NATIONAL QUALITY FORUM

Agenda

MAP Post-Acute Care and Long-Term Care Workgroup Web Meeting
February 9, 2015| 3:30 – 5:30 pm ET

Participant Instructions:

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Meeting Objectives:

- Orientation to MAP Off-Cycle Review Process
- Overview of the IMPACT Act Reporting Requirements
- Clarify the CMS Approach to Standardizing Measures under the IMPACT Act
- Review measures under consideration

3:30 pm **Welcome, Introductions, and Review of Meeting Objectives**
Carol Raphael, Workgroup Chair
Reva Winkler, Senior Director, NQF

3:40 pm **MAP Off-Cycle Review Approach**
Erin O'Rourke, Project Manager, NQF

3:45 pm **IMPACT Act Reporting Requirements**
Reva Winkler
Carol Raphael
Mitra Ghazinour, Project Manager, NQF

3:55 pm **Relationship of the CARE Tool and Existing Instruments**
Stace Mandl, CMS
Tara McMullen, CMS
Carol Raphael

4:05 pm	**Input on Measures Under Consideration**
5:15 pm	**Opportunity for Public Comment**
5:25 pm	**Next Steps** *Carol Raphael*
5:30 pm	**Adjourn**

Measure Applications Partnership

PAC/LTC Workgroup Web Meeting

February 9, 2015

NATIONAL QUALITY FORUM

Meeting Objectives

- Orientation to MAP Off-Cycle Review Process
- Overview of the IMPACT Act Reporting Requirements
- Clarify the CMS Approach to Standardizing Measures Under the IMPACT Act
- Review measures under consideration

MAP Post-Acute Care/Long-Term Care Workgroup Membership

Workgroup Chair: Carol Raphael, MPA

Organizational Members

Aetna	Joseph Agostini, MD
American Medical Rehabilitation Providers Association	Suzanne Snyder Kauserud, PT
American Occupational Therapy Association	Pamela Roberts, PhD, OTR/L, SCRES, CPHQ, FAOTA
American Physical Therapy Association	Roger Herr, PT, MPA, COS-C
American Society of Consultant Pharmacists	Jennifer Thomas, PharmD
Caregiver Action Network	Lisa Winstel
Johns Hopkins University School of Medicine	Bruce Leff, MD
Kidney Care Partners	Allen Nissenson, MD, FACP, FASN, FNKF
Kindred Healthcare	Sean Muldoon, MD
National Consumer Voice for Quality Long-Term Care	Robyn Grant, MSW
National Hospice and Palliative Care Organization	Carol Spence, PhD
National Pressure Ulcer Advisory Panel	Arthur Stone, MD
National Transitions of Care Coalition	James Lett, II, MD, CMD
Providence Health & Services	Dianna Reely
Visiting Nurses Association of America	Margaret Terry, PhD, RN

MAP Post-Acute Care/Long-Term Care Workgroup Membership

Subject Matter Experts

Louis Diamond, MBChB, FCP(SA), FACP, FHIMSS
Gerri Lamb, PhD
Marc Leib, MD, JD
Debra Saliba, MD, MPH
Thomas von Sternberg, MD

Federal Government Members

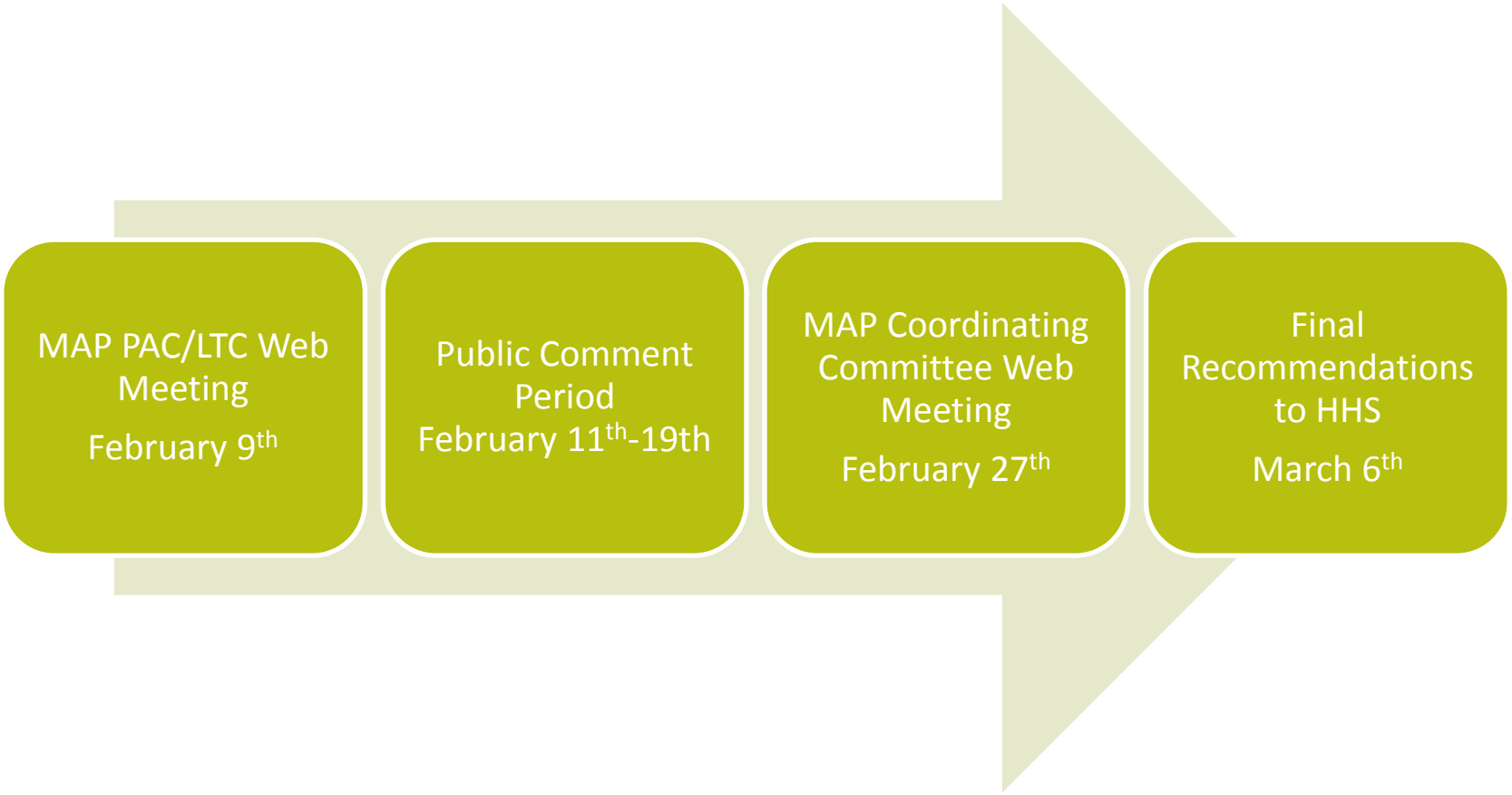
Centers for Medicare & Medicaid Services (CMS)	Alan Levitt, MD
Office of the National Coordinator for Health Information Technology (ONC)	Elizabeth Palena Hall, MIS, MBA, RN
Substance Abuse and Mental Health Services Administration (SAMHSA)	Lisa C. Patton, PhD

MAP Off-Cycle Review Approach

MAP Off-Cycle Review Approach

- In exceptional circumstances, HHS may ask MAP to perform "off-cycle" reviews of measures outside of the annual pre-rulemaking process.
  - These reviews are on expedited timelines and must be accomplished within a 30 day period.
- HHS has requested that MAP perform an off-cycle review of four measures under consideration to implement provisions of the IMPACT Act of 2014.
- Off Cycle Review Process:
  - February 9: PAC/LTC Workgroup Meets
  - February 11-19: Public Comment Period
  - February 27: Coordinating Committee Meetings
  - March 6: Final Recommendations due to HHS

MAP Off-Cycle Review Approach General Timeline



IMPACT Act of 2014

IMPACT Act of 2014

- Currently, patients can receive post-acute care from four different settings:
  - Skilled nursing facilities (SNFs)
  - Inpatient rehabilitation facilities (IRFs)
  - Long-term care hospitals (LTCHs)
  - Home health agencies (HHAs)
- PAC providers are now required to report standardized patient assessment data as well as data on quality, resource use, and other measures.
- The IMPACT ACT aims to enable CMS to:
  - compare quality across PAC settings
  - improve hospital and PAC discharge planning
  - use standardized data to reform PAC payments
- The IMPACT Act is an important step toward measurement alignment and shared accountability across the healthcare continuum, which MAP has emphasized over the past several years.

IMPACT Act Reporting Requirements

- The standardized quality measures will address several domains including:
  - Functional status and changes in function;
  - Skin integrity and changes in skin integrity;
  - Medication reconciliation;
  - Incidence of major falls; and
  - The accurate communication of health information and care preferences when a patient is transferred.
- The IMPACT Act also requires the implementation of measures to address resource use and efficiency such as total Medicare spending per beneficiary, discharge to community, and risk-adjusted hospitalization rates of potentially preventable admissions and readmissions

CMS Approach to Standardizing Measures under the IMPACT Act

Input on Measures Under Consideration

Requested MAP Input

- CMS has requested MAP input on four measures under consideration to meet requirements of the IMPACT Act that could be potentially used across settings to provide standardized quality data.
  - E0678: Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened
  - E0674: Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury
  - X4210: All-cause readmission to hospital from post-acute care
  - S2631: Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function
- While CMS will use the existing quality reporting programs to gather this data, MAP is asked to consider the requirements of the IMPACT Act as an overlay to the existing programs.

Measure: E0678 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened

Domain: Skin integrity and changes in skin integrity

- **Measure: E0678** Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened
- **Preliminary Analysis Result:** Support.
  - The measure addresses an IMPACT domain and a MAP PAC/LTC core concept. The measure is NQF-endorsed for the SNF, IRF and LTCH settings (NQF #0678).
  - The measure is currently in use in the IRF and LTCH quality reporting programs.
  - In the 2015 MAP pre-rulemaking cycle, MAP conditionally supported X3704 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened for the HHQR program.

Measure: E0678 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened

Program	Endorsed	In Use in CMS Program	Prior MAP Input
SNF QRP	X		
LTCH QRP	X	X	Adopted for this program prior to MAP process
IRF QRP	X	X	Adopted for this program prior to MAP process
HHQRP			Conditionally support in 2014-2015 pre-rulemaking cycle

VOTE: Measure: E0678 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened

- Do you support measure E0678 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened to assess skin integrity and changes in skin integrity across PAC/LTC settings?

