHS have wanted them to be quite, quite yet, but they will explain quite a bit of that.

We want to make it very clear though that the National Quality Forum fully supports as an organization the vaccinations, and particularly in this case, for the prevention of illnesses such as COVID-19, but that our selection criteria and algorithm at the moment resulted in that particular -- that particular recommendation.

The support of vaccines though is a

very different issue than what we're asking this group to do today, which is to provide feedback on whether this measure is the best way to measure the administration of the COVID vaccines and whether it's healthcare personnel or patients.

So evaluating a measure and the specifications or the preliminary analysis is different than our support of vaccine administration.

So just wanted to make sure that we clarified that and that just because it says do not support it does not in any way mean that National Quality Forum does not support vaccines. And a reminder that with potential for mitigation means that we also know that those specifications can be improved upon and provided in more detail.

So I don't know, Michelle, if you wanted to speak to this or if I'll just turn this over to Dan I believe.

DR. SCHREIBER: Thank you, Sheri. I'll pick it up please. If we can go to the next

slide.

MS. WINSPER: Okay.

DR. SCHREIBER: Thank you.

MS. WINSPER: Sure.

DR. SCHREIBER: So we first of all absolutely recognize that NQF supports COVID vaccination. But what we are bringing forward to you are supposed measures that, quite honestly, aren't fully fleshed out at the moment because we don't have the data, because this is all very new.

But we felt that it was important to bring these concepts in what measure specifications we do have to this group so that we can be thinking about using it in rule writing.

Now just to be clear with everybody, rule writing or putting these measures into place would not occur until 2022, likely at the earliest. And what we know about vaccination, what we know about COVID will certainly change in that time. But we wanted to bring forward COVID

vaccination to you to think about.

And you will see in subsequent slides we're asking you to consider two different types of measures. The first one will be for healthcare personnel vaccinations. And that will cover a broad range of the continuum of care.

And second, patient vaccinations which will be specific to ESRD and to the MIPS program. It is not in the nursing home program. And you might say well why not? That's possibly the most important one. And it has to do with the authority for data collection. So data is certainly being collected and will be looked at.

So I'm going to turn this over then to our colleagues at the CDC. Dan, thank you so much for being on the line. And then I may have a couple more comments, and Alan Levitt will lead the presentation from the CMS point of view. So Dan, thank you.

DR. PICKERING: Dan, are you there? You might be on mute.

DR. SCHREIBER: I knew that they were

on.

MS. WINSPER: I see Dan, but you can't hear him.

DR. SCHREIBER: I don't know, is there any other -- is there anyone else from CDC that wants to speak to this? Or we can -- probably between Alan and I can start this.

DR. BUDNITZ: Can you hear me now?

DR. SCHREIBER: There we go. Yes, Dan, thank you.

DR. BUDNITZ: I apologize for the delay. Thank you very much, Michelle. In the next 20 minutes or so, I'll be introducing the National Healthcare Safety Network, or NHSN, COVID-19 vaccination tracking modules that we released just three weeks ago.

This is the work of a whole team of CDC's Division of Healthcare Quality Promotion which operates NHSN, in collaboration with CDC subject matter experts, particularly Dr. Suchita Patel and Megan Lindley, CDC Immunization Services Division. Let's have the next slide.

Sorry. Next slide.

Let me start by very briefly reviewing current data on the burden of COVID-19. When we had to submit slides for this meeting at the end of December, we had a cumulative total of 18.9 million cases of COVID-19. But just as of this weekend, we now count over 22 million cases of COVID.

Similarly, the average number of cases per day has increased from 57,000 per 100,000 population per day to 74,000 -- I'm sorry, 74 cases per 100,000 population as of this weekend. And the total number of COVID-19 deaths has increased from over 331,000 to over 371,000 deaths as of this weekend.

Now something that has not changed is the age distribution of these deaths, with 80 percent of deaths occurring in patients 65 or older. Next slide.

And as you know, with just a level set there are two mRNA-based vaccines currently authorized for use in the U.S. Of note, these

vaccines are not approved by FDA, but rather authorized for emergency use. We have additional vaccines in Phase 3 trials. The application for authorizations for use of these vaccines are expected in this year.

