NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP (MAP)
POST-ACUTE CARE AND LONG-TERM CARE
(PAC/LTC) WORKGROUP

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MONDAY
JANUARY 11, 2021

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The Workgroup met via Videoconference, at 1:00 p.m. EST, Gerri Lamb and Kurt Merkelz, Co-Chairs, presiding.

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ALSO PRESENT:

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JANICE TUFTE, NQF MAP Coordinating Committee

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

1:03 p.m.

MS. MOYER: Let's go ahead and get started. Thank you for coming back for the afternoon.

This is the MAP PAC/LTC Workgroup. And I'm still Amy Moyer of NQF, the director on the project. And we're going to dive right in to talking about COVID vaccination measures.

We have a very full agenda this afternoon, so we appreciate everyone's assistance in staying on track.

And I believe I am going to hand it over to Gerri to start here.

CHAIR LAMB: You are, Amy. Welcome back everybody. And it's good to see you all. It would be nice to see you in person, but Zoom is a good second choice.

So welcome to our group. Welcome to Alan, it's good to see you again. Andrew, it's good to see you again. And we're looking forward to a very productive conversation today.

We had a good morning. And Janaki did a great overview of the preliminary analysis and the process.

Just a quick run through of the measure review process that we're going to be going through. It's a multi-step process, as you all know.

And Kurt and I and Amy and the NQF team will be guiding you through it. So if at any point you have questions just use chat or put up your hand, which I think we've all learned how to do in participants.

So what we're going to do, just a quick overview, is Amy is going to give an overview to the measure under consideration. We're going to call for public comments and collect those, okay.

And then we're going to move to the full introduction to the measure in our workgroup. You'll have an opportunity to make any comments, ask clarifying questions.

And we will bring in then the measure

developers to answer any questions or NQF, anything about the preliminary analysis.

And as you heard Janaki share this morning, we're going to move into a vote. Okay. If we vote to support the preliminary analysis, that will be the recommendation to go forward. We have to hit the, I think it's 60 percent criterion to do that.

If we do that, we still -- Kurt and I will still open up a conversation in the situation that if we are suggesting that, for the work needs to be done, that you'll have an opportunity to make recommendations to CMS.

And then if we do not support the preliminary review, then we will go into full discussion. Vote again.

And then after that, we will go into talking about the overall program and the gap. As Amy said, we have a very full afternoon. So we're going to be doing the COVID measures for the three settings. And we'll be doing a hospice measure and a SNF measure.

And just, if you would, please keep your comments succinct. And use the chat accordingly.

So, Amy, I'm going to turn it over to you and get us started.

MS. MOYER: Okay, terrific. Thank you, Gerri. So the first program for which we will be considering one of the COVID vaccination measures, if the Inpatient Rehabilitation Facility Quality Reporting Program. And this is pay for reporting and public reporting. And inpatient rehabilitation facilities that fails to submit data on data's program will have their applicable prospective payment system payment update reduced by two percent.

A reminder of the goals and program. It's to address the rehabilitation needs of the individual, including improved functional status and achievement of successful return to the community post-discharge.

Next slide. So we will actually open to public comment on this measure at this time.

DR. LEVITT: This is Alan. Could I just ask a question for a second?

I know for example, like Raj was not on for the morning meeting but I see him on here now. Can he or anyone else, do you need them to acknowledge their attendance here, and also to get them cleared in terms of any conflicts?

CHAIR LAMB: Amy, you want to take that?

MS. MOYER: Yes, that is probably not a bad idea. Maybe we can run through a quick attendance.

MEMBER MAHAJAN: Good. Thank you guys. Raj. And I apologize, we got our COVID vaccine delivery to our office this morning and obviously there were some issues with the freezer and monitoring, so I apologize I had to deal with that.

I did join towards the, maybe the last 45 minutes or so and got to hear that discussion. But again, Raj Mahajan.

I'm jumping the gun here.

Geriatrician from Chicago. I've been involved in post-acute care. No conflicts.

MS. MOYER: All right. Thank you, Raj. And anyone else who has joined the call this afternoon that we did not hear from this morning?

MEMBER DAVIDSON: Yes. This is Ed Davidson. I'm representing the National Transitions of Care Coalition on behalf of Dr. Jim Lett, who had a conflict.

And I do have a conflict in that I am currently receiving NIA funding with a project being titled, Impact C: Improving Vaccine Uptake in Skilled Nursing Facilities where we are focusing on health disparities in receipt of COVID vaccine model doses for workers in skilled nursing facilities.

MS. MOYER: All right.

CHAIR LAMB: Amy, do we need to do a roll call just to make sure we have a quorum by the time we get to a vote, or did you want to do that right before the vote?

MS. MOYER: I was thinking we'd do that right before the vote.

CHAIR LAMB: Okay.

MS. MOYER: That was part of the, we'll do a test question, and we'll have everyone respond.

CHAIR LAMB: Okay. That's great. All right, so back to the public comments.

We'd like to invite public comments on the measure under consideration. The 0044, the vaccination coverage among healthcare personnel. And this is in the inpatient rehab facility.

MS. MOYER: Okay.

CHAIR LAMB: Janaki, do you want keep us on track with, if we have any in chat or any people online?

MS. PANCHAL: I was just checking. We don't have any hands raised and we don't have any comments in the chat either.

CHAIR LAMB: Okay. Thank you. All right. So, Amy, if you would introduce the measure.

MS. MOYER: Absolutely. So this measure is a measure of vaccination coverage among healthcare personnel. Specifically in the new patient rehabilitation facility setting.

The measure does address a critical quality objective. And there are no other measures in the Senate that are currently giving the same information.

We do have some strong evidence that vaccination works and that these vaccines are protective against the vaccinated individual being infected with COVID.

We don't have as much information around the transmission, in terms of evidence behind the measure. It does address a quality challenge, particularly for vulnerable populations, such as those in these facilities.

And at this time it gets a little less clear when we talk about the actual calculation of the measure. So in terms of being an efficient use of measurement resources the feasibility of reporting and what the exact final

specifications of the measure will be, that is not as clear as those first couple of criteria I walked through kind of quickly.

So at this time, our preliminary recommendation for the measure is, do not support with potential for mitigation.

Now we have received some input. The Rural Workgroup had strong support for vaccination coverage for healthcare workers. They did raise concerns about potential access and distribution issues.

Although they noted that may be resolved by the time the measure is fully implemented. Other than that, they felt it was generally appropriate for the rural community.

We did also receive four public comments on those measures. And an expression of non-support.

The comments were generally supportive. However, there were questions raised, somewhere to what we've already heard, regarding availability of the vaccine,

clarification of the measurement specs, in particular, the definition of a worker.

Some groups felt it was premature to implement the measure given the unknowns. And there were also questions about the emergency use authorization and what effect that had on facilities' ability to mandate the measure.

In general, we do feel this measure would add value to the program measure set by providing visibility into an important intervention to limit COVID-19 infections.

But we do feel the incomplete specifications would require mitigation and that more development needs to continue. And that is the rationale behind the do not support with potential for mitigation preliminary analysis recommendation.

CHAIR LAMB: Thank you, Amy. And I would just refer everybody back to what we heard this morning in terms of Sheri Winsper's comments from NQF, as well as Alan's overview. And I know that Andrew was on chat responding to questions

as well.

And this is an opportunity right now to ask for any clarifications. Okay. So please limit your comments right now to things that you'd like clarification on.

And Kurt will be collecting those. And we'll go over those with the measure developer as well as NQF, related to the preliminary review.

So, does anybody have any questions that they would like clarified at this time?

MS. PANCHAL: Hi, Gerri. We do have a question in chat from Dan. And the question is, can you expand on the incomplete specifications?

I'm assuming this question is for Amy.

CHAIR LAMB: Let's hold it just for a moment and see if we have any other questions, and then we'll give Amy and the measure developers all of our questions at once.