VOTE: Measure: E0678 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened

- Do you conditionally support measure E0678 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened to assess skin integrity and changes in skin integrity across PAC/LTC settings?

VOTE: Measure: E0678 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened

- Do you not support measure E0678 Percent of Residents/Patients/Persons with Pressure Ulcers That Are New or Worsened to assess skin integrity and changes in skin integrity across PAC/LTC settings?

Measure: E0674 Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury

Domain: Incidence of major falls

- **Measure: E0674** Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury
- **Preliminary Analysis Result:** Support.
  - The measure addresses an IMPACT domain and a MAP PAC/LTC core concept. MAP provided a recommendation of conditional support for this measure for IRFs during the 2014 pre-rulemaking cycle.
  - MAP recommended "support direction" for this measure for LTCH quality reporting program during the 2013 pre-rulemaking cycle.
  - This measure is in use in the LTCH quality reporting program.

Measure: E0674 Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury

Program	Endorsed	In Use in CMS Program	Prior MAP Input
SNF QRP	X		
LTCH QRP		X	Support direction in 2012-2013 pre-rulemaking cycle. Measure should be specified and tested for the LTCH setting.
IRF QRP			
HHQRP			

VOTE: Measure: E0674 Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury

- Do you support measure E0674 Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury to assess incidence of major falls across PAC/LTC settings?

VOTE: Measure: E0674 Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury

- Do you conditionally support measure E0674 Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury to assess incidence of major falls across PAC/LTC settings?

VOTE: Measure: E0674 Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury

- Do you not support measure E0674 Percent of Residents/Patients/Persons Experiencing One or More Falls with Major Injury to assess incidence of major falls across PAC/LTC settings?

Measure: X4210: All-cause Readmission to Hospital from Post-Acute Care

Domain: All-condition risk-adjusted potentially preventable hospital readmission rates

- **Measure: X4210:** All-cause readmission to hospital from post-acute care
- **Preliminary Analysis Result:** Support.
  - The measure addresses an IMPACT domain and a MAP PAC/LTC core concept. NQF has recently endorsed these readmission measures for all four settings (IRF #2502; SNF #2510; LTCH #2512; HH #2380.)
  - Skilled Nursing Facilities: In the 2015 pre-rulemaking cycle, MAP supported #2510 for the SNF Value-Based Purchasing Program. Measure #2510 was also recently finalized for use in MSSP in the 2015 PFS rule.
  - The IRFQR, LTCHQR and HHQR programs currently include an all-cause unplanned readmission measure.
  - The measures are all harmonized in the approach to capturing readmissions.

Measure: X4210: All-cause Readmission to Hospital from Post-Acute Care

Program	Endorsed	In Use in CMS Program	Prior MAP Input
SNF QRP	X (as NQF #2510)		Support in 2014-2015 pre-rulemaking. This measure addresses a PAC/LTC Core Concept and is a required measure for the SNF value-based purchasing program under the Protecting Access to Medicare Act of 2014 (PAMA). MAP noted that this measure is well aligned with readmission measures used in other settings.
LTCH QRP	X (as NQF # 2512)	X	Support direction in 2012-2013 pre-rulemaking cycle. A consolidated, evidence based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings.
IRF QRP	X (as NQF #2502)	X	Support direction in 2012-2013 pre-rulemaking cycle. A consolidated, evidence based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings.
HHQRP	X (as NQF #2380)	X	Support in 2013-2014 pre-rulemaking cycle and support direction in 2012-2013 pre-rulemaking cycle. A consolidated, evidence based readmission measure should be developed to promote alignment and shared responsibility across the care continuum and PAC/LTC settings.

VOTE: Measure: X4210: All-cause Readmission to Hospital from Post-Acute Care

- Do you support Measure X4210: All-cause Readmission to Hospital from Post-Acute Care to assess all-condition risk-adjusted potentially preventable hospital readmission rates across PAC/LTC settings?

VOTE: Measure: X4210: All-cause Readmission to Hospital from Post-Acute Care

- Do you conditionally support Measure X4210: All-cause Readmission to Hospital from Post-Acute Care to assess all-condition risk-adjusted potentially preventable hospital readmission rates across PAC/LTC settings?

VOTE: Measure: X4210: All-cause Readmission to Hospital from Post-Acute Care

- Do you not support Measure X4210: All-cause Readmission to Hospital from Post-Acute Care to assess all-condition risk-adjusted potentially preventable hospital readmission rates across PAC/LTC settings?

Measure: S2631 Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function

Domain: Functional status, cognitive function, and changing in function and cognitive function

- **Measure: S2631** Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function
- **Preliminary Analysis Result:** Conditional Support.
  - The measure addresses an IMPACT domain and a MAP PAC/LTC core concept.
  - MAP reviewed this measure in its 2014 pre-rulemaking for the LTCH QRP and provided a recommendation of conditional support, pending NQF-endorsement. This measure for LTCH (2631) is currently under review by NQF.
  - The Person and Family Centered Care Standing Committee did not reach consensus to endorse this measure due to concerns about the inclusion of the "plan of care" data elements for this measure. It was noted that the specifications indicate a discharge goal related to at least one of the assessment items rather than a plan.
  - Concerns were raised about the evidence for a plan of care being related to outcomes. The Committee evaluation and recommendations will be posted for public comment very soon and NQF will make a final recommendation on endorsement in the Spring.

Measure: S2631 Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function

Program	Endorsed	In Use in CMS Program	Prior MAP Input
SNF QRP			
LTCH QRP			Conditional support in 2014-2015 pre-rulemaking cycle.
IRF QRP			
HHQRP			

VOTE: Measure: S2631 Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function

- Do you conditionally support measure S2631 Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function to assess Functional status, cognitive function, and changing in function and cognitive function across PAC/LTC settings?

VOTE: Measure: S2631 Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function

- Do you support measure S2631 Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function to assess Functional status, cognitive function, and changing in function and cognitive function across PAC/LTC settings?

VOTE: Measure: S2631 Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function

- Do you not support measure S2631 Percent of Patients/Residents/Persons with an admission and discharge functional assessment and a care plan that addresses function to assess Functional status, cognitive function, and changing in function and cognitive function across PAC/LTC settings?

Opportunity for Public Comment

Next Steps

- MAP PAC/LTC Workgroup upcoming off-cycle review activities:
  - February 11-19, 2015-Public comment period
  - February 27, 2015-Coordinating Committee Meeting
  - March 6, 2015 – NQF submits MAP's final recommendations on the Ad Hoc to CMS

Points of Contact

Name and Title	Role	Contact Information
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Laura Ibragimova	Project Analyst	libragimova@qualityforum.org

Thank You!

NATIONAL QUALITY FORUM (COMM PARTNERS)

Moderator: (Carol)
February 11, 2015
1:52 p.m. ET

Operator: Welcome to the Measure Applications Partnership Post-Acute Care Long-Term Care Meeting. Please note today's call is being recorded and all public lines will be muted. Committee members, please note your lines will be open for the duration of today's call so please be sure to use your mute button when you're not speaking or presenting. And please turn your computer speakers off if you dialed in on the phone. Please do not place the call on hold at anytime today.

If you need assistance on the phone, please press star zero and an operator will assist you. For technical support, you may either send a message through the chat box or in the e-mail to NQF@commpartners.com.

Today's meeting will include specific public comment period. You may make a public comment by pressing star one and these instructions will be repeated later in the program.

You may also send your questions and comments in by the chat box. To do so, simply type your question in the chat box on the lower left corner of your screen. Please be sure to click the send button located next to the box.

You will also notice the links area to the side of the slide. You will find a copy of the presentation materials and resource information relative to today's meeting located there. Clicking on the links will not disrupt your viewing if they will open in a separate web browser window from which you can print or save the file.

Committee members only, you will be voting on measures to be included in the four programs under the IMPACT Act using the voting tool during the meeting today.

When a voting question appears on your screen, committee members should click in the box next to the answer of your choice. Your responses will be captured and send directly to our presenters. You do have the ability to change your vote but we ask that you do that quickly to allow the votes to settle and register.

And now, it is my pleasure to welcome you to the meeting. Let's get started.

(Carol): Thank you so much. And I would like to join in welcoming everyone and really thanking you for your flexibility as we engage in this off-cycle review of measures that are outside our usual pre-rule making process.

And as you're all aware, we're dealing with expedited timeframes and need to accomplish our process within a 30-day period which involves our review of the four measures under consideration to implement the IMPACT Act and providing initial recommendations followed by a public comment period and then a meeting of the MAP Coordinating Committee on February 27th to finalize MAP's recommendations.

So I would like to, in addition to welcoming everyone, ask Mitra to do a roll call, so we will know who is on this call today.

Mitra Ghazinour: Thank you, (Carol). This is Mitra Ghazinour. I'm a project manager at NQF, supporting the work of the MAP Post-Acute Care Long-Term Care Workgroup. And I also would like to welcome everyone to today's call. And just would like to do a roll call.

Starting with (Carol) is here. Joseph Agostini? Suzanne Snyder Kauserud? Pamela Roberts.

Pamela Roberts: I'm on the call.

Mitra Ghazinour: Thank you. Roger Herr?

Roger Herr: Here.

Mitra Ghazinour: Thank you. Jennifer Thomas? (Lisa Venzil)?

(Lisa Venzil): Yes, I'm here.

Mitra Ghazinour: Thank you. (Ruth Left)? Allen Nissenson? Sean Muldoon? (Robin Grant)? Carol Spence?

Carol Spence: Present.

Mitra Ghazinour: Thank you. (Arthur Stone)? James Lett?

James Lett: I'm on the call.

Mitra Ghazinour: Thank you. Dianna Reely?

Dianna Reely: Here.

Mitra Ghazinour: Thank you. Margaret Terry? Louis Diamond? Gerri Lamb?

Gerri Lamb: I'm here.

Mitra Ghazinour: Thank you. Marc Leib? Debra Saliba? Thomas von Sternberg? (Allan Levesque)?

(Allan Levesque): I'm here.

Mitra Ghazinour: Thank you. Elizabeth Hall? (Lisa Patton)?

(Lisa Patton): Yes, I'm here.

Mitra Ghazinour: Thank you.

Did anyone join the call while I was doing the roll call and I missed your name?

OK …

(Carol): OK. Is there anyone else on the call who Mitra did not recognize?

(Stacy Mendel): Hi this is (Stacy Mendel) and there's CMS folks that are gathered on the line, too.

Mitra Ghazinour: OK, thank you. So I guess I let NQF staff who are in the room with me to introduce themselves, starting with Erin.

Erin O'Rourke: Hi, everyone. This is Erin O'Rourke. And I'm one of the senior project managers here at NQF supporting the work of the PAC/LTC group.