Vaccination requires two doses of these currently-authorized vaccines, recommended to be administered 21 days apart for Pfizer-BioNTech vaccines, and 28 days apart for the Moderna-manufactured vaccine. Among the vaccines in Phase 3 trials, there is at least one that requires only a single dose.

The Pfizer vaccine is authorized for patients 16 years of age and older. And the Moderna vaccine is authorized for patients 18 and older. Next slide.

Now CDC's Advisory Committee for Immunization Practices is recommending phased allocation of vaccines due to current supply distribution and administration limitations. We see here these four phases are recommended.

In phase one, it's recommended for

healthcare personnel and long-term care residents. That's phase 1A. Phase 1B, front line essential workers, and persons 75 years or older. Phase 1C, persons 64 to 75 -- to 74 years, and others.

Although it's important to know that local jurisdictions, states, and their health departments may adjust these recommendations for their jurisdiction. For example, the state of Georgia is now opening up vaccination eligibility to persons 65 to 74 and not other groups in phase 1C. Next slide.

Now as with COVID-19 case counts, vaccinations are changing daily. As of January 8th, CDC now reports over 22 million doses of vaccine have been distributed to jurisdictions, and nearly 6.7 million, up from the 1.9 million listed here, people who have been vaccinated with the first dose.

And you may be familiar with the Federal Pharmacy Partnership Program for vaccinating long-term care residents. And

through this program there have been over 4 million doses of vaccine distributed, and nearly 700,000 persons in LTCFs vaccinated.

Now the majority of folks vaccinated by the Pharmacy Partnership Program are long-term care residents. But long-term care facility workers also can be eligible for vaccination through this program. And that brings me to the next slide, which has some key points and why vaccination coverage to healthcare personnel matters.

First, vaccination can prevent healthcare personnel from acquiring diseases themselves from patients, because when healthcare personnel fall ill, their absence from work can result in disruptions of care for patients.

Also, vaccination of healthcare personnel can prevent outbreaks of disease among patients in healthcare settings, or residents in long-term care facilities. We have much evidence of nosocomial transmission and outbreaks of measles, mumps, rubella, influenza, and

pertussis.

And finally, provider recommendations for vaccination -- I'm sorry. Provider vaccination is a predictor for vaccine uptake of patients in all ages. Next slide.

Here's some data on the burden of COVID among healthcare personnel. And as we have seen before, these numbers continue to increase. As of yesterday, CDC now reports over 352,000 cases among healthcare personnel, and 1,210 deaths among healthcare personnel. Next slide.

Now there is precedent for tracking healthcare personnel vaccinations as a quality of care measure. NQF 0431 measures influenza vaccination in healthcare personnel. This was first endorsed in 2012.

The denominator used for this measure is all healthcare personnel who physically work in a facility for at least one day of the flu season between October 1st and March 31st. The numerator for this measure is the number of healthcare personnel in the denominator who are

vaccinated at this facility or elsewhere, plus the number of contraindications and the number who decline vaccination.

NQF 0431 is reported annually via CDC's NHSN program by over 5,000 facilities participating in CMS' Hospital Inpatient Quality Reporting Program, LTCH Hospital Quality Reporting Program, and Inpatient Rehabilitation Facility Quality Reporting Program.

NQF 0431 was formally utilized in reporting programs for ambulatory surgery centers, outpatient dialysis facilities, and inpatient psychiatric facilities. Next slide.

I'd like to review a few points about NHSN for folks that may not be as familiar with the system. It's a web-based system for monitoring healthcare-associated adverse events, healthcare worker vaccinations, and other prevention practices. It's been in operation in its current form since 2005. At the time it replaced several predecessor CDC systems that had been used since the 1970s. It includes over

37,000 participating facilities in all 50 states.

Once data are entered, they are available in realtime. Available for facility level, clinical performance measurement, improvement by facilities themselves, and networks of facilities. The data are also used by state health departments and CDC health surveillance for prevention activity. And the data are used for public reporting of facility-specific data, as in the case for NQF 0431. Next slide.

Here is just a table of the key facility types and the number of facilities that are enrolled in NHNS. Among the long-term care facilities are included 15,400 SNPs. Next slide.

So that, that background gives some details about the COVID-19 vaccination coverage modules, which were initiated just the third week of December of last year. Next slide.