So, an expansion on the incomplete specifications. Other requests for

clarification?

MS. PANCHAL: I don't see any other hand raised or questions in your chat, Gerri.

CHAIR LAMB: Perfect. Thanks, Janaki. Okay, so, Dan, is your question then to NQF, related to the preliminary analysis?

DR. ANDERSEN: Yes. I believe so. I just wanted, incomplete specifications could mean a number of things, so I guess just to make sure we're making educated decisions here.

Can you expand on what was incomplete exactly?

Was it the data collection or something else?

MS. MOYER: Absolutely. And just as a small caveat. At the time we wrote the preliminary analyses, there were not actually any approved vaccines. Even for emergency use. So that has been kind of a moving target.

But our question was around, how the different vaccination protocols would be tracked, a definition of healthcare personnel, how the

data would be gathered and tracked. And how automated that would be or kind of a burden or a challenge that might be to complete data collection.

And so, given the kind of number of unknowns. We knew we were measuring vaccination but not really any of the details. Those were the concerns we had in the specifications.

DR. ANDERSEN: So, I mean, I guess then a follow-up. Are some of those concerns around incomplete specifications alleviated now that we're talking about at least vaccines with the authorization at least?

Have some, I guess, have some of those concerns been addressed, and if not, which ones remain, I guess?

MS. MOYER: Sure. I think things are becoming clearer. And I think we saw during the presentation more information.

It sounded like there is stern, a lack of clarity on the exact portal and the exact method that will be used for data reporting. And

I do think as vaccination evolves and we know more, is this kind of a one-time thing, is it a multi-time thing.

Those are questions that will probably be answered in the near future. But we did have those questions that remained.

But I do put that back to, or I mean, I have never reported a vaccination measure myself. I've been the person getting vaccinated.

So I am curious to hear, if we get to the discussion point, the workgroup's thought on that for the people who may have done this.

CHAIR LAMB: Great. Dan, did that answer your question?

DR. ANDERSEN: Yes, that answers my question. I think I see some other questions in the chat that are probably along the same lines.

CHAIR LAMB: Okay. And Pam, you had a question. Do you want to share it?

MEMBER ROBERTS: Sure. I was just, a need to clarify for the measures. Is it going to be a initiation of the vaccine or the completion

of vaccine or both?

CHAIR LAMB: Okay. Alan, Andrew? Actually, let's collect those. So this is specific to the measure, and then we'll hand it over to you, Alan. Is that good? Okay.

And then we have one from Terrie. Do you want to share your question?

DR. BLACK: Yes. When I read through the measure, I was just wondering if worker included any worker or if it was specific to healthcare personnel directly?

Also, two, what about agency staff or contracted employees as well. How would that be captured?

I think we had an earlier discussion in terms of, well, if you had staff and they're going between different facilities and they're an employee it's one thing, but what about agency or contracted staff?

I wasn't sure if that was clearly answered. And I definitely had a question about that. So that's it for now.

CHAIR LAMB: Okay. Thanks, Terrie. Okay, we have those two questions. Alan, would you step in and respond to the timing and whose included questions?

DR. LEVITT: Sure, I'll start and then I'll pass it off to my NHSN colleagues, maybe to go a little bit into the denominator question.

First of all, getting back to Dan's question. When we started this there was really kind of this understanding of the specifications as we kind of look at measures all the time here at the MAP, would be really incomplete.

I mean, we started with the IRF program and I worked taking care of stroke rehab patients my whole career. And you kind of look at these things operationally as to, well, much like I look at a stroke patient, what are they going to look like six months, nine months, 12 months from now.

It's really that way too. When we were first starting to look at these measures, going back to when vaccination was first even

being started, and all the uncertainties that were then, that still are now in terms of where this measure is ultimately going to be, let's say a year from now, because we don't even know whether or not they all need to be re-vaccinate or what frequency we're going to need to be re-vaccinated. There is still all these uncertainties there.

And I think that really kind of lends to the NQF concept and idea that looking at this that there are really these uncertainties. We're very used to saying, well, the measure is going to be calculated with the numerator, the denominator is going to be collected this exact way.

And what we've been able to do with our NHSN colleagues is, as Dr. Budnitz was able to kind of show, is kind of developed forms for collection of information that would be able to evolve as we know more and more as to how this is going to be done.

And that's what we've tried to bring

to the table here. With the understanding that normally we wouldn't.

I don't want to insult your intelligence. I don't want to think things here that aren't completely vague. But it really is under the circumstances of this public health emergency.

You know I value, we value this partnership and want to get this feedback and stuff, but also with the understanding that we want to take this sort of feedback in terms of, kind of fully baking and developing this measure as the more information we know about vaccination and how to really get this done.

And we really did kind of look at this measure, and I'll turn it over to my NHSN colleagues, in terms of defining things like the denominator, and some of the questions were just asked, well, who do you include, who you don't include.

Very similar in a way to kind of looking at the denominator for healthcare

personnel vaccination for flu. Which, again, is part of the IRF QRP.

So maybe I'll, I don't know, Dan, if you're on maybe you can talk a little bit about who is and who isn't included?

DR. BUDNITZ: Yes. Can you hear me now?

CHAIR LAMB: Yes.

DR. BUDNITZ: Great. Yes, I saw some questions in the chat about volunteer secretarial staff and contract workers. And all those folks are meant to be included in the denominator right now.

There are, there is a category for other non-employees, and that's where contract staff would go if the current folk's choice to do this categorization. Does that answer your question?

CHAIR LAMB: And I think in the chat Andrew has put in additional. Dan, would you also answer the question about how the first and second immunizations are handled?

DR. BUDNITZ: Yes. So our intent at CDC is to collect both the first and the second dose as we track, in the coming weeks, progress.

And we are interested in completing --

(Off microphone comments.)

CHAIR MERKELZ: Just a reminder, if you're currently not speaking to make sure you mute your call.

(Off microphone comments.)

CHAIR MERKELZ: Raj.

DR. LEVITT: And just to follow up with what Dan said. Like I said in my presentation, it really is a measure that is going to be reporting on up-to-date COVID-19 vaccination.

And so, as we're looking at it in terms of the measure that would be publicly reported on the Compare websites, it would really be those percent of the personnel that have up-to-date vaccination. And so we would want to be able to, if it turns out that a year from now or two years from now it really is requiring, let's

say these two vaccinations at a time, that's what we would want to be looking at.

CHAIR LAMB: Okay.

MS. LINDLEY: And this is Megan Lindley. I'm sorry, could I add, Megan Lindley from CDC, I just wanted to add a historical thing regarding the question of whose included and why the employee categories are separated out and required for reporting and the other is voluntary.

We did, we've reported a measure like this, as I think you all know, for healthcare personnel vaccination in other healthcare facilities. As we did some very extensive testing of the measure.

And just the validity of the facilities ability to report. In particular, those contract and agency staff. But to a lesser extent so that the non-employee categories was very, very poor.

And so we determined for our routine reporting it was better not to make them required

than to require something that there was not necessarily an indication that the data would be good. And again, that's for flu, but just to add that context. Thank you.

CHAIR LAMB: Thank you. Eugene, you have a question?

DR. NUCCIO: Yes, I had it on mute. My question had to do with, is this, Alan, intended to be a public health measure and you will report simply the national rate for compliance at the level of a unit, like a hospital, or is this intended to be a comparison at the individual provider level?

So individual hospitals will be compared by their rate. And if so then, what is the expected rate if you're going to be doing individual hospitals and how would you account for the reluctance to take the vaccine due to religious or other things?

You know that we've discussed this in the world of home health prior, so hello again.

DR. LEVITT: I got to try to get off

mute here. I don't know if someone from NHSN wanted to talk about kind of how we do it within the IRF setting right now for the flu vaccination measure in terms of, it's really a comparison of provider-to-provider in terms of the rates for flu vaccination.