Reva Winkler: I'm Reva Winkler. I'm a senior director at NQF and I'm also helping support the work of MAP in this group.

Laura Ibragimova: Hi, everyone. This is Laura Ibragimova and I'm a project analyst here at NQF supporting the work of the MAP.

Mitra Ghazinour: Thanks, everyone. (Carol), back to you.

(Carol): OK. The only other points I'd like to just make in or introduction here is that we have developed as a workgroup sort of our core measures which have six main categories and 13 core measures overall. And we try to really focus on the measures we think are consequential. And I think that a number of the measures here really do fit into the core measures that we have developed over our work during the past few years.

The other issue that we have emphasized repeatedly is the need for alignment and harmonization, both across post-acute care settings and with post-acute care and acute care. And I think that as this unfolds today, you will hear that one of the goals of the IMPACT Act is in fact to move toward greater standardization and harmonization.

So with that, Mitra, let me turn it over to you.

James Lett: (Carol)?

(Carol): Yes?

James Lett: This is Jim Lett. I apologize for interrupting.

(Carol): I don't mind, Jim. You have to interrupt because there's no other way I'm going to know that you want to say something.

James Lett: Oh, I click raise hand and I was hoping that might work.

What I'm going to ask about is just simply administrative, and that is I didn't keep track, but what are the rules about a quorum and how many we need to have it in order to effectively move these measures forward.

(Carol): OK. I think that's an important question, because we had eight members of the workgroup by my count that are present, and I don't know if by our charter and rules of engagement there is a quorum requirement. So I'm going to turn to Mitra and Erin and Reva to address that.

Rob Saunders: Hi, (Carol). This is Rob Saunders. I think that – sorry …

(Carol): Go ahead, Rob.

Rob Saunders: I didn't announce myself, but I should have. So, that's a good question and one that where we were keep in track of on our side as well.

We had a running total of about 10 folks around, eight who are voting committee members and two (HER) liaisons. We are also tracking and see a few more people are trying to enter but haven't been able to get through yet. But, there are – was a contingency plan here since we knew this was a very fast turn around and this meeting was scheduled very quickly, that if we're unable to get to quorum on today's call that we were going to follow up with folks after this call with electronic and electronic survey to get more feedback. So that today would be a discussion, process and then staff would synthesize that discussion and follow up with all of the members and then have voting done that way so that we made sure that we had a quorum requirement.

And we recognize that we have to take some of these extraordinary measures given the trying to hit this type of that turn around and get on everybody's schedules. But, we're trying to track that as we go.

Is that helpful in sort of …

(Carol): Rob, what is the quorum requirement? What number need to be …

Rob Saunders: So these …

(Carol): … present.

Rob Saunders: Sure. And this year, we've set a new process in place in terms of quorum, and we've decided to hit 75 percent of the workgroup as the quorum requirement.

So – and that's of the voting members that's somewhere in the order of about 16, so that's the number that we would like to hit. And if – again, if we don't hit that today, we'll let people know and we'll immediately follow up with electronic voting.

(Carol): OK. Are there other questions from anyone on the call on this particular issue?

Dianna Reely: This is a comment from Dianna Reely. I do only have an hour for the call today. So, before I have to sign off, I should – how would you prefer that we announce that?

(Carol): Well, I think you should let us know so what …

Dianna Reely: Yes.

(Carol): … minutes before you have to leave.

Dianna Reely: All right, thank you.

(Arthur Stone): This is (Arthur Stone). I don't know whether you have me down, but I'm now on the call.

(Carol): Oh, OK, thank you. So we're now up to nine.

Jennifer Thomas: Yes, hi. This is Jennifer Thomas. I don't know if you – I raise my hand, but I didn't know if it was counted.

(Carol): OK. I don't think it has been, so that brings us to 10.

Sean Muldoon: Same with Muldoon.

(Carol): Hello, Sean. Thank you. We're at 11. OK. Very good.

All right, Mitra, why don't we move since we want to do as much as we can before we lose Dianna.

Mitra Ghazinour: Sure. I guess we're moving to the – our (slides) process, Erin is going to talk about that.

(Carol): OK. Erin.

Erin O'Rourke: Hi, (Carol). Thank you. Just to give the group a quick refresher on what the MAP off-cycle review approach is. As a quick reminder, in exceptional circumstances, HHS can ask MAP to perform this type of off-cycle review of the measures outside of our annual approval making process. And we apologize that we just concluded that.

And thank you everyone for being willing to join us today and make the time for this.

As Rob was mentioning, these are on extremely quick timeline. We only have 30 days to accomplish this review. Normally, this takes place over eight weeks when we do our annual pre-rule making. So, only about half the time to finish the work.

So, for today, we've been asked to perform an off-cycle review of four measures under consideration to implement provisions of the IMPACT Act.

And just to walk you through the process quickly, obviously, the PAC/LTC Workgroup is meeting today. On the 11th of February, we'll be opening up a free public comment period which will close on the 19th. The 27th, we'll be convening the coordinating committee to review the public comments and finalize the workgroup recommendation. And on March 6th, we'll be submitting the final recommendations to HHS.

So that's just a visual of what we just went through. And I can take any questions, or if not, I can turn it back to Mitra and (Carol) for a brief overview of the IMPACT Act.

(Carol): And we will also take public comments today as part of our workgroup.

Erin O'Rourke: Absolutely, we will have a public comment period today for the – during the meeting and then a formal one for written public comments via 11 through the 19th.

(Carol): All right. Why don't we go on to reviewing the IMPACT Act and the reporting requirements?

I think we will hear more about this, but we spent time at our workgroup and we also spend time as the MAP Coordinating Committee reviewing the IMPACT Act, which was the bipartisan bill passed in September of 2014.

And I think there are a number of key objectives which include enabling CMS to really standardize the provide assessment, instruments and data that's used on quality and resources and to be able to compare quality across post-acute care settings, hopefully, to improve the whole transition and discharge planning process and to have data and be able to make informed decisions about how best to reform the payment system.

And our ultimate hope is that it also changes the experience of the patients and beneficiaries so that they really have the ability to access the most appropriate care for them.

So, with that, Mitra and Erin, are there key things you want to add?

Mitra Ghazinour: So, just going to the next slide, the domain side are authorized under the IMPACT Act for domains, functional status and changes in function, skin integrity and changes in skin integrity medication reconciliation, incidence of major falls and the accurate communication of health information and to preferences when a patient is transferred.

And as realized, major sizes resource use efficiency such as (inaudible) medical spending to beneficiary, discharge to community and risk adjusted hospitalization rate of potentially preventable admissions and readmission.

(Carol): OK. All right. And I think we're going to fortunately hear from CMS because I think one of the things that we are very interested in is the approach that CMS is taking to standardizing measures.

One of the things that we heard during our rule-making public comment period was concern about the care act – care assessment instrument being layered on top of the current assessment instruments, and that would really undermine the parsimony and kind of effort that we are making to make all of this as usable as possible and as valuable as possible.

So I'm going to turn to our representatives in CMS to describe the approach they are taking to standardizing these measures.

(Stacy Mendel): Hi, good afternoon. Thank you very much. This is (Stacy Mendel). I am the deputy division director in Division of Chronic & Post-Acute Care. It's really an honor to be here with everybody and I'll try to make this very brief because I know folks – there are some folks that need to leave.

So just to build off of what has already been described, the IMPACT Act was a bipartisan bill that was passed. It has many, many obligations within it and requirements. But among the many is to move towards the use of standardized assessment data in the very assessment instruments that are used for multiple purposes, payment, quality, (serving and certs), certification and care planning.

And in patient rehab facilities, long-term acute care hospitals, home health agencies, skilled nursing facilities, I think I got all four.

The quality measures specifically are to be built from standardized data so that's – this described the five domains that we must at least develop measures to accommodate. And then also there are health assessment status domains as well that are to be used across the settings.

In a sense, this work really build upon many, many, many years predating the IMPACT Act such as with (DEPA) back in 2000 and Deficit Reduction Act in the mid 2000s about the use of a standardized data for multiple purposes.

And with the birth of the Deficit Reduction Act came the Post-Acute Care Payment Reform Demonstration, where an item set called the care item set is tested to find out which data elements within the item set had nice strong integrated reliability and could be applied for multiple purposes across settings. And that's where the care instrument, the care item set really lived.

But there seems to be a lot of sort of confusion out there that the act required the care instrument which is actually not a fact at all. That being said, there are data elements within the care item set pertaining to function that has – have had very strong integrated reliability in the testing and from which many measures have been recently developed and actually also submitted through the endorsement process at NQF.

And I am actually joined by my colleague, Dr. Tara McMullen, as well can answer questions.

But, what I really wanted to emphasize is that the IMPACT Act, T is for transformation, that this is really a wonderful golden opportunity to take the time overtime for transformation to get to an ideal state where there are standardized data elements that are used for multiple purposes, not just for payment or quality, or care planning at the local level, but data that can sell the person for care coordination purposes that the data can be interoperable.

The experts in the field of health information technology make it very clear that if – when you apply standardized data elements that the ability to trend for information across settings for purposes of care coordination is far more feasible, far more accurate.

And so those are some of the golden items spelled out very clearly in the IMPACT Act, where it speaks to assessment and quality measurement uniformity, quality care and improved outcomes, the comparison of quality across post-acute settings, improving discharge planning and interoperability

and facilitating care coordination are all called out in the IMPACT Act through these standardized data.

And so, there isn't a whole lot of time to meet the initial specified application dates that quality measures for the quality measurement domain and as well as the resource use in other measures are specified by setting, and by date by setting.

And so, what you're seeing is the first phase of quality measures for consideration as we take the initial steps towards an ideal state. But this is the first phase.

And so when we went about, you know, with the measures under consideration list that we landed on for the timeframe of 2016, fiscal years '17. We took into consideration, and calendar year '17, measures that would address a current area for improvement that is tied to a stated domain in the act. So whereas, they are still a quality gap, the domains are made very explicitly clear. There is really no turning back on those, but measures that would address the gaps associated within domains.

We should look at our current portfolio of what we ought to (stirred off) and not having that are endorsed and currently used and prosecute payment, quality reporting programs that have already received support by the MAP.

We look to seeing such as minimizing added brand to the providers and wherever possible avoiding any impact on the current assessment items that are already collected.

So with all of those sort of principles for this first round, we've applied that to the logic for the measures that are currently under consideration. But, we do wanted to – you know, we did want to make sure that we emphasize that this is going to be an evolution overtime.

And I want to really thank everyone for taking the time to take this first step on this journey.

So that's really all for me.

(Carol): Thank you, (Stacy).

Tara, is there anything that you want to add?