Now the NHSN COVID-19 vaccination modules were created to collect weekly facility-level vaccination coverage among initial priority

groups for vaccination. We've seen these are healthcare personnel, residents of long-term care facilities, and finally patients cared for by outpatient dialysis facilities. And this module is not yet available but is planned to be introduced early this year.

Individual health care personnel or patient data are not being reported. Instead it's the cumulative number of healthcare personnel or patients who've received COVID-19 vaccination by vaccine type, currently Pfizer or Moderna, and dose, first or second, whether either at this facility or elsewhere. Next slide.

And the purpose for collecting these data at this time is to address a current public health need to track the progress of facility-level vaccination coverage. These data can be used by jurisdictions to target and address areas of low vaccine coverage, and to assist federal planning by preparing vaccine coverage in participating facilities for vaccine

distribution.

But a key point is that currently these modules are optional. So while CDC encourages jurisdictions to promote the use of these modules through reporting, as of today it's currently voluntary. Next slide.

To give an overview of key aspects of the healthcare personnel modules. As I mentioned, the frequency is weekly reporting. The denominator question is the number of healthcare personnel currently eligible to work for at least one day during the reporting week, similar to the influenza NQF measure talked about earlier.

And for the numerator, although facilities report data weekly, they are not reporting incident vaccinations, but rather the cumulative number of healthcare personnel or patients vaccinated to that date. And again, similar to the influenza measure, cumulative vaccinations over the season.

Facilities can submit vaccination by

several categories of healthcare personnel. But submitting by these categories is optional. It is required to report the number of healthcare personnel with contraindications to vaccination, but it's optional to report other variables of interest such as healthcare personnel who decline vaccination, unknown status of vaccination, and documented history of SARS-CoV-2 infection.

Here's some additional questions about vaccine availability at the facility and incidence of adverse events. Next slide. Finally, I'll show some slides that represent the data collection modules themselves.

Facilities enter their total number of healthcare personnel on a screen shown here. And they subset this number based on the category of worker. These worker categories are based on NHSN's COVID-19 staffing module from earlier last year. Next slide.

For a long-term care facility, the worker categories are a little bit different than for other facilities. These healthcare personnel

categories are based on the influenza vaccination modules. Again, reporting by these categories is optional, but the total is required. Next slide.

On this screen we show the data collection to distinguish the first and second doses of vaccination. Here you see the Pfizer-BioNTech vaccine selected. Additional vaccines can be added as they are authorized for use.

Again, the total number of healthcare personnel vaccinated is required, but categorization is optional. Next slide. And the data collection for the other conditions mentioned: contraindications, declinations, history of previous COVID-19 vaccine. Next slide.

And finally, I mentioned there are questions about vaccine supply, which is not directly relevant to the discussion today, but were designed to supplement our other vaccine supply tracking systems. And next slide.

And finally, a question about adverse events. It's really designed to encourage

reporting to VAERS -- the Vaccine Adverse Event Reporting System -- but also it provides a measure of incidence of adverse events in that facility.

Next slide. And so that ends this presentation. But I think others will continue to talk about the specific NQF measures we discussed today.

DR. LEVITT: Okay. Thank you, Dan.

This is Alan Levitt. Can we move ahead a couple of slides to -- perfect. Okay. Thank you once again.

I'm Alan Levitt. For those who don't know me, I'm the Medical Officer in the Division of Chronic and Post-Acute Care at CMS. And for the next few minutes, I'm going to give you an overview of the quality measures we've developed in collaboration with Dan and our NHSN colleagues regarding COVID-19 vaccination.

And that's MUC20-0044, SARS-CoV-2 vaccination coverage among healthcare personnel, which is under consideration for multiple

settings and CMS programs, and MUC20-0048, SARS-CoV-2 vaccination coverage for patients in ESRD facilities, which is under consideration for the end-stage renal disease, or ESRD QIP.

As we continue to meet the challenges of the COVID-19 pandemic, there are some important lessons we have learned so far, including the importance of our public-private partnership, a partnership best represented by the work we do here together at the MAP, work that I've now had the honor to be the CMS representative for the PAC/LTC Workgroup for now my eighth year.