But to answer your question, I guess in that sense it would really be a comparison of that provider to a similar provider. Similar as to how we do with our Compare websites in terms of being able to compare one to another of a like type.

Regarding refusals. Unfortunately you heard my personal comments about some of the reluctancy that we've seen. And I think it's all of our hope that as this rollout proceeds that everybody becomes more comfortable with getting vaccinated and sees the enormous benefits of it that we will get rates that will be much higher.

But the measure is meant to be reported and to be useful for really comparison and for consumers to be able to use also. To be

able to get a comparison as to what percentage of those staff within that setting that they may be choosing, are vaccinated against COVID-19.

We would consider, similar to flu vaccination measure, that we would really want to be looking at the rates of those who should be getting the vaccine, who have actually received it.

CHAIR LAMB: Thanks, Alan. We have two more questions and then I think we're going to move to a vote. Kurt, I'm thinking that because these are foundational questions for all three reviews, if we take just a little bit longer and make sure we get these on the table, that it will serve us well. Are you okay with that?

CHAIR MERKELZ: Absolutely. Sounds good.

CHAIR LAMB: Okay. So I think, Dan, this is a question to you which is, the difference between the number of IRFs in the NHSN and the number nationally. Can you comment on

that?

DR. BUDNITZ: I think so. I'm still learning my acronyms for some of the systems.

So, for the long-term care facilities we listed that they were on the order of 17,000 registered for NHSN. The vast majority are SNFs, skilled nursing facilities, on the order of 15,000.

And the others are a collection of assisted living facilities who have a much smaller number, the remainder, are those less intensive facilities that provide some level of care but not skilled measure.

Does that answer the question?

CHAIR LAMB: Let's see. Terrie, does that answer your question?

DR. BLACK: No. There is currently about 1,100 inpatient rehab facilities.

DR. BUDNITZ: Ah.

DR. BLACK: Throughout the --

DR. LEVITT: As far as --

DR. BLACK: So how, and I believe that

one slide showed that only 384, so a very small proportion actually belonged to the network. So --

MS. LINDLEY: This is Megan. I can clarify. The 384 alone number ought to be the long-term acute care hospitals. The IRFs, last I remembered, was on the order of 1,000 or 1,100 because they're required to report the flu.

DR. LEVITT: Right. IRFs are already reporting NHSN measures, both the flu vaccination measure, as well as fatality measure as well.

DR. BLACK: Okay.

DR. LEVITT: And C. difficile measure through the NHSN.

DR. BLACK: So maybe the slide was erroneous perhaps?

You answered my question, thank you.

DR. LEVITT: Okay.

CHAIR LAMB: Okay. We have a question from Alice. If the collection is for both the first and the second vaccine, will there be any attempt at reconciliation since the denominator

will likely change for the first and second, or will the first and second be viewed as independent of one another?

DR. LEVITT: Dan or Megan, do you want to discuss how you calculate the measure?

DR. BUDNITZ: Yes. So I'm not certain if I quite understand the question. The intent of the measure, as we collected, for example, weekly, is to look at the current census.

And so, one of the challenges with using data from, for example, the Pharmacy Partnership program, is they are counting vaccines.

And so, I think as implied by the question is that a, someone who, well, when there is a patient or, I guess we're not talking about residents here, but if there is a change in the denominator, and these are, for example, in this case I guess we're talking about healthcare personnel, if that person stops working in a facility and he's not there and eligible to get another vaccine, then they'll no longer be a

denominator.

I think this becomes more of an issue with, I think like, for example, the skilled nursing facilities and residents who have turned over, obviously. And that's something that cannot be accounted for in just counting doses.

And the intent of the measure is to have a current population who is either working in a facility or being treated by the facility and what their vaccination rate is at the point of assessment. Whether it's weekly or quarterly.

So, I'm not quite sure if I understand the question about, yes, there would be some, I don't know if there would be a different denominator for a first or second dose. Same denominator of either workers or residents who are in the facility of the time period of data collection.

CHAIR LAMB: Thank you. Okay, I think we're ready to go to a vote. Amy. And just to remind everybody, the first step in voting is to vote on the preliminary recommendation, which for

this measure was do not support with potential for mitigation.

And I think we heard from NQF this morning that this is specific to the measure, is not a reflection on the support for vaccination. And we've heard from NQF the rationale for that and had the opportunity to ask questions.

So, I think we are ready for this vote. And, Amy, do you want to add anything to do that?

MS. MOYER: No. I think that's a good summary.

CHAIR MERKELZ: Amy, there is, Alan is asking a question.

MS. MOYER: Sure. Alan, go ahead.

DR. LEVITT: Okay, thank you. And, again, first of all, we appreciate all the deliberation done here.

I guess, what would be really helpful to us for this, the other vaccination measures and then for the other measures that are coming, is also, getting kind of a consensus as to what

do we mean by mitigation. Like, what would you like us to be able to have so by the time of rule proposal, within reason, what can we do to help to take the discussion here and kind of move it forward.

So, besides the voter somehow, we can get that.

CHAIR LAMB: Yes. Thank you, Alan. And the plan is that once we take the vote if there is support for the preliminary recommendation, then we will go into a discussion of mitigation.

If we don't get to the magic number, then we're going to have to go through full review. Okay.

But we will, we do plan to talk about, so, now that you've supported the recommendation, what's the mitigation look like. Is that, does that respond to your concern? Good.

Okay. So, Amy, I think we are ready to call the vote.

MS. MOYER: All right. And I believe

we're going to start with a test vote. A warm up. Give everyone a chance to make sure they can get into the application without any pressure of actually evaluating another.

All right. So you should have on your Poll Everywhere screen, a test vote with a question about your favorite color. And we only gave you two choices. So go ahead and click your votes.

And, Janaki, feel free to jump in if I'm leaving something out.

MS. PANCHAL: No problem. Are you able to see my screen? Can you see the test vote pop up? Okay.

MS. MOYER: I can see it.

MS. PANCHAL: Awesome. So before you begin voting, I just wanted to send one reminder. That all organizational members should send in only one vote on behalf of your organization. So if there are multiple individuals from your organization on the call, please coordinate with each other and send in only one vote.

So like Amy said, the test vote is now up. We have 14 people who have voted. That actually takes us to quorum, but I will wait for a couple more seconds to see if there are any lasting votes that should go in.

MS. MOYER: And if you're having any difficulty with the voting, please just say something in the chat or raise your hand and we can make sure to follow-up with you and assist you.

MS. PANCHAL: Okay. We still have 15. Anyone else who hasn't voted or is having issues voting?

All right. Okay. So I will show the responses. All right, Amy, I think we are at quorum, so let me go ahead and lock the votes.

MS. MOYER: All right.

MS. PANCHAL: Awesome. Great, so I will stop sharing. And are we ready to go on to the first question?

CHAIR LAMB: Yes. Please.

MS. MOYER: We are.

MS. PANCHAL: Awesome. Let me share my screen again. Is everybody able to see my screen?

CHAIR LAMB: Yes.

MS. PANCHAL: Okay. Voting is now open for MUC2020-44 SARS-CoV-2 vaccination coverage among healthcare personnel measure for the IRF QRP.

Do you vote to support the staff recommendation as the workgroup recommendation?

Option A is yes. And B is no. Or 1 is yes, 2, no.

MS. MOYER: Okay. And as a reminder that preliminary recommendation was, do not support with potential for mitigation.

MS. PANCHAL: We have 16, 17 votes in. That is quorum. Let's wait for a couple more seconds and see if there is anyone else who is still casting their votes.

Okay, not seeing any more I'm going to lock the votes and show responses. We have 16 people who voted 1, yes. And one person voted 2,

no.