Tara McMullen: No, no. This is Tara McMullen. I work with (Stacy) on the IMPACT Act. I'm an analyst in Division of Chronic & Post-Acute Care. Really, (Stacy) said it all, I think the one thing that we always underline is that, we are, you know, developing and trying to meet the mandate of the IMPACT Act in phase approaches.

So what you see today with the measures, this is just Phase 1, this is the first step that we're taking to meet the mandate.

And touching back to what (Stacy) said so well, the care tool or the care item set in its entirety was never intended to be tool that really takes over the MDS and the OASIS and it's not all encompassing.

And today, we will present to you a function measure that does use care data and those are data elements that are from the subsection of the function domain that rests in the care item set. But at this point, that's all we're really using from the …

(Crosstalk)

Female: By pressing star one, we'll be heard on the phone.

(Carol): OK. (Inaudible) question from the workgroup for our CMS representatives.

Suzanne Snyder Kauserud: Yes, this is Suzanne Kauserud. Can you guys hear me OK?

(Carol): Yes, we can hear you, Suzanne.

Suzanne Snyder Kauserud: OK, good. I've been on the call the whole time but having …

(Carol): Oh, OK.

Suzanne Snyder Kauserud: … technical difficulties but ask that question at this time, so.

(Carol): OK.

Suzanne Snyder Kauserud: I have a question about the functional measures and I apologize because I've been working to get on the phone. But – so, the idea is that there could be functional items that are measured such as transfers from bed to wheelchair, but both an MDS or IRF (pie) or OASIS and that would also be measured under the care tool?

Tara McMullen: This is Tara McMullen. I think I'll start this and we'll see if (Stacy) wants to add.

So the care tool has given us many gifts, and one of those gifts is that it gives us data items that have been tested reliable and valid in each setting.

And so within the care tool, there's multiple domain breakup sections, like function, cognition, so on and so forth. Out of the function section, we have items, ADL items, IADL items.

And what we have simply done is taken some of those items out, items that are reliable and valid and we developed quality measures with those items.

In moving forward, we're standardizing those measures across each setting. So, the items that were reliable and valid that were tested within the care item set, those items will be placed within the assessment instruments.

Suzanne Snyder Kauserud: OK. OK. And I think my concern and I probably voice this a few times, but at the risk of sounding like a broken record, if there – you know, for inpatient rehab at least and I know for the MDS as well and OASIS, some of the – how we put patients in the categories for payment is based off of a seven-point scale of functional items.

And so, some of my theories, if we have two scales that are at one to six-point scale and the language is very close to seven-point scale, and we have staff members measuring both of those items, we run the risk of decreasing the reliability of both scales.

So, I just – I understand that the care tool was out and reliable in that very desirable in the quality measurement area. But I just have concerns about the stability of the measure for payment and the measure for quality being so similar and both so important.

Pamela Roberts: This is Pamela. I was just to add to what Suzanne said. I mean, just to – for doing them simultaneously, there are some differences in definitions that also could add to the reliability and validity for both groups and it's so important to have accurate data.

(Carol): OK. Are there other comments or questions from workgroup members?

James Lett: Yes, (Carol), it's Jim Lett, if I may.

(Carol): Sure.

James Lett: I think we all are very much in favor of a – being able to compare apples to apples with this initiative.

What I would ask about just the information from the C.S. folks if they have thought – or planned this, is there's no question that you can't live without data. However, how actionable and available is that data going to be, that is at each site in the post-acute continuum, fills out the same tool, which I'm certainly for.

What is the availability from site of care to site of care for this data that is, is that all just going to go to CMS, or will it be available if, for example, a patient at a nursing home then moves to a home health agency, is then readmitted back to a nursing home. Will the nursing home or the home health agency have the ability to access the data and understand exactly where in the process of recuperation a given patient is?

(Stacy Mendel): So this is (Stacy) at CMS, if I can – see if I can try to tear it back and the answer the question. And I think you have a fantastic point about interoperability. So I think you're headed with the data.

So the data, standardized data enables the kind of interoperability that you're describing through the use of health information technology.

And through the ONC challenge grants, exactly what you're describing has been achieved actually. For example, there is work done in Massachusetts as one of the ONC challenge grants, doctors (Terry Omali) and (Mary Garber), worked in Boston to develop the impact tool, no pun intended, that was built from the discrete standardized data elements, and worked in under consensus building for what was important data to exchange.

There is information that providers need to exchange with each other that CMS does not necessarily need to see when they are in the process of exchanging that data in real time.

You know, CMS currently receives the data on these assessments at the patient level everyday through QIES ASAP system. But that is separate and apart from data exchange across providers such as what goes on in the Geisinger system up in Pennsylvania as well as an example.

So, the kind of exchange of data is actually happening. The caveat for post-acute care is that they did not receive any funding for such types of activities.

So, as sort of an aside here at CMS, I've been working with our – with (Red Hana) the contractor in developing the CMS data element library that will house the data elements as the discrete data elements and they're mapping to both CCDA or the clinical documents for electronic exchange as well as to the health information technology standards such as the (Lankin) and (Snomed) and RxNorm code.

So that providers who want to engage in health information technology adoption as well as health information exchange are – is just more feasible for them. It's not required.

That's a long answer I hope to what you're suggesting, but that's where we're at.

(Carol): You know, (Stacy), it seems to me there is sort of three buckets up here of purpose. One is to correct standardized data for quality and to compare outcomes and results. A second is for payment, both current and future payments. And the third is to facilitate the exchange of information in real time.

(Stacy Mendel): I think you just summed it up. Yes.

(Carol): And so, the question for us is how those – and much more for you is how those three pieces are going to fit together.

Margaret Terry: This is Peg Terry. Can I just ask a question here? Can you hear me?

(Carol): Yes. We can, Peg.

Margaret Terry: I just want to validate what I heard from Suzanne, and I guess I didn't understand this before. So, they – these new items that – or new measures would be in the different data sets as well as the ones that are currently being used that speak to issues such as functional assessment and some of the others.

So, they'll be there simultaneously. I never understood that, I thought it was not going to be simultaneously. So, if you could just clarify that, (Stacy), that'd be great.

(Stacy Mendel): Whether there's going to be duplication of data, is that what you're …

Margaret Terry: Right. That's the question.

(Stacy Mendel): Well, I think we're, right now, in the step, Peg, of looking at measures under consideration. And then, the next step is, obviously, going through rule making with potential measures. And that's kind of where we're landing at.

Sean Muldoon: Ladies, this is Sean. Well, maybe as we're stepping through this, you can outline for us why it's not redundant and what it adds having two metrics up to the same measure.

(Carol): OK. Peg, did you get your question answered?

Margaret Terry: I – yes, to some extent. So, I'll wait to hear (what else) has said.

(Carol): OK.

Margaret Terry: Thank you.

(Carol): All right. Any other comments or questions because this is important in framing our work today.

All right. If not, why don't we go onto the gather input on the four measures under consideration in our Phase 1 here and …

Mitra Ghazinour: (Carol), this is …

(Carol): … I think we're going to move towards the first measure, the presented resident patients, persons with pressure ulcers that are new or worsened.

Mitra Ghazinour: (Carol), before we move on to measures, Rob has an announcement.

(Carol): OK. Rob.

Rob Saunders: And (Carol), we've been tracking attendance as the call (inaudible).

(Carol): Right.

Rob Saunders: And a number of people were able to join while we've been talking and in fact as of our last count, we gone at least over a quorum, we have 18 people on the call.

(Carol): Wow.

Rob Saunders: At least 16 …

(Carol): That's great.

Rob Saunders: … vote in.

So, as we have it right now, we have a surpass quorum and we'll keep track, of course, as things keep going. But, we – we're fine for voting right now and we don't need to take any contingency plans as of this moment.

(Carol): Great. Thank you.

I have author Jennifer, Sean, Suzanne and Peg having joined the call. Are there other people who joined I should be aware of?

Rob Saunders: You mean in terms of folks that have joined, we've got a longer list.

Maybe we could submit to you by the chat box, or would there be a better way to …

(Carol): Oh, that would be great.

Rob Saunders: Great. We'll do that.

(Carol): OK. Thanks a lot.

All right. Mitra, to a measure number one on your consideration in the domain of skin integrity and changes in skin integrity.

Mitra Ghazinour: Thanks, (Carol). Yes.

So, the first major to review is measure 0678, percent of residents, patients, persons with pressured ulcers that are new or worsened.

According to the staff preliminary analysis, this measure addresses an impact domain as (relies) MAP PAC/LTC core concept. The measure is NQF-endorsed for skilled nursing facilities and patient rehabilitation facilities and long-term care hospitals.

The measure is publicly reported on nursing home compare for short-stay patients, and also in use in the IRF and the LTCH Quality Reporting Program.

In the 2015, MAP pre-rule making cycle, MAP conditionally (inaudible) this measure for Home Health Quality Reporting Program.

The result of the staff preliminary analysis is support for this measure across the full setting.

(Carol): OK. Does anyone from CMS want to weigh in at this point?

Female: On the pressure ulcer …

(Carol): Yes.

Female: Well, just to note that it's already used in the SNF quality – well, public reporting program. It's already been adapted, proposed and finalized for – since data collection began in 2012 for the IRF and the LTCH Quality Reporting Programs. And it was a measure under (participation) for the home health program, quality reporting program as well.

So, this point, it would be, basically, you know, we're looking for input on the (inaudible) measure for the intent under the IMPACT Act.

(Carol): Mitra, do you want to add anything?

Mitra Ghazinour: No, I guess that covers it. So, I guess if there are no any questions from the workgroup, we can move to voting.

(Carol): OK. Let me just make sure that there are no question from the workgroup.

Sean Muldoon: This is Sean. So, the vote is – here is the deal. Know that everybody – or previous meeting what – you know, things to measure is OK, but we always get stuck on, you know, how are you going to get the data and what – you know, what precision and accuracy issues are there with how about data is extracted. Are we voting on that technical aspect or simply on the numerator and denominator?

Rob Saunders: And so, this vote is actually on the entirety of the measure, so both the numerator and denominator. But, I mean, technical aspects as well. So the vote is really on whether MAP supports or recommends including this program and including this measure notes for a program.

Female: Yes.

Female: (Great).

Margaret Terry: So, I have a question. This is Peg again.

So, when we look at the home health, one to have a conditional support. There were comments made, and I saw them in the final report that the comments were made.

I don't know – my question is, will they incorporate it into the final measure?

Female: So Peg, you're talking about some of the caveats (inaudible) about necessary exclusion for half the patients who …

Margaret Terry: Exactly.

Female: … like never heal.