As I mentioned to the Rural Health Workgroup last Wednesday, that's why we're here presenting these COVID-19 vaccination measures to you, to present and discuss measures under consideration that under normal circumstances we would likely not be proposing at this level of uncertainty. But this past year has been far from normal circumstances.

And so I wanted to thank the NQF staff

once again for their understanding and allowing us to present these measures today. And we understand their perspective in their preliminary analysis of these measures.

And thank you, Sheri, once again for that explanation.

Can we go to the next slide, please?

The first measure I'll be discussing today is MUC20-0044, which is SARS-CoV-2 vaccination coverage among healthcare personnel. When we first started considering with our NHSN colleagues approaches to publicly reporting COVID-19 vaccination data this past spring, we recognized that there would likely be evolving recommendations of vaccine administration, such as contraindications leading to exclusions for vaccination, frequency and timing of an initial vaccination, and ultimately the frequency of re-vaccination to remain COVID-free.

First and foremost, we should all be enormously thankful for the ingenuity of our scientists, who developed in record time

remarkably safe and efficacious vaccines. As I mentioned last week, the data on efficacy and safety of the COVID-19 vaccines are beyond what I think even the most optimistic vaccine proponents could have ever expected.

However, we are dealing with managing a pandemic in real time, and recommendations regarding vaccine administration will likely evolve. And so, in collaboration with our NHSN colleagues, we developed a healthcare personnel COVID-19 vaccination measure that would allow for flexibilities in vaccine administration. The result of this measure is a measure of healthcare personnel vaccination coverage for your review today.

Next slide, please.

The NHSN is the measure steward because they have successfully done these healthcare personnel vaccination measures before. As Dr. Budnitz just noted in his presentation, this measure is NQF0431, influenza vaccination coverage among healthcare personnel.

We built on that success, as our NHSN colleagues were able to develop data collection forms in their modules similar to those used in this measure, but would also allow for any necessary flexibilities based on changes in vaccination requirements and administration over time as our rollout proceeds.

Next slide.

Next slide is an example of how 0431, the healthcare personnel flu vaccination measure, gets currently publicly reported on our Care Compare websites. This is an example from the inpatient rehab facilities. You can see a comparison of staff flu vaccination rates over a flu season for three different facilities.

Go to the next slide.

The next slide lists the federal programs by workgroup that you will be considering MUC20-0044 for this afternoon for this coming rulemaking season. So, starting at 1:00 p.m., you will be discussing these measures for these six federal programs in the Hospital

Workgroup. And for those of you in the PAC/LTC Workgroup with me, we will be discussing the measure for the three federal programs listed here.

Go to the next slide.

The next slide describes the numerator and denominator for these measures. The numerator is based on the data collected on the forms described by Dr. Budnitz earlier and allows for the flexibilities as we continue to learn more about how to successfully and safely vaccinate healthcare personnel.

But in summary, we will be reporting the percent of the eligible healthcare personnel working in that setting who are up to date with the current COVID-19 vaccination requirements, whatever up to date might mean in the future.

Next slide.

The measure will exclude those healthcare personnel with contraindications to the vaccination, which will hopefully remain very few. If adopted into our programs, the measure

would be initially calculated on a quarterly basis by the NHSN for public reporting on our CMS Compare websites for that applicable healthcare setting.

I do want to note that the reporting of data for the purposes of the necessary surveillance of vaccination efforts may be at a greater frequency, especially initially during this rollout period. But for the purposes of the calculation of these quality measures for the CMS programs, it would initially be calculated on a quarterly basis by the NHSN for the public reporting on these websites.

And as a reminder, as Dr. Schreiber already mentioned, if these measures do get promoted and finalized in rulemaking, it would likely be publicly reported -- we'd be looking at the earliest by this time next year.

Let's go to the next slide.

This next measure under consideration is MUC20-0048, which is SARS-CoV-2 vaccination coverage for patients in end-stage renal disease

facilities. This measure is being considered for the ESRD QIP and, once again, would be stewarded by and collected through the NHSN. As noted in the measure description, this measure would track up-to-date COVID-19 vaccination coverage of ESRD patients.

Next slide.

Similar to the healthcare personnel COVID-19 vaccination measure, numerator allows for the flexibilities as we continue to learn more about how to successfully and safely vaccinate ESRD patients.