And this shows percentages. We have 94 percent of the Committee workgroup voted yes. And six percent voted no.

CHAIR LAMB: Okay. With that then, our recommendation supports the preliminary recommendation so we will not go into full discussion. But this is an important opportunity to provide feedback to CMS related to what areas would you like to see address, that you would recommend related to the potential for mitigation.

So please do share your recommendations. You can either raise your hand or just kind of say it. Dan, did you have something? Was that you?

DR. ANDERSEN: Yes. Yes. Dan Andersen. I'll take it off.

I mean, just in my perspective it seems like, to me the only thing that would lead to believe that this shouldn't just be recommended to go forward is any, you know,

around the uncertainty or technical specifications it seemed like just guidance should be issued to users.

That the collection apparatus and rules support by NHSN will dictate who is in the denominator and what gets counted in the numerator and how it gets divided, if you're talking about first or second dose and reported.

And granted, things are evolving since it's the middle of -- still going on with a public health emergency, but that, to me, shouldn't preclude the reporting of the measure. It seems like there is less uncertainty that I had originally thought.

I mean, there is now two vaccines. It answers that question, from the comments, it seemed pretty clear who should be getting -- who should be included in the "vaccinatable." And it doesn't seem that uncertain to me. That's my perspective.

CHAIR LAMB: Other recommendations? Yes.

MEMBER TRIPP: This is Aaron Tripp from LeadingAge. So, I think, and I appreciate Andrew's clarification about the NHSN if we get to multiple vaccines. Some that might be one dose versus those that we currently have that are two.

I think if this, if we talk about mitigation for this to be used as a quality measure as it relates to the QRP, I think it would be important to consider the specification to be whether it's one or two, a complete vaccination.

Because I think if we have different measures for two different things, that will make the, both the, maybe not the reporting, but the understanding of the measure and what it means difficult. So I think to the extent that things rollout and we end up in that situation, we need to think about that pretty seriously.

MS. PANCHAL: Gerri, we don't have any hand raises.

CHAIR LAMB: Okay. Ed?

MEMBER DAVIDSON: Yes, this is Ed Davidson. I think, actually, there is some pretty good precedence with another vaccine, and that's the pneumococcal vaccine.

Where that, people of different ages in long-term care have different requirements or polysaccharide versus conjugate vaccine in using that premise of up-to-date as we continue to approve other vaccines that are perhaps one dose.

And it looks like right now it's possible getting new clinics. We're still in kind of a chaos phase. At least in skilled nursing facilities in rolling out the vaccination, particularly among healthcare workers. So I think we're going to learn a lot.

And I think someone just posted in the chat, the instructions for long-term care staff. If there could be a systematic way that that information could make it into the infection prevention in skilled nursing facilities, that would foster moving that quickly.

CHAIR LAMB: Any other comments or

suggestions?

I would just like to go back to what we heard this morning in terms of suggestions and support. While we're still in these early stages, number one, to think about the feedback from the rural committee related to concerns about access and how that influences some of these rates.

As well as the comment about different health care professionals and team members, and issues related to acceptability and access so that we have opportunities for improvements here as hopefully the vaccination numbers increase.

So, any final comments, otherwise we're going to go to the gap discussion.

MS. PANCHAL: Gerri, we have a question from Alice in the chat.

CHAIR LAMB: Okay. Alice, do you want to bring out your question?

MEMBER BELL: Sure. And it's, thank you very much. It's kind of maybe further clarifies my prior question. And it goes to the

previous commenter.

So, is the standard met with any level of vaccination or only with full vaccination dose?

So, in the instance where two doses are required, I know we're collecting the first dose and the second dose separately, but what actually meets the standard?

DR. LEVITT: Dan or Megan, can you explain how it's done currently for flu vaccination in terms of understanding whether a staff member may have been vaccinated alternatively?

MEMBER BELL: And not so much alternatively, but --

(Simultaneously speaking.)

PARTICIPANT: -- vaccination.

DR. LEVITT: Yes.

MEMBER BELL: Yes.

DR. LEVITT: Yes.

MEMBER BELL: Yes.

DR. LEVITT: In other words, may have

received it other than directly through the facility. Is that the question?

MEMBER BELL: I guess the question is more, regardless of where they received it, are we measuring the standard based on each individual dose or measuring the standard based on the full dose having been received?

DR. LEVITT: So the denominator is the healthcare personnel.

MEMBER BELL: Right.

DR. LEVITT: And so the numerator would be those who have received kind of a completed --

MEMBER BELL: The completed, okay.

DR. LEVITT: -- up-to-date. Right, the up-to-date core.

And again, that up-to-date may be a one time, you know, vaccine course. It may require --

MEMBER BELL: Right.

DR. LEVITT: -- an annual -- we don't know that part yet.

MEMBER BELL: Thank you. I appreciate the clarification.

DR. LEVITT: Okay.

DR. BUDNITZ: This is Dan Budnitz from CDC. Just to add. I know it's a bit confusing because we, in addition, this is also a public health process measure.

So you have this first and second dose, but, I'm sorry for the lack of clarity, but for this particular measure it's the completed dose that would be the primary unit of measure of analysis.

CHAIR LAMB: Thanks, Dan, that helps.

MEMBER BELL: Thank you. Sorry for my 15 --

CHAIR LAMB: Okay, I'm going to turn it over --

(Simultaneous speaking.)

CHAIR LAMB: Keep perseverating, Alice. It's good to have these things clarified.

Kurt, we're going to move now into gap discussion. And I'm turning it over to you.

CHAIR MERKELZ: So, on the table we have our, part of our gap discussion regarding the parts of the quality reporting program. What are the gaps in the program measure set that CMS should consider addressing.

Program measure set is on the next subsequent slides here, will reference there are some identified points.

Amy, is there any specific details of how deep we want to get into each of these referenced components?

MS. MOYER: Sure. And just to remind everyone kind of where we've been. So, the initial item you'll see listed on each of these slides, the high priority meaning should be meaningful measures areas.

Those were areas that were identified by CMS, kind of at the beginning of this year, as areas they saw as priorities for measure development for these areas.

The workgroup identified gaps, is my best attempt to capture the discussion we had,

what feels like a long time ago, but was just in fall, on our orientation meeting, about these programs and where we saw opportunities as a workgroup for additional measure development. And we promised at that time we'd kind of circle back and check in at this meeting.

This is our opportunity to kind of give input to CMS on areas we see as priorities for the inpatient rehabilitation facility measure development and gaps in the program.

CHAIR LAMB: I'd be interested in those of you who work in this area to make recommendations in terms of high need areas. One thing just generally I'd like to suggest is hearing meaningful measures 2.0, is to look at our, the measures that we have been looking at and cross reference them.

Certainly things that we've identified before, related to the patient experience, care coordination, patient goals, we still don't have good measures in those areas. Those still remain priorities.

But given the movement to the electronic health information, and what Michelle was talking about with the digital measures, I think we have an opportunity here to use those systems differently. And to be more creative of what we have access to.

So, I'd like to see us actually look at that new 2.0 and look at where we're at with MUC measures.

Kurt, you want to kind of bring this to a close, and I'll pass the baton to you then for the next --

CHAIR MERKELZ: Certainly. And we have Eugene's comment in there, which gets into the continuation as we continue to speak about the vaccination measure.

I think that certainly has a lot of each individual's head space of getting their mind around what this type of measure would look like and how effectively and how quickly we could get it to implement it.

Are there any additional comments, or

any comments at all, anybody want to make before we move on with the additional gaps?

And if that's the case, then we will close out that section and move on into the long-term care hospital quality reporting program. And, again, specifically dealing with the SARS-CoV-2 measure.

I think it will be a continuation. It's a continuation of our previous discussion. And we can continue right in.

I think Alan is ready to jump right in. Eugene, do you want to give, Amy, do you want to give a clarification of this before we get into the question and discussion?