I'd – you know, I think we just gave that feedback to CMS on February 1, so it's probably too soon for, you know, anything really – have been changed regarding it, but I think that's to us the caveat we can continue to carry over.

I don't think that necessarily goes away for this review that – so, I think we can continue to note that.

Margaret Terry: OK. Thank you.

(Carol): All right. Any other questions or comments?

(Arthur Stone): Hey, (Carol). This is (Arthur Stone).

(Carol): Go ahead, (Art.

(Arthur Stone): There was also a comment, I believe, we talked a little bit about some never events that happened throughout the continuum, and I don't know whether that was included into this as well.

(Carol): Can you amplify what you mean, (Art)?

(Arthur Stone): There are never events particularly in the acute care side that uncertain pressure ulcers, they're actually not reported. Some of them are (unstageables).

(Carol): OK.

(Arthur Stone): Yes.

(Carol): All right.

Mitra, did we include anything in our comments on that?

Mitra Ghazinour: Not for the February 1st deliverable, but we can include it for this (inaudible).

(Carol): OK.

All right. Are we ready to vote?

James Lett: I'm sorry. This is Jim Lett. I just wanted to – I think that's a huge point and I just like to understand a little bit more.

When someone comes in with an unstageable pressure (one), you may well know that it's a stage four under that. But, it's just marked unstageable. So, when – as that wound, as it will excavates, and is excavated down to its (base), it will appear as if it is worsening.

How does the measure handle that since the stage four was legally there but unstageable that now opens up and becomes officially a stage four?

Is that counted against the post-acute continuum?

(Stacy Mendel): Hi, this is (Stacy). So I think I can answer that question.

If the wound is unstageable and then – and it's present on admission and then, is debrided or what have you, that initial debriding finding stage, whatever stage it is, is considered present on admission.

James Lett: OK. Thank you.

(Stacy Mendel): Sure.

(Carol): OK. Any other questions? All right. Then, let's go to vote.

Female: Hi. So, the question is, do you support measure E0678, percent of residents, patients, persons with pressure ulcers that are new or worsened to assess skin integrity and changes in skin integrity across PAC/LTC settings.

(Carol): Well, let me ask one clarifying question, Rob. We have new 60 percent of benchmark for approval. Are we going to be doing that as well in this case?

Rob Saunders: That's right, (Carol).

(Carol): Thank you.

All right. Are we ready to vote then?

Female: Yes. You can vote now.

Male: We just vote by using the chat room, right?

Female: No. You have the options to click A or B on the voting – on the platform …

Male: Oh, OK. Got it.

Female 42:45: And any PAC/LTC Workgroup members who were unable to join us via web conference, (inaudible) you can add your votes for the total if you're comfortable saying them out loud.

So if there's anyone who is not logged in, that is voting, member of the workgroup and would like to vote, please, speak up now or e-mail your vote to Laura if you're not comfortable saying it.

Female: And if at any point when you're voting, the boxes do not appear on your screen, you can refresh your screen by pressing F5 on your keyboard or command R for a (MAC).

Debra Saliba: I'm – this is Deb Saliba. I don't think I ever got the final information to be able to vote. I have the public SharePoint site information.

Female: Hi, Debra. Sorry about that that you didn't receive the link. Would you want to vote via the phone?

Debra Saliba: Can you just send me a link so that I don't have to interrupt? That'd be great. Thank you.

(Carol): OK. Do we have a tally?

Female: We got 16 to 0.

Female: Yes. 16 to 0. 100 percent of the present who've been voting say yes, they would support this measure.

(Carol): OK.

So, we need to add Deb.

Female: OK.

(Carol): We have 18, so we're missing one or maybe someone dropped off.

Rob Saunders: Oh, and (Carol), that 18 included some non-voting members, so …

(Carol): Oh, OK.

Rob Saunders: … vote. So that's OK.

(Carol): OK, for the clarification.

All right. So, this is a yes.

OK. Why don't we go on to our next measure to percent of residents, patients, persons, experiencing one or more falls with major injury.

Mitra Ghazinour: So, for this measure, the preliminary analysis concluded that this measure – this is an impact domain as well as a MAP PAC/LTC core concept.

And MAP provided a recommendation of condition on (software) for this measure for IRF during the 2014 period making cycle. MAP's also recommended data recommendation of (software site) action for this measure for long-term care hospital quality reporting program during the 2013 period making cycle.

This measure is publicly, again, recorded on nursing home compare and it's finalize for use in the LTCH Quality Reporting Program for the fiscal year 2018 payments determination.

So, I guess, I'm not sure, (Stacy) and Tara, do you have any additional comments or remarks on this measure?

(Stacy Mendel): Tara, feel free – excuse me, feel free to jump in at anytime, keep me honest here.

So, the – this particular measure, obviously, addresses a major (hoc). It also speaks directly to the measure domain.

The data elements are already collected in the MDS. It is a measure that's used with the nursing facility long – what we call long stay residential population. It has been finalized for adoption already into the LTCH Quality Reporting Program that was submitted with support by the MAP for use in this year for using the IRF Quality Reporting Program.

It's an agreed upon quality area, it is – falls with major injury. And then, Tara, if you anything you'd like to add, I'd love to have – to turn it over to you.

Tara McMullen: No, pretty much, I think that says it all. Thanks.

(Carol): OK. A question from the workgroup.

James Lett: Yes, please. This is Jim Lett.

I'm certainly in favor of the measure. I think what I want to ask about is nailing down a little bit better the definition of a major injury because what you have in the short notes here is, it ends – the list ends with among other major injuries.

And I do not believe the list that is here defining there's a major injury is the same as in the state operation manuals for long-term care facilities.

So, those need to be harmonized or we get into trouble with defining in long-term care.

(Stacy Mendel): Thank you.

(Carol): OK.

Sean Muldoon: Hey, this is Sean.

(Carol): Yes, (inaudible).

Sean Muldoon: Remind me whether the denominator is – senses that the time of the measurement or its discharges over the reporting period.

Tara McMullen: Hi, Sean. It's Tara McMullen.

It's looking back, it's a look-back scan. So this is a measure originally and originated out of the nursing home setting. And the look-back scan was developed to be able to link together the appropriate number of assessment within the nursing facility setting for public reporting.

So, it's looking at the look-back scan assessment. So, basically, one or more within a targeted period within a specific quarter and that's in a number of 275 days look back.

And the reason that CMS does this is for public reporting so that CMS is appropriately reporting an adequate number of falls with major injury in the nursing facility setting.

And if I may go back to the last comment, it was a very good comment about the definition involved with major injury, and I just wanted to say that this specific definition was taken from (RAI) manual for nursing home, since this measure did originate from the MDS.

And I think that it is important to be able to delineate what major thoughts are for the entire long-term care spectrum and CMS will definitely take that into consideration.

Sean Muldoon: Thank you.

Tara McMullen: Thank you both. Thank you.

(Carol): OK. Any other comments or questions?

Dianna Reely: (Carol), it's – this is Dianna Reely, I'm sorry and I'm – after this vote just to let you know, I'll be signing off.

(Carol): OK, thank you so much, Dianna.

Dianna Reely: Thank you.

(Carol): All right. Are we ready to vote?

Margaret Terry: No, I have …

Male: I …

Margaret Terry: … question.

Male: … question.

(Carol): OK, hang on, one at a time.

So, I can't recognize all the voices, so let me have one question now.

Margaret Terry: OK, I'll start if that's OK. This is Peg Terry and …

(Carol): OK, go ahead.

Margaret Terry: My question is about home health. And I don't think this has been a measure yet that I've seen in home health.

So, two issues, one, it is always like I say it's a different setting and it is because most falls are unwitnessed in home health. And so, there is that issue because it is different to trying to get a hand along what is injury or what happened to the patient.

The second part is, what are we actually voting on here because, you know, we haven't really seen this in the home health setting as a measure. So that's a technical or process question.

Tara McMullen: So, if this is for CMS, Peg, I – this is Tara, I'd be able to answer your first question, a very important question. And as we really discuss how to standardized a measure of the size into a home base setting, I think that this should be top of the mind. Who would be coding that, how do we appropriately assess what follows, and really what's going on as CMS is, you know, kind of figuring out the assessment instruments and how to correct that data.

And as I may not be able to speak to how CMS is going to go about this, I will tell you that the home health team is looking at these measure specifications and we are meeting with experts (inaudible) to be able to figure out if they trained clinician would be able to collect this assessment or would it be a social worker. How do we appropriately assess when a fall with major injury happened and appropriate look back and how do we appropriately collect that?

So, know that CMS – this is top of the mind for us and that we're looking into it.

Margaret Terry: OK, thank you.

(Crosstalk)

Margaret Terry: The second question is how – what are we voting on if this is not anything we've seen before in home care? That's kind of the process question.

Reva Winkler: Yes, this is Reva from NQF.

To answer the question before you is to how the MAP feels in terms of supporting the standardization of these measures across the four settings as required by the IMPACT Act.

So if – we know a lot about measures in some of the settings, those will have to be extended to the other settings. So the question to you is, does MAP support the use of this measure under the terms of the IMPACT Act which will require standardization across the four settings?

Marc Leib: This is Marc Leib: And I have a question.

(Carol): OK, go ahead Marc.

Marc Leib: Well, going back to the home health issue, certainly the other three settings by using resource and then personnel should be able to prevent or reduce the incidence of falls. There's – that's three obvious statement.

But when you talk about home health and you're talking about having someone there for an hour, two hours a day or whatever it is, but not all day long, how do you achieving the same level of responsibility for what a related per off hours that, you know, when they're not there as opposed to an in-patient setting where they are – do have personnel and are there. Does that make sense?

Male: Sure, it does.

(Carol): I mean, I guess the question is, what is the range of responsibility for a home health agency.

Mary Pratt: Right, this is Mary Pratt at CMS, and that's a really good question and it's – I think it's obvious it's not the same responsibility as one would find in an institutional setting.

So you can certainly, you know, help us in our efforts to find ways to make this a meaningful measure across care settings as we're being directed to under the IMPACT Act.

Clearly, if there are people with risk for – or, you know, having major falls or major injuries, I'm sorry. That is something I think home health agencies would be attending to and would be very concerned about. I'm sure of that.

So, but you're correct, the level of responsibility in terms of preventing somebody from doing something when they're not – when they're not there is not possible.

Female: So would this measure have a standardized assessment that would be done as part of it?

Tara McMullen: So this is Tara from CMS.

This measure would be standardized (a couple of) setting.

So, items would look the same apples to apples comparisons between the OASIS and the MDS as for the mandate of the IMPACT Act. And we need to remember that the measure report from the percent, basically, individuals who had one or more major falls.