Next slide.

Exclusions for this measure would be similar to the healthcare personnel vaccination measure and will hopefully be minimal. If adopted in the ESRD QIP, this measure would be initially calculated on a quarterly basis.

Finally, I'm going off the topic regarding these measures just to make a personal comment. It's not an official comment, official CMS comment. But it's a personal comment on the

hesitancy we have heard about in the news reports about healthcare personnel who are delaying to receive COVID-19 vaccination that you may have experienced in your own roles as leaders in healthcare.

For almost a year now, we've been in, as was noted earlier, a national crisis, a war against a worldwide viral pandemic, a pandemic that has affected our lives, the lives of those we love, the lives of our patients that we care so much about, as well as our livelihood. We've had and continue to have, as Dr. Budnitz has pointed out, far too many casualties in this pandemic.

But we are not just civilians who are helpless and are at risk here, but we are also soldiers who have weapons that can fight and eradicate this virus and help us win this war against COVID-19. So, please, let's all use these weapons at our disposal, whether it's wearing masks, PPE, practicing social distancing, or now that we have safe and effective vaccines,

when it's your turn, please get vaccinated as well as encourage others around you to get vaccinated, for yourselves, for all of those you love, including your patients, and for our country.

Now I'll turn it back to Sheri and the NQF staff for questions and comments. But also note that you'll have time to ask questions and comments on these measures and each of the federal programs this afternoon. Thank you.

DR. PICKERING: Thank you, Alan. Thank you, Michelle. And thank you, Dan, for the presentation.

We'll now open it up for questions. And, as well, you can use the raise hand feature.

DR. PERERA: We have a question from Aaron.

PAC/LTC MEMBER TRIPP: Good morning, or I guess good afternoon for some of us. One question that stands out that I'm sure we can talk about when we break into separate groups this afternoon but I wanted to raise with

everybody -- putting aside that they're not in NHSN, one of the provider categories that is represented here today is home health, who also are included in the priority for healthcare personnel.

I wonder what thoughts CDC and CMS have given to how do we track the home health worker vaccination?

DR. LEVITT: First of all, Aaron, thank you. Thank you for that comment. And the inclusion or exclusion of any healthcare settings from the measures that were chosen is absolutely no reflection on the importance of vaccination of healthcare staff within that particular setting.

One of the other important lessons I think we've learned here as well is, besides the importance of the partnership that we have here, is also the operationalizing of what we're trying to do and thinking early about things and what we can accomplish and what may be barriers to accomplishing such things.

And so when we've taken into account,

really, what settings to initially include in terms of this vaccination measure, we've taken into account such things as enrollment within the NHSN itself and the burden that may be in terms of either enrolling a healthcare setting or the burden on even our NHSN colleagues in terms of getting the setting in particular enrolled.

That doesn't change the importance of vaccination. It doesn't change the importance of getting data collected on it. It's really just a matter of, in terms of these measures that we're initially first looking at is, where can we definitely be successful in this initial step while continuing to work with all the other settings in terms of looking towards being able to successfully publicly report such data, including healthcare personnel vaccination measures for home health or for other healthcare settings, or even looking at things such as flu vaccination and where healthcare personnel flu vaccination measures may be most important?

And, again, please don't take this as

a message that vaccination in that setting is not important.

DR. PERERA: Thank you so much.

Next we have a question from Janis.

HOSP MEMBER ORLOWSKI: Thanks very much for the information, and I have a couple of questions. And I, like you, would like to start off by acknowledging the importance of the vaccination and the importance of rolling out as quickly as possible the COVID-19 vaccines.

I have a couple of questions. One is that, as you take a look at what institutions have to put in for their denominator, my understanding is that that denominator could change because not all employees are eligible, and even if they are within a certain category, say in a nursing category, if they're in administration, they're not patient-facing; they are not eligible for the vaccine right now.

So there is a number of issues with what I would say is a changing denominator as the vaccine rolls out. The second thing is, my

question is about the portal that's being used. Hospitals have been strongly instructed over the last couple of months that the HHS portal would be the portal that would be used for all of our daily requirements and reporting. And I see that you're using the NHSN portal in this, and I was wondering if you could comment about that.