MS. MOYER: Sure. First, I do want to welcome Sean Muldoon, who is joining us from Kindred. He is subbing in for a brief moment.

Sean, can you introduce yourself and let us know of any potential conflicts of interest you might have?

MEMBER MULDOON: So, I'm Sean Muldoon, chief medical officer for Kindred's Long-term

Acute Care Hospital division. And other than being an employee of Kindred, I have no conflicts.

CHAIR MERKELZ: Welcome back to the workgroup, Sean.

MEMBER MULDOON: All right.

MS. MOYER: And, Sean, if you haven't already pulled up Poll Everywhere and logged in, you should have an email with instructions for that.

MEMBER MULDOON: All right. Thank you.

MS. MOYER: Perfect.

DR. STOLPE: Amy, just one other point for Sean. We need to ask for, have a written form pulled filled out for the disclosures of interest before we can allow a vote. So please make sure that you complete that before the voting begins.

MEMBER MULDOON: All right. I'm working my way through the sign in right now. But I will not vote until I have that. Thank

you.

DR. STOLPE: Thanks very much.

MS. MOYER: All right, thank you. So overview of the long-term care hospital --

CHAIR LAMB: Amy? Amy, before you do that I think we need to call for the public comments in this area. We don't want to not get those.

CHAIR MERKELZ: First thing, the introduction of the program details and then we can jump over to the public comment. And maybe we can open it up and see the, Alan's --

CHAIR LAMB: Okay, that's fine.

CHAIR MERKELZ: -- response to the --

MS. MOYER: All right. So this program is very similar to our last discussion. It is a pay for reporting and public reporting.

And any long-term care hospital that does not submit the data will have their applicable annual program for a payment update reduced by two percent.

A reminder of the goal for program,

they furnished extended medical care to individuals with clinically complex problems. And with that, I believe we can move to public comment.

CHAIR MERKELZ: We can certainly, at this time, open up to any type of public comments that may come across.

MS. PANCHAL: No hands raised and no comments in the chat. So far.

CHAIR MERKELZ: We do have one previous point, Janaki, that was raised by Eugene that's in the chat box. We can jump, Eugene, do you want to clarify on that? Do you want to expand and let Alan respond?

DR. NUCCIO: It's pretty straight forward. My concern is if the measure will be used in any kind of value based program that I'd like no, I think the providers would like to know what is the acceptable performance level for such a program that has financial incentive built into it.

MS. MOYER: Sure. And, Eugene, that's

actually a great context question.

For, as we are stepping through each of these programs, the program discussed in the overview is the specific context that we are discussing and measured.

And so for instance, in this program it would be part of quality reporting for long-term hospitals. And the financial implication would be if they didn't submit their information.

And so the structure of this program is not based on performance on the measure, but on the submission of data. But that is a great point. We're not just talking about the measures, there is the context of the program.

DR. NUCCIO: Yes, there is a bit, some data, that is not the standard and they're good to go. That's fine.

MS. MOYER: Sounds good. All right. So moving forward. I will talk extremely briefly about the measure.

The specifications, the preliminary analysis, the concerns and recommendation for

this measure are identical to the previous program. The only difference is substituting the program of long-term care hospitals or inpatient rehabilitation facilities.

That and we received one less comment. We did not get a specific comment from the rehab groups on this. But otherwise, all of the material is the same so we're not going to read it through in detail again.

CHAIR MERKELZ: And all the prior discussion, the employee categories, the refusals, issues reporting, all that still stands. We certainly understand the uncertainty around components of the measure.

But certainly in the spirit of the necessity of the measure admits the public health emergency and its importance, it certainly does rise to all the components of relevance and importance.

However the NQF recommendation does still stand, do not support with potential for mitigation, similar to our previously discussed

measure.

Is there anything additional that the workgroup would like to have clarification?

MEMBER TRIPP: I got a clarification question based on Amy's point to Eugene's question. With recognition that we're talking about this in the context of QRP, one thing that's been referenced in a number of occasions is also public reporting via the Care Compare.

And so, is the thought with this, a lot of the NHSN data, or at least the COVID-19 is already publicly available where you can pull that down. Is the expectation that this would be within, the reporting would be your NHSN for the QRP but that it would also be publicly reported under Care Compare?

DR. LEVITT: Would you like me to answer? Is that okay?

CHAIR LAMB: Yes.

DR. LEVITT: Okay. Thank you, Alan, for another excellent question.

And the answer is, yes. The mandate

for all of these programs is that data gets reported by the providers. There is a, I guess, I hate to say a penalty, but there is a requirement that they submit the data and that the data would be submitted and available on CMS website.

And the advantage of these websites is really the ability to compare from one facility to another. So in other words, looking at it from a provider's standpoint. Obviously getting the data and being able to compare themselves to others within that setting.

But then also for patients and families when they're selecting a provider within a certain setting to be able to pull up that data and then be able to compare it one to another. And that doesn't preclude, there is so many moving pieces here. And that's a whole another part that we kind of alluded to in the morning call.

I mean, there is so many possibilities here of how the data may end up being mandated or

required that are outside of what we're really looking at here.

But our goal here was, really from the start, was really, despite whatever comes in terms of the vaccine administration, all the other data submission requirements that may be necessary for the NHSN for surveillance purposes to be tracked as to where things are going, whatever.

But ultimately, we believe that we would want to have a measure available of, similar to the way the flu vaccination healthcare personnel measure is, that would be publicly reported and available for our Compare websites.

DR. ANDERSEN: This is Dan Andersen. Can I ask a procedural question?

CHAIR MERKELZ: Go ahead.

DR. ANDERSEN: So these vaccination measures, if the -- like the previous measure, if the recommendation to support with potential for mitigation goes forward, what does the mitigation look like?

And I guess importantly, what is the time frame that the developers have to make those changes and eventually get them into the public's hands via one of these programs. I mean, because that, I mean, probably nuances, being what they are, the fact that we're in the middle of a crisis sitting on these measures are making it so that we can't get the measures implemented in time is a challenge.

I just thought, this is in the back of my mind is, what does that mean when we're making these votes like pragmatically.

MS. MOYER: That's a great question. And the rule of the MAP is to be advisory to CMS. So the measures need to, come through the MAP process in order to be included in federal rules.

But the recommendations we make are non-binding. That said, CMS has been very respectful and responsive to those recommendations with a very strong relationship.

So the input that comes out of the workgroups is frequently taken. I know I've seen

it appear in the federal rules, like what the responses were and a discussion of that. But it is non-binding, it is advisory.

CHAIR MERKELZ: And what kind of time frame do you believe, Amy, will be, will NQF have in getting back those comments?

MS. MOYER: So we don't necessarily get a response to the mitigation or the condition we put on these things. We do frequently get an update from Alan when we start the next cycle of MAP. He's been very good about closing the loop and making sure we understand where our recommendations went.

But there is no, you have to get back to us by April or anything like that for a time frame.

Okay. Alan, did you have another --

DR. LEVITT: Yes. I keep trying to turn on a red light here that I don't have. And I hate, you know, I don't want to interrupt a discussion, so you tell me when you want me to respond.

But again, these are such special circumstances. And you've probably seen we've had several, we call IFCs, final rules with comments, where we've actually gone ahead for different things like a submission of COVID-19 data for long-term care facilities where we've just gone ahead and recognized that we need to take into account public comment.

But we need to, sometimes not use kind of the more traditional or the processes we want to use, like this pre-rule making activity and then public comment. Normal rulemaking as well.

But when possible we want to use this. And that's why we're here today. We'll make a decision based on determinations here and the hospital workgroup. And then there's also going to be, there's a measure for MIPS program that's going to be brought to the clinician workgroup.