So, as it may not be perfect, assessing falls and really a fall that had a major injury is somewhat important to track for every single setting. So, at this point today, all we can do is be able to, you know, act with an impact and then that mandate, but we need to remember that the outcome is to be able to see if an individual experience the fall, and if that fall was accompanied by a major injury.

It's an important concept, so.

Sean Muldoon: So this is Sean. So with all of these – the thing we're voting on is an all or none according to the way the question was teed up. So if we are – what we really – we really like it for three settings and don't think it's appropriate or the (fourth), is that translate to a no vote?

(Carol): But I don't think that is not appropriate. I think that it needs to be defined differently for a home health care setting.

Sean Muldoon: But it can't be.

(Stacy Mendel): This is (inaudible).

Sean Muldoon: They have to have the same in order to be crosscutting to have same definition.

(Stacy Mendel): This is (Stacy) from CMS, let me clarify one point.

Yes, it does allow for a certain latitude of appropriate risk adjustment for these measures. So just to take that into considerations, we have the domain. We can't undo what Congress has already discovered as an important area.

The quality measure put before you on the (mock) list addresses falls with major injury with data element collection that is easily standardized.

And then, we can work at the application of the measure for the setting, you know, for whatever risk adjustment would be necessary for the home health setting.

(Allen Levesque): Yes. And this (Allen), (Allen Levesque). You know, just to remember again that, you know, we can't say that, you know, the measure is bad or whatever. I mean, again, Congress has told us that, you know, we're supposed to take into account falls with major injury in the home health setting. I think our role together is to find the best measure to do that.

I mean, we all realize that attribution is not as direct as it is in other settings. But, you know, we do feel that there is some attribution that – or some effort that home health agencies can do to decrease fall risk. And we're trying to find the best measure to do that.

(Carol): OK, Sean, does that answer you concern?

Sean Muldoon: It explains it, it's not particularly satisfying. But that's not new. OK, thank you.

Male: Can we make our vote conditional? All right, so at our previous (inaudible), that's no.

Female: Yes, you could make the vote conditional if you explicitly state the condition.

(Carol): OK. Rob, do you want to weigh in here in regard to that?

Female: (Carol), the process would be is, you could ask for a motion and someone would motion to move this from support to conditional support. And then, if they could – it clearly state what their conditional be so we can capture that in the report.

(Carol): OK, all right. So let me see if we can have someone make a motion for conditional support with an excellent (notion) of what that condition is that would need to be met.

Who would like to tackle that?

Sean Muldoon: I'll take a crack at it.

(Carol): OK, go to it.

Sean Muldoon: The support would be in the affirmative under the condition that the home health metric, methodologic …

Male: Can you hear me now?

Sean Muldoon: … to reflect the lack of – the lack of similar attribution to the outcome to the provider.

(Off-Mike)

(Carol): Any comments on the motion?

Female: I think – can I just ask, could you explain exactly what's your contingency and what the conditional is again? Is that Sean?

Sean Muldoon: Yes, I'm trying to leave open a set of requirement but leave open how it's done to say that we got to under – the measure has to reflect the fact that attribution of the fall is much less attributable to a home care provider than …

Female: Got it.

Sean Muldoon: … to the other three.

Female: Got it.

(Carol): So then the contingency would be that, as you work on the application of this standardized measure to the home health care setting, you would address sort of the attribution issue and the risk adjustment issue.

Sean Muldoon: Yes.

(Carol): OK.

Is everyone comfortable with that? Then, can we go to the voting?

And if we vote yes, we're voting yes with this contingency.

Female: Yes, so the …

(Carol): Do we need – I need someone from NQF to guide me here. Should we have pure yes, yes with contingency and no, or should we assume that the yes is with contingency?

Female: You can assume the yes is with contingency. The question is …

(Carol): OK, all right. So if you vote yes, it is with this contingency.

Female: Yes. It's a conditional support (and are) typical.

(Carol): OK, thank you.

All right, let's go to vote.

Female: So the question is, do you conditionally support measure E0674 percent of residents, patients and persons experiencing one or more falls with major injury to assess incidence of major falls across PAC/LTC setting? A, yes, B, no.

And the results are 16 for a 100 percent yes.

(Carol): OK, thank you.

(Off-Mike)

(Carol): All right.

So let us go onto measure three on the all-cause readmission.

Female: So this is measure X4210 all-cause readmission, dealing with the domain of all-condition risk-adjusted potentially preventable hospital readmission rate. So this MUC ID actually includes four NQF-endorsed measures nested within it. This measure (adjust as an) impact domain in a PAC/LTC core concept.

NQF has recently endorsed these readmission measures for all core settings. It would be for the inpatient rehabilitation facilities, NQF member 2502 for skilled nursing facilities. This is NQF member 2510. For long-term care hospitals, this is measure 2512 and for home health agencies, this is measure 2380.

We've weighed in on some of these measures in the past, in the most recent pre-rule making cycle, not supported number 2510 for the SNF Value-Based Purchasing Program.

This is also recently finalized for use in the Medicare insurance savings program.

The Inpatient Rehabilitation Facility Quality Reporting Program, the Long-Term Care Hospital Quality Reporting Program and the Human Health Quality Reporting Program currently include all-cause on planned readmission measures.

And the measures are all harmonized and the approach could capture in readmission.

Next slide, this captures where the measure is endorsed and used and prior input. We've provided quite a bit of input on these measures over the years.

(Carol): OK. Does anyone from CMS want to comment before we open it up to the workgroup members for questions?

(Stacy Mendel): So – go ahead, Tara. Oh …

Tara McMullen: That wasn't me, (Stacy). Yes, that wasn't – sorry.

(Stacy Mendel): OK. So this is (Stacy), so this – at CMS. This measure was proposed and finalized in the LTCH program. And it applies standardized data elements like the others that would inform, you know, goals of care which is very, very, very important consideration as we move forward and not backward in health services.

So that's – I just wanted to chime in with that.

(Carol): OK. Questions from workgroup members?

James Lett: Just one, this is Jim Lett.

(Carol): OK.

James Lett: What's the attribution for a patient who is discharged from the hospital, goes to a skilled nursing facility, is routinely discharged from that skilled nursing facility, (thought) to be stable, goes home and then is readmitted to the hospital, but within 30 days of the hospital readmission? Who gets – is this is a SNF attributed readmission or is this hospital attributed?

(Allen Levesque): So, this is (Allen Levesque). It's shared attribution, so in other word it's still fact the, you know, acute care hospital, you know, the responsibility in terms of care coordination and discharge planning in that 30-day post discharge period as team receiving facility in this case to SNF in terms of the care that's being provided at the SNF so it would be shared.

Male: Well, that's responsibility. I'm really asking about attribution. Whose numerator and denominator would gets (ding) with that? And it's more – I have no dog in that fight. I'm just really curious.

(Allan Levesque): Well, I mean, it affects both of their readmission rates. I mean I'm not sure, you know, how – what's the answer – answer the question. They would be in the numerator of both measures.

Male: So one readmission gets (counted) against both a SNF and a hospital?

(Allan Levesque): But – it is different. I mean, again, it's it maybe one patient but you're really looking at readmission rates in both facility. You got to look at it, you know, by that patient within the facility and not the single patient or the single episode that's occurring.

Female: So, for clarification, it would be the timeframe so it should be more than two that are affected two that are infected, is that correct?

Female: Yes, because as I understood it now and I'm not sure I have this right but for in IRF, it's the timeframe is within 30 days of discharge. For a long-term care hospital it's within 30 days of discharge from that long-term care hospital.

For home health care where there's been a prior stay in the hospitals at least five days, again, it's within 30 days of discharge from home health care but the with the SNF, it's within 30 days of the prior hospitalization. So, as I charted this, it seems to be a different timeframe for SNFs.

Male: The average length of stay home care SNF is 21 days. So, if that clock starts ticking for the hospital at time zero, if the clock ticking for the SNF is clicking but also in last nine more ticking. Then also to add to Allen's question, of course, the home care that's involve once (we will) repeat this step, it's the same thing. All three could happen within 30 days and all would be attributed to readmission, is that correct?

Male: Again, if it – it is within the window of time then yes, it would be in the numerator of, you know, all three. So in other way if somebody who was discharge home and was in the home health window that would, you know, be part of the numerator of their measure.

Male: Right. And then only where further clarifying question, for the hospital and admission within 24 hours of discharge attribution of the hospital makes sense

but within 24 hours for the SNF or for a home care, is there any recognition that those would graph the individuals that were never even having had time with adequate reassess or even involve with their care they were readmission, is there any consideration about within a short timeframe that the other players are not part of the calculation?

Female: Isn't the definition for home health after five days?

Female: But I thought the question that was raised is if someone (due date) had a five day prior hospital stay of at least five day.

Male: It can be up to five days after hospital discharge for a patient to be part of the Home Health's measure.

Female: So, if they're admitted within – to the hospital within 24 hours, and they're sent back to the hospital within 48 hours in the next stay, it is attributed to the Home Health's Agency, correct?

Male: If the Home Health Agency is not yet seen, the patient have been part of the patient's care, it would not.

Female: Right. But if the did it that the patient within 24 hours and the next day, they were readmitted, it would be attributed to the home health, I think is what I think the question was. Is there any consideration for those very short stay in any of the post-acute settings. I think that was the question.

Male: I'm not sure I mean if the IRF and (inaudible), you know, would be post-discharge, so I'm not sure that would matter in home health, if you know, once the patient becomes part, you know, under the care of the agency.

And again, these measures were all, you know, reviewed by the NQF. And, you know, already have tentatively been endorsed by the NQF. I mean this were all look at as well in somebody's questions were asked during that endorsement process.

Female: Right.

Sean Muldoon: And I'm not questioning their adjustment, just want to submit clarity around those considerations because again at the end of the day, there are always will be – need area that's where it's a little bit awkward but I just want at least ask that question.

Female: OK. Are there any other questions?

Female: I just have …

Female: I had other question that I want you to ask, for home health, if the person turns up in the emergency department but it's not admitted is that counted or no?

Male: Not in this measures, as you might remember there is a separate, you know …

Female: OK.

Male: … or does it measure that also is in that same window but that's not measure that we are using for this.

Female: OK. Thank you.

Male: And Mr. Sean, so by not admitted that includes observation status?

Male: In the ER used measure that is correct.

Female: So, I just have one more question, are these measures all – do they all have the same risk adjustment model or are they different depending on settings. I know we look at this separately but I wondered if as they look at them in this context is it different factors in the risk adjustment model for each setting or is it the same?

Male: The – it basically has – it starts with the same factors but then the risk adjusters would be, you know, setting and specific after that.

Female: OK.

Female: OK. Are we ready to vote?