And then, third, again, even though this is a critical vaccine and I in fact have received it and intend to receive my second in a very short period of time, it still remains under an EUA. And an EUA is different than being FDA approved. And I think that that has -- that particular factor has really had many healthcare institutions pause as to making the vaccine mandatory for employees.

And so those are sort of my three questions. Happy to stop now to hear your thoughts.

DR. SCHREIBER: So, Janis, this is Michelle. I'll start with a couple of them.

One is the data collection with the

HHS versus the NHSN, and we recognize that there could be potential challenges, but we don't think so because we are at least going to try hard to make sure that if the data is in a different area than NHSN that we can make sure that they communicate. So thank you for raising that.

The second one is the question of the EUA. And actually, to your first question, too, recall that we're bringing this forward now for consideration for a measure that probably won't be in effect until 2022. And we recognize that those numerator and denominators -- we kind of wrote it broadly for eligible people to have gotten the vaccines, the correct series of vaccines.

In other words, we're trying to leave this with some flexibility to be able to better define that as we continue writing measure specifications. There's nothing in this that says there is a mandate for vaccination, although I think all of us would like to think that it is highly important to get vaccinated, and certainly

the percentage of healthcare workers that are vaccinated, as well as patients, is clearly important. But none of this implies a mandate.

On the other hand, we think it is absolutely essential to be tracking vaccination for, certainly, healthcare personnel and ultimately for all patients. We couldn't do it in the means we had available to us right now, but we would envision over time that we will do this in a more widespread fashion. So we are bringing this for comment now, recognizing that some things may change.

HOSP MEMBER ORLOWSKI: And I think, probably to the last point, is I don't think that we have any information right now on whether this is going to need to be an annual or triannual or whatever. We still don't have sufficient information on how long an individual will remain with certain, I guess, antibodies or antibody recall, so that it might be a one-and-done shot and you come back in ten years, or you might come back annually. So --

DR. SCHREIBER: And, God willing, we hope that's true.

HOSP MEMBER ORLOWSKI: Yeah. But a lot of moving parts here.

DR. SCHREIBER: Dan or Alan, did you want to make any comments on HHS versus NHSN reporting?

Okay.

DR. PERERA: Okay. We do have three other questions that are in the queue. The first is from Tejal.

HOSP MEMBER GANDHI: Hey there. So my question -- and I totally appreciate that these are very early days for these measures. But as you're thinking about your planning as you go forward, how are you anticipating trying to bring an equity lens to these particular measures?

Particularly when I think about the healthcare workforce, for example, we have survey data showing that there's very different attitudes towards taking the vaccine across job types. And I think, as mentioned, that those are

optional fields in NHSN, but I'm thinking that that's going to be an important thing to follow to then try to do quality improvement to narrow some of those gaps on the workforce side, and I'm sure on the patient side, as well, we would be seeing those kinds of gaps.

So just curious what your thoughts are on that front.

DR. SCHREIBER: I mean, I think from our point of view, this is the opportunity to, again, stratify the data to be looking at that. We encourage every organization to be doing that.

Dan or Alan, I don't know if you want to comment from an NHSN point of view, if you guys are looking at this data stratified for equity.

DR. BUDNITZ: So yes. Thank you. Thank you for the question.

While our initial emphasis had been on getting total vaccination data and these additional data elements were made optional initially, data elements can be made required in

the future as we ensure that data collection is continuing and if it may become -- the whole form might become required in the future.

So these optional and required data elements can be altered in the coming year or years.

DR. PERERA: We have a question from Akin.

HOSP CHAIR DEMEHIN: Thanks. And thanks, Dan and Alan and Michelle, for the introductory comments.

Just a clarifying question. This employee vaccination measure is proposed for both the inpatient and outpatient quality reporting programs. There will be a subset of employees who work in both inpatient and ambulatory spaces. How are you thinking about the reporting of the data for those employees that might overlap? I know that this issue has been one that's come up with respect to the flu vaccination measure over time. So can you talk a little bit about how that would be handled?

DR. SCHREIBER: I think at this point in time they're counted in whatever facility, so the facility is providing the report. So, for example, in the flu vaccination, it's anybody who has worked in your facility for at least one day in that year. If you worked in three different facilities, each facility would be able to list you as having been there and gotten credit for the fact that you had a flu vaccination. I think the same thing would hold true here for COVID.