We'll make a decision as to how to proceed from here. And even if we do proceed, let's say we proceed it with rulemaking, we want to take into account all of these factors in

terms of both proposing it through the rule as well. Because we want to work together with you.

And like Amy said, no matter what, I end up coming back. If I'm here next year in October.

And I'm a strong believer. I'm the one who started the feedback loop for CMS because it's what we needed to have. It's a matter of respect for all of your work, is to kind of come back and say, this is what we did, this is why we did it. So to speak. And so, no matter what you can expect that from us.

CHAIR MERKELZ: I think that's very helpful, Alan. Do we want to proceed then to voting on our acceptance of the preliminary MAPs?

CHAIR LAMB: Yes.

MS. MOYER: And as we pull up the voting slides -- and, again, we wanted to make sure everyone understands what we are voting on.

So, the vote to accept the preliminary recommendation, which is do not support with potential for mitigation, means we feel these

measures need to be reworked a little bit before they're implemented in the program.

So, if you go back to kind of the slides this morning, that recommendation usually comes into play when there's a gap in quality information and evidence and it addresses a challenge.

But then we start to get into more of the concrete things about the measure like the specifications or testing or things like that, and we feel that there do need to be some changes in that area.

So, I do want to make sure we're not telling CMS we don't think you should measure those, we don't think this is important, it's we think this needs a little work before it goes into the program.

I just want to make sure that that was clear.

DR. ANDERSEN: Sorry -- and Dan, sorry if I'm annoying people, but I guess one of my questions about the procedural thing was like if

workgroup members really feel like these measures should be recommended, the only way to do that then is to basically say no to this, then, and force a full conversation; is that correct?

MS. MOYER: Correct.

DR. ANDERSEN: Okay.

MS. MOYER: That is correct.

MS. PANCHAL: Great. So, voting is now open for MUC2020, COVID to Vaccination Coverage Among Healthcare Personnel Measure for the long-term care QRPD vote to support the staff recommendation as the workgroup recommendation.

Option A -- or Option 1 is yes. Option 2 is no. We have 15 votes and I believe we had 17 last time.

So, we'll vote for -- I will wait for a couple more minutes to see if there's any more votes that trickle in.

(Pause.)

MS. PANCHAL: We have 16 votes in. Seventeen votes in.

Amy, are we good to lock the voting

now?

MS. MOYER: I believe we are.

MS. PANCHAL: Voting is now closed. We have 16 votes for Option 1, yes. And 1 vote for Option 2, no.

Which means we have -- percentage-wise we have 94 percent of the workgroup members voted yes and six percent of the workgroup members voted no.

CHAIR MERKELZ: So, we have our workgroup recommendation at this point in time. We can actually move forward and move into discussion regarding any gaps in long-term care.

MS. MOYER: I do want to just really briefly follow up.

So, the mitigation, we spent some time discussing that for the last program, I have uncertainty around the technical specifications that the NHSN recommendations in that should prevail.

The numerator should be completed vaccination, which I believe we clarified it is.

And then education around vaccination would be helpful for facilities.

We also, of course, would like to see it go through NQF endorsement with NQF. I just want to make sure I adequately -- I captured the mitigation.

MEMBER MULDOON: This is Sean and I'm late to the game, but the denominator is, is it as important?

I mean, do you want the frontline -- the meaningful one is the frontline, which ought to be quite high.

But if you start adding in the salespeople, the administrative staff, the accountants and all that, it's a very easy number to get and you can't get it wrong, but it will reduce the public's vision of what that number means.

MS. MOYER: Okay. So, I heard potential mitigation to consider limiting the denominator to frontline healthcare personnel.

MEMBER MULDOON: Well, I don't know --

that's very hard to do, but that's really the denominator you want.

MS. MOYER: Okay.

DR. LEVITT: Sean, would it -- I'm not sure if -- would the NHSN colleagues want to comment on the appropriate denominator to consider for this measure?

DR. BUDNITZ: This is Dan. I think this is an excellent question. I don't know if we know the answer. The way we constructed it is, right now, people who work in the facility.

So, that, you know, and, as you described, there's a range of folks from people that might be clerks to people that might work back office billing.

I would also ask if Megan Lindley, who has worked with the flu vaccination measure, would like to comment as well.

MS. LINDLEY: Thanks, Dan.

Yeah, I think the point is well-taken. I guess my first thought hearing that is we're talking about implementing these in 2022.

I think that the, you know, the availability and the recommendation of who should be vaccinated and even, you know, potentially if it's a virus that ends up -- I mean, something that circulates seasonally in the way of influenza like the pandemic flu strain H1N1 did and just gets incorporated into the routine vaccine, it might be a little bit broader than just the frontline.

And, of course, further do we -- we do measure everybody and not just the frontline personnel, because it's a long-established recommendation for all healthcare personnel.

I think it's another one of those things where the situation now versus the situation when the measures might be implemented is divergent.

DR. LEVITT: And certainly from the CMS standpoint, we will always follow the guidelines as, you know, currently best known in terms of who should or shouldn't be vaccinated.

But at this point, the denominator

would be considered to be, you know, all healthcare personnel in the facility since transmissibility of COVID within a facility may occur well beyond due to frontline healthcare workers.

Obviously, we'll know more as things go on, but at this point that would be the denominator that we're talking about, Sean.

MS. PANCHAL: Kurt, we have Ed Davidson whose hand is raised.

CHAIR MERKELZ: Ed, go ahead, please.

MS. PANCHAL: You're on mute, Ed. We can't hear you.

MEMBER DAVIDSON: Just wanted to throw out the consideration of use of the classification system that's used in the payroll-based journals.

We actually use that as a covariant in a recent trial where we looked at full-time, part-time and contracted staff.

So, those strata might be, you know, useful in some regard because payroll-based

journal reporting is required in skilled nursing facilities.

CHAIR MERKELZ: And we have additional questions coming to the chat regarding further clarification on frontline staff.

For instance, cleaning personnel may have contact with the patient though not directly involved in delivering hands-on care.

The same thing would go with the activities coordinators, dietary. All these individuals potentially would have interaction.

MS. MOYER: And just to clarify, the current -- I believe the current definition and plan specification in the measure is not to break the measure out by employment categories.

This was something we were considering as a group. So, I would not expect CMS or CDC to really have a planned answer for our kind of hypothetical denominator, but I will include that in our notes that, you know, the discussion of the pros and cons of knowing that denominator.

MEMBER TRIPP: Was that -- I'm missing

the -- was NQF's definition of healthcare -- I'm not seeing it going back in the chat -- was that listed somewhere?

I don't see it quickly when I pulled up the measure specs in the materials.

MS. MOYER: Um-hmm. So, the definition of healthcare personnel would come from the measure developer. So, CMS and CDC.

And I believe, at this point, it is anyone who works -- can work in the facility, but please correct me if I have that incorrect.

DR. BUDNITZ: This is Dan from CDC -- yeah, this is Dan from CDC. It's people who are eligible to work in the facility.

So, it does include, you know, folks that are -- what we discussed during the earlier question like folks that might do other activities, certainly folks that do cleaning of the rooms, might be food service. Those are included in this definition.

The eligible to have worked means that folks that might be on leave for one week, but,

you know, on vacation, but are going to be, you know, are currently employed or contracted to do work at the facility.

DR. LIVESAY: Hi, everyone. This is Sarah.

I'm just sitting here kind of philosophically thinking about this discussion and agree there's pros and cons on both sides.

I just think that from a practical operational standpoint to try and break out subgroups of employees is extremely challenging and probably will result in more work for organizations -- I mean, significantly more work -- than a blanket statement as it's currently written.

And then I also think about, you know, what is our overall goal here, and I think it's to keep our patients safe, to keep our staff safe, decrease transmission, right, and the list goes on and on.

And I do think that in order to meet those goals it matters whether or not -- it does

matter that your back office staff, if you will, that may not be interacting directly with patients on a daily basis, but are interacting with each other and are interacting with other healthcare providers, it would stand to reason that they should be vaccinated as well.