Male: … would mix to, you know, plan readmissions would also be, you know, sometimes setting specific.

Female: All right.

Male: Well, and Mr. Sean, the risk adjustment is the Yale methods. I mean the unplanned determination is the Yale method for all of them?

Male: Yes, I mean that is because of the template that they use of it.

Female: OK. Are we ready to vote?

Male: OK. So, it's possible that something planned from LTAC will be unplanned from home health?

Female: Sean, can you explain that?

Sean Muldoon: Well, my understanding is that (Yale) method is that it matched, you know, gave a list of reasons that you got and readmitted that we're not related to the reason of the previous admission which I've – I get it for short term hospitals and I understand that for LTAC that's fine, we've added that but when you get to SNF and home care, I'm – I just want to know how you determine whether it's planned or unplanned.

Male: Sure. And I'm not sure whether there is a diagnosis that is planned for LTAC and unplanned for home health.

Sean Muldoon: So, the list would be the same. You show it would less be the same?

Female: If I remember correctly, I think they're different.

Male: Yes, not necessarily Sean.

Sean Muldoon: OK.

Male: It would be …

Sean Muldoon: So the same way the LTAC took the STAC list then, you know, through of you out and not a few, that process would have to be done for SNF and home care.

Male: Right. That was done in each setting.

Sean Muldoon: OK. Thank you.

(Carol): All right. Are we ready to vote? OK. Let's go to the voting.

Female: These are the question is do you support measure S421, you know, all-cause readmission to hospital from post-acute care to access all condition, risk adjustments, potentially preventable hospital readmission rates across PAC/LTC setting. A, yes. B, no.

(Carol): OK.

(Off-mike)

Male: (Carol) I'm not on the computer. Can I vote verbally or do I have to just …

(Carol): You can vote verbally.

Male: OK. I'll go to (inaudible) and that would be the same for the home care order or home care one as well.

Male: So (Carol) really (inaudible) comprises all?

(Carol): Yes.

Male: Thank you.

Female: The results are 100 percent yes.

(Carol): OK. Thank you. All right. So, we are going on to our fourth and final measure which is the percent of patients, residence, persons within admission and discharge functional assessment and a care plan that is function. Hi Mitra.

Erin O'Rourke: It suggested the domain or functional status …

(Carol): Oh, Erin go ahead. Sorry.

Erin O'Rourke: Sorry. So, this is adjusting functional status, council of function and changing in function and cognitive function as the domain. These addresses an impact domain obviously and a MAP PAC/LTC core concept.

MAP reviewed this measure during a 2014 pre-role making after the LTAC quality reporting program and provided a recommendation of conditional support depending NQF endorsement. This measure is for association that is currently under review by NQF.

The person whose family centered care standing committee is the one conducting that review. They were unable to come to consensus to endorse this measure. They had concerns about the inclusion of plan of care data elements that is measure and it was noted that the specifications indicate a discharge goal related to at least one of the assessment items rather than a plan.

Concerns are raised about the evidence for a plan of care being related to outcomes. The committee evaluation and recommendations are working their way through the NQF process and will be posted for a public comment very soon and NQF will make a final recommendation on endorsement for this measure in the spring.

(Carol): OK. So, in this instance the preliminary analysis resulted in a recommendation by the staff of conditional support, is that correct?

Erin O'Rourke: That is correct. Even that this measure is still making its way through the endorsement process, we see this as a conditional support funding that it's eventually NQF endorsed.

(Carol): OK. And can you highlight Erin the conditions?

Erin O'Rourke: To the condition of the NQF endorsement.

(Carol): OK. All right. Let me turn to committee members for questions and comments on this one.

Sean Muldoon: So, this is Sean, stepping to the numerator's statement you got two things. There are three things that have to be present in order to get a yes. You have to have a plan which you just tick, yes or no, you have to have a numeric score of your functional goal and that's presumably a (FIM) or (FIM) like number and then I'm in little foggy on number three. Three allows you to just bail from the whole thing because it was not accessible.

Tara McMullen: This is Tara from CMS. So, in essence I could see where this got – this could go a little confusing. But in essence what is measure in assessing is, at admission and at discharge, a resident status and their functional status and admission, admission the functional goals for at least one health care or one mobility item at that time. I'm not …

Sean Muldoon: So you get the pick. So one person could do impendence and one …

Female: You're picking – well Sean, you're picking from one activity. So at admission say like a person had a goal to or walking, or …

Sean Muldoon: Yes.

Female: … It would be that you have at least – you have to choose at least one. You could choose at least one self-care, one mobility item at the time of admission whether it's a discharge functional goal. So it could be any goal, it's very individual. There's no set criterion.

And as you know Sean, the scale is a little bit different then the (inaudible) scale, it's the (inaudible) scale. And so, it's a little bit different. It's basically – I'm looking at the MDS. It's basically one through six or six through one, depending on how you look at it. The six is independent, the one is dependent.

Sean Muldoon: But one patient can have – then I – will I be able to walk, score me before and after and another patient could have – will I be able to eat, score me before and after?

Female: Right. I mean, we're just tracking at admission and at discharge.

Sean Muldoon: And you get credit for the fact that you ask and assess, not for what that progress was.

Female: Well so credit – interesting because at this time, this is just the process measure.

Sean Muldoon: Yes. Yes, OK.

Female: OK.

Female: So that means that this – it just occurred. So in a different setting, in the way that it is written, you would be doing the care element types as well as whatever they're doing for payment, is that correct?

Female: I can't speak the payment. I'm just quality, so what I could tell you is from the quality perspective, (Dave) would be collecting data on this measure.

Female: Sorry, I can't …

Female: So I'm not really clear myself on this. You get credit for doing a functional assessment at the point of admission and after point of discharge. Is that …

Female: What facility will be doing is collecting on specific self-care and specific mobility items at admission and at discharge. And at admission, they're tracking whether an individual for at least one self-care or one mobility item had a – if that was a goal. So they're tracking or marking if that was a goal.

So credit, I think, is an interesting concept because this is just a process measure. So at this point, this measure is collecting data for reporting purposes.

Female: OK. And then how does the care plan fit in to this?

Female: So just at that, like at admission, an – whoever is collecting that data would delineate that – let's say like for self-care item or mobility item walking, with delineate. Is that walking item with the functional goal for that individual?

And (Dave) would be able to delineate within the assess measurement whether that was a goal that have been reflected based on the scale.

And that – I think that's kind of the main (inaudible) hang out with the NQF panel right now is the discussion between goals of care and care plan. And that was on kind of the discussion that the NQF panel had, was whether this would fit appropriate into it. And what CMS is trying to raise is, it is clinically relevant and analytically acceptable to be able to correct on a goal. And to delineate is there was a self-care, mobility activity and if that was linked or tie to a goal.

But all CMS wants to know is if on the self-care and mobility activity whether that is tied to a goal and what is that goal.

Female: OK. Just point of clarification, we would be using that care elements for doing this measure, is that correct?

Female: Yes, yes, ma'am.

James Lett: Well this is Jim Lett. I'm sorry but this seems to be a very confusing measure that is not very clear and how you qualify for a Yes versus a No.

And I think what I'm hearing is if you'd complete what I will call the care tool, the new one, if you compete all these things about functional assessments, then you're just simply doing something that's already required to be done. How is that a quality assessment?

And then are there exceptions? That is people sign out against medical advice, people are readmitted to the hospital, people who die, who you cannot do, repeat assessment on.

Female: OK. So these are good question. So within the differentiation for this scale, so going to the second question first. There are coding options, there are –

within our care functional scale, where due to the medical depict condition or due to a safety concern, or basically if the task was simply not completed, an individual can be coded on that, so that when that data is submitted, CMS will know, "This wasn't applicable for X, Y, and Z." (Inaudible) the patient refuse, something happen with that patient and it was a medical condition, so on and so forth.

So if something happened, we would know. Going to the first question, so you write there are differentiation and in some ways the label of this items may be analogous to the items that are currently being collective in different assessment instrument. Just following the mandate at this time, we're developing quality measures or concepts of measures that could be standardized between all settings.

It just for the mandating.

Male: So, there's a fact that the NQF and MAP hasn't totally sorted this one out which is unlike the others, does that figure into its readiness?

(Stacy Mendel): It's measured was adapted into the ALTEC quality reporting program with the (inaudible).

Female: We didn't hear what you said. Could you speak up a little bit?

(Stacy Mendel): Sure. This is (Stacy) at CMS, this measure was finalized in adapting (inaudible) the ATEC quality reporting program.

Female: So what (Stacy) said before the beep happen was, that the measure was adapted into the ALTEC Quality Reporting Program, so that program will begin collecting a reporting on the measure.

Male: (Inaudible), but I think …

Female: Yes.

Male: … someone was talking about, it's "hang up it in some NQF reviews" or did I misunderstand it?

Female: It's being reviewed by one of the standing committees in NQF, having to do with patient-centered care, I believe.

Male: OK. So does that fact that it's still being reviewed some placed in NQF figured into our assessment of it's readiness for a vote?

Female: Hello. This is …

Female: No, both in this case is conditional support. It's not full support.

Male: Got you. Thank you.

Suzanne Kauserud: This is Suzanne Kauserud. I agree that the language about – at CarePoint, you know, setting the goal doesn't necessarily mean that there's a care plan that address this function, does means that there's a goal set.

But even getting around that, again, I come back to using the (inaudible) and the care tool side by side for a very similar measures. And I just, you know, I think about the amount of time and resource we've put into the (inaudible) which is a challenging instrument to learn and how much we teach that and how much we tell them about the exceptions and these things you need to learn about and then, to go and layer on top of that.

Another tool, we would either need to have a completely separate staff scoring it or we would just need to accept that we're going to reduce of the quality of data we're getting both on the payment side and on the quality side.

It just doesn't fit right with me.

Female: But I think the issue is the same for SNF and home health, because they also have their own different tools that they use, which is a difference between ALTECH that didn't have a tool.

Female: OK. Any other comments or questions here? Does anyone from CMS just want to address these whole issues that we hear coming up several times, which is the fact that we are layering tool and increasing provider burden?

Tara McMullen: Well I – this is Tara. I think, I could speak (Stacy) and I when we say that we hear you and we understand. And that burden is most important to understanding what's going to go on for the providers and for the individual who are coding the assessments and that we understand your concerns.

Sean Muldoon: So, being that – this is Sean. Being that this is conditionals input before we vote, could someone's clearly state that condition?

Female: Yes. I think that it's useful. I mean, no, it's someone for more NQF staff can capture the conditions here?

Female: Yes. The condition is not – is – the support of conditional on NQF endorsement.

Female: OK.