Dan, I'll ask you to confirm.

DR. BUDNITZ: Yes. Thank you, Michelle. That is our thinking. And the goal of these facility-based vaccination modules is to gauge the protection of the fellow workers and the residents or patients at the facility. So, while it might appear to be, quote, double-counting having that same worker who works in multiple facilities being counted in each facility, it's to assess the coverage and protection in that facility.

HOSP CHAIR DEMEHIN: So, in other

words, you might have to count that same employee multiple times in the denominator, but you can also claim credit for them in the numerator.

DR. BUDNITZ: Yes.

HOSP CHAIR DEMEHIN: Okay. That helps. Thank you.

DR. SCHREIBER: I think, Udara, maybe one more question?

DR. PERERA: The next question is from Mike.

HOSP MEMBER WOODRUFF: Well, I'd echo the comments of gratitude for the proactive approach on this very important topic. I just wanted to get a little clarification on the time frame for reporting. I think if I read correctly, weekly reporting of a denominator can certainly be a significant burden of reporting. And thoughts on weekly versus a longer time frame of reporting?

DR. SCHREIBER: From the program point of view, it will be quarterly reporting. But from the having to report COVID vaccine data to

NHSN or, frankly, HHS or wherever it is going to mandate being reported, Dan, I will ask you.

But I think that, certainly, as the vaccine rolls out, there is the absolute desire to have data that's very timely. Quarterly wouldn't be acceptable.

Dan, do you want to comment?

DR. BUDNITZ: Yes. Thank you.

So, as you saw with numbers in the pandemic advancing and changing so quickly, we thought it's important to collect data weekly initially. But, again, that may change in the future. And also, for reporting, that could change to be just based on a quarterly report of the denominator and a cumulative count of vaccination over the quarter if that's the interval for the numerator as well.

HOSP MEMBER WOODRUFF: Great. Thank you.

DR. PICKERING: Well, this is Matt. Thank you, Dr. Schreiber, Alan, Dan, once again for the presentation and for the question-and-

answer session. And thank you to the workgroup members for your participation and questions with this.

I will state that as we break off this afternoon, there will be some additional -- there will be some individuals who will be participating from CDC during those portions of the measure evaluations. So there will be some opportunity to potentially pursue further questions or clarification if needed.

I do want to recognize it's 12:30, so we will be breaking for lunch and reconvening back in our separate workgroup meetings at 1:00 p.m. If you look into the chat box, what you'll find is that there are now being posted two separate links for the workgroups, one for Hospital, one for PAC/LTC. So keep an eye on that as well. So those will be the links you'll use to come back to the 1:00 p.m. separate individual workgroup.

And, with that, we will go ahead and --

DR. SCHREIBER: Hey, Matt? I'm sorry.

DR. PICKERING: Yes.

DR. SCHREIBER: Can I make one last comment?

DR. PICKERING: Yes. Please.

DR. SCHREIBER: So this is Michelle from CMS. I just want to thank the post-acute care team. I won't be on your call this afternoon because I'll be with the Hospital team. So, Sean and Akin, you're still stuck with me.

But for the post-acute care team, Alan Levitt will be leading from CMS's point of view, and he obviously is a tremendous expert in this area. But I wanted to just take a moment to thank all of the members of the PAC team, and thank you for your continued participation.

So thank you, Matt. Sorry to have interrupted.

DR. PICKERING: Oh, it's not a problem. It's not a problem. I will go ahead and just mention again that you'll have those links that's provided in the chat available to

you. And also, if you could dial in just a few minutes early, again, just to make sure that everything is up and running and you're good to go so that we can sort of kick off right at the top of the hour.

But thank you all very much for the morning sessions. The joint session will be breaking away, and we will be reconvening at 1:00. But please try to log in just a little bit earlier. Thank you all.

(Whereupon, the above-entitled matter went off the record at 12:32 p.m.)

A

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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: Joint Meeting of Measure Applications Partnership Hospital Workgroup and PAC/LTC WGs

Before: National Quality Forum

Date: 01-11-21

Place: Video Teleconference

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