So, at least as I'm currently thinking about it, I really am supporting the original language here.

CHAIR MERKELZ: Thank you, Sarah.

Amy, do you want to further comment on that?

MS. MOYER: I would just say that that is a consideration we had as we were reviewing the measure and the question about splitting that out and what that might do to feasibility.

I do want to kind of close this discussion if, you know, we've kind of addressed all of the issues, and then discuss what the gaps in the program measures then might be briefly.

CHAIR MERKELZ: Absolutely. CMS established the high-priority meaningful measure

areas, which included person and family engagement, functional outcomes, exchange of electronic health information and interoperability measure concept and healthcare-acquired infection.

In addition, the workgroup last year got into further discussions regarding other identified gaps, which included care coordination involving the patients and caregivers in the care design, care aligned within meeting patient goals, and availability of palliative care in the long-term care health hospital environment.

It's certainly open up to further discussion regarding any other identified gaps or other areas worth commenting on.

MEMBER MULDOON: So, the question is, are there more gaps or are we --

CHAIR MERKELZ: Absolutely, Sean. If there's any other areas -- any other areas that you can recognize or feel need attention regarding gaps in the long-term care hospital environment.

Janaki, any other comments or anything else that's come in?

MS. PANCHAL: I don't see anything. There are no hands raised either.

CHAIR MERKELZ: In that case, that puts us actually back on track and on time and we can hand it back over to Gerri to continue the discussion.

CHAIR LAMB: Okay. So, we're going to move into the third COVID measure similar to the previous two.

So, Amy, would you do the intros?

MS. MOYER: Certainly. So, very similar to the previous two programs we've discussed, the Skilled Nursing Facility Quality Reporting Program is pay-for reporting and public reporting.

So, the incentive structure of the program is that SNFs that do not submit the required quality data will have their annual payment update reduced by two percent.

The program goal is to increase

transparency so that patients are able to make informed choices.

And we can -- it's open for public comment.

CHAIR LAMB: Thanks, Amy.

MS. PANCHAL: Gerri, I don't see any hands raised and haven't seen any comments come through in the chat either.

CHAIR LAMB: Okay. Thank you, Janaki.

Alright. Amy, if you would go ahead and introduce the measure then?

MS. MOYER: Alright. So, this is pretty much exactly the same measure as we've been discussing.

It is simply applied to skilled nursing facilities and in that setting and program, received the exact same comments as the previous measure, and has the exact same mitigation plans recommended by staff. So, it would be do not support with potential for mitigation.

Our mitigation points were that the

evidence should be well-documented and that the measure specification should be finalized.

That should be followed by testing and NQF endorsement. I believe that also captures kind of the workgroup discussion we've been having as well.

CHAIR LAMB: Okay. Let's open it up for any questions specific to the application in the skilled nursing facility area. Questions?

MEMBER MAHAJAN: This is not a question. Just a quick comment on how effective or overall uptake has been with the QRP and the dollars related to it.

I -- we've gone through our first couple of sessions through the facilities with the current vaccination.

So, I just would love to have CMS or anybody higher here consider a different way to incentivize, or disincentivize, based on how you're looking at characteristics of this particular measure for the SNF programs.

I -- this is just -- we -- 50 percent

is a very good rate right now for what we -- again, this is totally anecdotal from my personal experience, but I'm talking at least half a dozen facilities that have gone through their first session.

So, if it is just included in -- within QRP, this particular -- I just -- I would think that we have to do something bigger and better to help with the uptake of this particular measure. And that was my comment.

MS. PANCHAL: Hi, Gerri. There's a question from Muldoon. I sent it to you if he wants to ask that question. And then we also have Aaron Tripp who's hand is raised.

CHAIR LAMB: Great. Sean, do you want to ask your question?

MEMBER MULDOON: Yeah. And, again, I apologize for being late to the party.

Do these measures assume, No. 1, that vaccine is plentiful, that; 2, it's easily distributed and; 3, that it has a full FDA approval?

CHAIR LAMB: Alan, do you want to respond or Dan?

DR. LEVITT: Well, I guess a couple of things. We did talk a little bit about this, this morning.

Just getting back to Raj's comment, certainly something I actually mentioned in almost a personal comment this morning about, you know, trying to improve the vaccination rates for healthcare personnel.

Certainly we want to maximize that as much as possible and want to work with, you know, the provider organizations and everyone else in terms of trying to improve the rates of vaccination.

Regarding looking at this measure and vaccine availability, again, to remind ourselves that we're talking about measures that if we did propose, finalize, and implement them into our quality reporting programs for public reporting, would likely be getting public reporting sometime around the earliest probably this time next year.

And that some of these questions regarding availability and such would be answered by then.

Our goal is obviously to, you know, vaccinate, as I'm sure yours is to appropriately vaccinate our staff, and be able to hopefully by the time that this measure would be publicly reported, that that would be, you know, an accurate reflection of the availability of vaccine, you know, nationwide.

CHAIR LAMB: Thanks, Alan.

Aaron, you had a question?

MEMBER TRIPP: Yes. So, the question when I was flipping through the slides, is probably more fits into the gap piece because I didn't see that for SNFs.

So, I don't know if I should go ahead with that now or do we wait for after that preliminary vote?

At least it wasn't in the pre-shared slides. So, I wanted to double-check.

CHAIR LAMB: Okay. We will have a gap

discussion, Aaron. So, definitely please hold it, but make sure you say it. Okay?

MEMBER TRIPP: Okay.

CHAIR LAMB: Perfect. Let's see. I think, Jennifer, you had a question about whether hospice providers were included in the count.

Do you want to state your question?

MEMBER KENNEDY: Yeah. I basically wanted to make folks aware that, you know, hospice providers are coming into hospitals. And if it is in a rural area, then they'd be going into LTCHs or CONS (phonetic) and are definitely going in to SNFs and nursing facilities to provide that end-of-life care.

And there has been a debate actually since COVID has started, whether hospice is really included in healthcare staff in these facilities since they're coming in and out, if the facility lets them.

So, I just wanted to throw that caveat in there that you do have community people coming in if the beneficiary has elected their Medicare

hospice benefit.

CHAIR LAMB: So, Jennifer, is that a question or are you just recommending? Because I had understood, from some of the dialog this morning, that some of the contracted providers like OT/PT in some of the rehab facilities are included.

Are hospice individuals --

MEMBER KENNEDY: That's unclear. You know, that's really unclear at this point via CMS.

So, I guess I'm just putting it out there as a comment for examination and inclusion.

CHAIR LAMB: Okay.

DR. LEVITT: Can -- I'm not sure whether any SNF colleagues could -- can you clarify whose in the denominator?

DR. BUDNITZ: This is Dan from CDC.

So, I think you're asking a question and I'm not entirely clear, like, how these hospice providers are paid for.

So, if they are contracted by the

long-term care facility, then certainly they would be in the denominator.

But if they are providing services and it's not affiliated with the facility, per se, I think we'll have to think about how -- well, as you raised the question, how should those folks be counted if they are nonemployees and noncontracted?

MEMBER KENNEDY: Yeah, they're nonemployees, noncontracted.

DR. BUDNITZ: And nonvolunteers through the facility, then how are they counted?

MEMBER KENNEDY: Yeah. Yeah. I guess that's what I'm -- I just want to put out there.

DR. BUDNITZ: Okay. I think that's something we'll have to think about.

MEMBER KENNEDY: Alright. Thank you.

CHAIR LAMB: Great. Good point, Jennifer.

Other questions?

(Pause.)

CHAIR LAMB: Okay. then I don't see

anything more in the chat, Janaki. So, let's call the vote.

And, Amy, if you would clarify the vote again, as you have in the past?