Female: The group is welcome to add additional or change that condition. Now that was the start to where the staff winded on our preliminary analysis of the group, (so it's not until that). The proper condition, you're welcome to change it. If you want to add a condition, that's fine as well. That was just where we came to at our first (inaudible).

Female: All right, does everyone understanding then, the condition for support. Why don't we go to voting?

Female: So the question is, do you conditionally support measure S2631 for sign of patients (inaudible) with an admission and discharge functional assessment and a care plan that addresses function to assess, functional status, cognitive function, and changing in function and cognitive function across like LCC setting? A, yes. B, No.

Male: I'll vote yes.

Female: Yes.

(Lou): (Carol), this is (Lou) (inaudible), I'm voting yes.

(Carol): OK. Thank you (Lou).

(Off-Mike)

(Carol): All right.

Female: So the results are …

Female: We have two yes.

Male: 58 percent.

Female: So 58 percent yes and 45 percent no.

Male: Actually – wait, no, I'm sorry.

Female: Hold on. Hold on.

(Carol): We had two yes says verbally.

Female: So the results are now 50 percent yes and 50 percent no.

(Carol): OK. So then this means that it would move to the MAP without a recommendation.

Female: So we can push this one up to the coordinating committee to decide or you could also ask for an alternate motion if someone …

(Carol): OK. That would be fine. Is there anyone in the workgroup who would like to shape an ultimate motion?

Suzanne Snyder Kauserud: This is Suzanne. I don't know if I will use the right language so I might lean on my peers to help with this, but – I mean, could we do a conditionally support? I mean the measure, it's not a bad measure and we certainly all know that function is so very important.

(Carol): Right. It's our number one for a measure, right?

Suzanne Snyder Kauserud: Right. So I hate to get locked up and seem like, "Hey, we're going to support this." The idea is, you know, are very much supported. But just

that the hang up about the payment and the quality piece being in conflict, if there is some way we can say we conditionally support at this direction, this content but until those issues are resolved in a way that we know we're still going to get high quality data with not too much provider burden. It's just hard to say to support it.

(Carol): All right. Does anyone want to take Suzanne's point here in any way modify it? Because it would add two conditions to our conditional support, NQF endorsement and addressing this need to really reconcile the payment and quality measure approaches.

Female: Maybe that the payment and quality measures are aligned …

Female: OK.

Female: … if they were aligned.

Tara McMullen: May I say something? Can I say something? This is Tara McMullen from CMS.

(Carol): Yeah.

Tra McMullen: I do want to put this out there that we do come from the world of quality at CMS. So even though quality and payment do work together, there is maximum flexibility that we have within quality. So when the massive voting on whether payment and quality should work together, we agree with you. However, we're bringing forward this measure today in terms of the perspective of quality.

And what this would mean for a longitudinal data assessment, following someone as they traverse the care continuum. You know, we can't speak of that what will happen with payment because we don't come from the payment side of things. And in fact, I'm not able to represent payment in any fashion or form.

So I'm wondering if that just can be taken into consideration if we can look at this quality measure as a equality measure. And what this mean for …

(Carol): But I think there will be issue for us, Tara, is that as providers, those of us who are in the provider community, we are being asked now to really integrate payments and quality.

Tara McMullen: Right. I understand. Trust me, I really do understand.

(Carol): Right.

(Crosstalk)

Male: Carol?

(Carol): Yes.

(Off-Mike)

Male: Remind us with the (inaudible). Aren't we also …

(Off-Mike)

Male: … quality group of the CMS versus the payment group, which means that lost motion that we put on the table does make sense. Because we're not submitting a (inaudible) entire CMS. So the notion of (inaudible) and alignment payment and quality seems (inaudible) within our purview, it seems to me …

(Off-Mike)

(Carol): OK. Any other comments or kind of modifier to this replacement motion that (Suzanne) put forth. With help …

Male: But we should …

(Carol): With help, a little help from her friends.

James Lett: This is Jim Lett. I certainly am not oppose to the concept, not oppose to what (Suzanne) is trying to say. And for me it's not a matter of payment versus quality, it's a matter – you don't have a measure here, you have multiple measures within this measure. You have to meet this measure, you have to do

something on admission, you have to do something on discharge, you have to have a functional assessment, and you have to have a care plan at two different times, admission and discharge.

And then also map all that to something else. I think it is not personal, it is – I think it is not clear. And I don't know anybody that can easily meet this measure.

(Carol): OK. All right, so let me try to frame what we're going to vote on for second time.

Mary Pratt: (Carol), this is Mary Pratt. I'm sorry, I just wanted to make one, hopefully …

(Carol): Sure. Go ahead.

Mary Pratt: … helpful comment. We – This clearly isn't awkward kind of situation and you all are seeing how – sometimes we are faced with information that we have to take action upon, based on where we ultimately want to go. You all have a bird's eye early view into some of the mechanics of the sausage that's made it CMS. There is a lot of work that have to be done between now and, you know, when things get polished and shined, and to look right.

We understand exactly what you're saying. We talk about these issues here. We're putting something forward right now for a longer, greater purpose down the road. We can't make all these things line up. Congress doesn't always listen to what we tell them. And we're just dealing with the cards that we have dealt with right now. And you all are sort of right there in the box of – (box seats, seen it) – see in the drama play out right now.

You have a capacity to, you know, make this move forward – help us make this move forward. We have to move forward. We are mandated by Congress.

(Carol): All right, so let me try and sum up where we are. We took one vote, we came up 50 percent, yes 50 percent, no, which would move into the map coordinating committee without a recommendation.

We have a second motion for a measure that it requires by the impact. It is by the impact law. It is one of the required domains. It is one of our core measures. It's number one on our core concept.

And so (Suzanne) put forth conditional support with two conditions. One has to do with NQF endorsement and the other is trying to align the quality and payment approaches. We heard from (inaudible), one of a concern that they can't really speak for the payment division as this unfolds.

So that would be the motion that we have heard. And we heard from (Jim) with his concerns about the multiple measures that are embedded in this. So with that, I'd like to move for a vote on conditional support with these two conditions.

So how do we do that now?

Female: You should be able to recast the vote.

(Carol): Recast, yes, conditional support with the two conditions or no, against it even with the two conditions.

Female: Right.

(Carol): All right, so we should just do it again?

Female: Yes. We may vote now.

(Carol): OK.

(Lou): Hello (Carol), this is (Lou) (inaudible).

(Carol): How do you vote (Lou)?

(Lou): Yes.

(Carol): OK. Was there another verbal vote?

Male: Yes. Dr. Tom Stenberg vote yes.

(Carol): OK, thank you. All right, how did we (inaudible)?

(Off-Mike)

(Carol): OK.

Female: So we have (inaudible) percent yes and 30 percent no.

(Off-Mike)

(Carol): OK. So then, that becomes a yes with two conditions, conditional support recommendation.

(Crosstalk)

Female: Yes, (inaudible) this on conditional support with the recommendations that you laid out, for NQF endorsement and alignment between quality and payment requirements.

(Carol): OK. So let me now turn to public comment and see if we have any.

Operator: If some of you like to make a comment, please press star then the number one. There are no public comments at this time.

(Carol): OK. So I would like to just extend my thanks to the work group. I really appreciate your giving the time to this and the attention that you have given on very short notice and in a very expedited timeframe. And I thought that the comments today were very thoughtful and productive. And I very much appreciated it.

And I want to also thank the staff, Mitra, Erin, Reva, and Rob, looking over all our shoulders. And Laura as well, organizing this and putting together all of our briefing materials.

And again, a very accelerated timeline. So thank you all so much.

Female: (Carol), I apologize, we did just have a caller come into the queue.

(Carol): OK. We'll be flexible. All right, let's go.

Operator: OK, your comment is from Akin Demehin.

Akin Demehin: Good afternoon. This is Akin Demehin with the American Hospital Association. And I too would like to extend the AHA thanks both to the NQF staff for pulling together this review on such a tight timeframe, and also to CMS.

One of the requirements of the Impact Act, is that CMS is trying to use the map process to the maximum extent possible. It's not mandatory to use the map process, and so we really do appreciate the agency, actively seeking the inputs of a broad variety of stakeholders by using the map process.

Just a couple of comments on the measures that the workgroup has just discussed, we absolutely have heard from our members who have post-acute care facilities about their concern about the notion of using two different reporting methods for reporting on issues like functional status. They do dedicate an enormous amount of resources to collecting functional status information for payment purposes, it would be disruptive to say the least, to have dual reporting that would include the care tool.

And certainly it's good to hear that CMS hears that concern, and we will be very eager to see how one can reconcile these two different things.

With respect to the readmissions measures, what of the other requirements of the Impact Act is a study, so it looks that the impact of things like sociodemographic factors and other factors that aren't clinical factors that are really beyond the control of providers.

And obviously the NQF has been very busy in the states over the past year. One concrete recommendation that I would have both for the workgroup to make it in terms of recommendation and to CMS, is that really we make use of the upcoming sociodemographic adjustment trial period, and really put this measures through that assessment process, in addition to completing the other report that CMS is required to do.

And I actually think that taking that – taking the measures through that trial period would be a very useful input. We continue to hear significant concerns that while all of us agree that there's shared accountability for reducing readmission, holding providers accountable for factors beyond their control. And the many community factors that can contribute to the likelihood of readmission is really something that needs to be looked at, and appropriate adjustment need to be applied as soon as possible.

And then the last thing I'll leave you with in the interest of time is, in many of these – with many of these measures, CMS faces incredibly challenging statutory timeframes that have been laid out in the impact legislation. It would be, I think, very ,useful for the agency to think about, making sure there is some feedback loop, so that when these measures are implemented, that there's some assessment of whether the data really can be collected in the consistent fashion that the agency is hoping for.

Certainly we appreciate the goals of the Impact Act are consistent data collection. The extent to which one can use the exact same measure specifications every single care setting, I think it's something that is still very much up for debate. And something – we're actually getting some feedbacks from providers to provide a useful input to policy making in the future.

Thank you very much for the opportunity to comment. And thank you again, both to the MAP and to CMS for convening this ad hoc review.

(Carol): And thank you for your comment. And I wanted to also conclude by thanking CMS. And I agree that this has been, I think a remarkable partnership as we work through this and we really appreciate their taking multistakeholder perspectives. But they have also shared with us their valuable perspectives and given us important information as well, to take into account, in our deliberation.

So thank you to the CMS staff who have joined us today. And thanks again to everyone else. And I think we are concluded.

Male: Thank you, (Carol).

Female: Thank you.

Female: Thank you.

Male: Thank you.

Male: Bye-bye.

Male: OK, thank you very much.

Operator: Thank you. This …

Male: Thank you.

Operator: … concludes today's call. And you may now disconnect.

END