MS. MOYER: Absolutely. The current vote is to accept the recommendation on the preliminary analysis, and that is, do not support with potential for mitigation.

And, again, the mitigation points are that the evidence should be well-documented, that the measure specifications should be finalized, and that it should be followed by testing and NQF endorsement.

MS. PANCHAL: Great. So, the voting is now open for MUC2020-44 SARS-COVID Vaccination Coverage Among Healthcare Personnel Measure for the Skilled Nursing Facility Quality Reporting Program.

Do you vote to support the staff recommendation as the workgroup recommendation? Options are 1, yes; 2, no.

(Pause.)

MS. PANCHAL: Looks like we have 17 votes in already. I think that's how many we are expecting. So, I will go ahead and close the voting now.

We have -- voting is now closed. We have 16 votes for 1, yes. And one vote for 2, no.

In terms of percentages, that is 94 percent of the committee voting yes and six percent of the committee voting no.

CHAIR LAMB: Okay. So, that is -- we accept the analysis. So, does anybody have any suggestions/comments related to mitigation?

(Pause.)

CHAIR LAMB: Okay. I don't see any in the chat.

Amy, do you want to summarize for us, then, the mitigating comments that we've heard so that -- just so that we can kind of sum this up before we take a break?

MS. MOYER: Sure. So, the mitigations are primarily focused around the technical

specifications and the lack of clarity there.

So, we want to see fully developed technical specifications followed by testing, once there are data to test with, and NQF endorsement.

There was also a recommendation, perhaps an implementation in the measure, that education around vaccination for the facilities would be helpful.

MS. MOYER: Okay. Anything to add to that?

MEMBER TRIPP: So, I want to go back that sort of relate to mitigation and sort of with the gap.

MS. MOYER: Okay.

MEMBER TRIPP: So, one of the things that I want to come back to that I had mentioned this morning particularly in the context of post-acute care, that there's a lot of talks of reform and change going on within CMS and HHS and we've got three of the four categories included.

So, the fact that home health is not

part of that given the comparison and everything, I think that should at least be brought up in the context of the post-acute side of the workgroup.

And then also to Jennifer's earlier point, because if I think about the members that we have at LeadingAge, we have folks that are in skilled nursing and home health and hospice and really with a lot of the -- one of the biggest topics right now in all of the vaccine conversations we are having as a staff and with our members, is distribution and uptake across different sites.

So, I do think it's important that as valuable as these are within setting-specific silos, there does need to be thought for what items are not -- do not have specifications.

And in some instances that's related to a fair reporting and NHS Internet, but for those that are not, which I know home health isn't and I'm pretty sure hospice is also not anything in NHSN, that we ought to think about those settings that are intimately -- you know,

there's very porous borders for, in some instances, workers and, in many instances, the Medicare, Medicaid, private-paid beneficiaries who are accessing these services.

DR. LEVITT: Thank you, again, Aaron for those comments.

Again, I think, as you saw this morning, what we are trying to do here is, you know, operationalize a system that, you know, already was in place to be able to use this.

And certainly, you know, we agree with you, you know, that, you know, healthcare personnel vaccination is important in the home health setting and that, you know, we should look at whether or not the NHSN system, you know, should be used, you know, for this or whether there are alternatives or things like that. So, we do appreciate your comment.

CHAIR LAMB: Thanks, Aaron.

And, Amy, I hope we've captured that in our notes in terms of the comments back.

Okay. We are scheduled for a 15-

minute break and --

MS. PANCHAL: I'm sorry, Gerri. You have one more hand raised if you want to call on --

CHAIR LAMB: Certainly. Can you tell me who, Janaki?

MS. PANCHAL: Yes. Eugene.

DR. NUCCIO: Yes. I just wanted to support Aaron's point and make the point to the developers that there are some fundamental differences between a brick and mortar kind of setting that is described here with IRFs and LTCs and SNFs and ESRDs as opposed to home health.

And as well as the fact that the reporting requirements are fundamentally different between those kinds of settings and in home health.

And so, if CMS decides that they want to migrate these measures to home health, it will be more than just a simple cut and paste.

And so, I don't know whether that's part of the mitigation comments, but I think that

they should be very sensitive to the demands or the uniqueness of home health as compared to brick and mortar kinds of settings such as described in the description here.

DR. LEVITT: I apologize for interrupting again, but one suggestion may be is when we do discuss the home health quality reporting program, you know, in terms of gap area for that program, is to, you know, if the workgroup agrees, you know, with that opinion that, you know, that could be considered a gap area.

CHAIR LAMB: I would totally support that. Gene, I think that's an excellent point in terms of kind of the whole venue of post-acute/long-term care and especially with the goal of alignment of the measures across post-acute/long-term care is really looking at that.

And I would include, as Jennifer was saying before, let's also look at hospice so that we look more at the continuity across these settings, but we also take into account that

they're not the same.

So, I really support that comment, Gene. I thought that was excellent. Okay. Any others?

Janaki, any other hands up?

MS. PANCHAL: No. I think we're good to go on the break.

CHAIR LAMB: Great. So, Amy, 15 minutes is about 5 -- let's see -- I'm cross-checking between the Pacific here. So, it's 2:41.

Do you want to go to 3:00 or do you want to go to 2:55?

MS. MOYER: I'm going to ask everyone to stick to 2:55 because we may need that five minutes coming up.

CHAIR LAMB: Okay. So, 2:55. Please come back on a minute or two early so we can get started and we're going to move directly in to hospice. Thanks. Have a good break.

DR. BUDNITZ: And thank you all for your thoughtful comments on these measures.

Appreciate it.

MS. MOYER: Thanks for being here, Dan.

SPEAKER: Yeah. I want to thank the entire NHSN team. They've really been a wonderful team to work with from the beginning.

Like I said this morning, this is something we've been working on really since almost the springtime trying to envision this and, you know, it's been a pleasure to work with them.

(Whereupon, the above-entitled matter went off the record at 2:42 p.m. and resumed at 2:55 p.m.)

CHAIR MERKELZ: Alright. Everyone is present. Everybody is ready to get going. I certainly appreciate Amy giving us five extra minutes as we get into the Hospice Quality Reporting Program.

Do we have -- is Amy here on the call? And do we have -- there's the first slide with the Hospice Quality Reporting Program.

We will be discussing the MUC20-0030

and potentially any other gaps that may currently take place in the Hospice Quality Reporting Program.

With that, I would love to be able to get Amy to get us kicked off and into it and give some of the descriptions of the Hospice Quality Reporting Program.

MS. MOYER: Alright. Thank you, Kurt, for getting us started.

This Hospice Quality Reporting Program is pay-for reporting and public reporting. Hospices that fail to submit quality data will have their annual payment update reduced by two percent through fiscal year 2023, and then that increases to four percent beginning in fiscal year 2024.

The program goal is addressing pain and symptom management for hospice patients and meeting their patient-centered goals while remaining primarily in the home environment.

CHAIR MERKELZ: Thank you so much, Amy. We can certainly go to see if there's any public

comments.

As a reminder, we're commenting just now under the Hospice Quality Reporting Program. Certainly try to limit your comments to under two minutes and certainly you can address the measure under consideration, the Hospice Care Index, or any additional measures as it pertains to the Hospice Quality Reporting Program.

Janaki, do we have any --

MS. PANCHAL: Yes. Yes, Kurt. We have Janice Tufte. Her hand is raised.

Janice, if you want to go ahead?

MS. TUFTE: Sure. Thank you for having me today.

I serve on the MAP Coordinating Committee and I am a public panel member, subject matter expert.

And so, I am trying to learn more about the MUCs before our big meeting, but I wanted to say I read this over before and I was -- I'm really happy to see a hospice measure because I personally am very involved with

healthcare for the homeless in Seattle, King County, and this is a population particular, as well as isolated, individuals that sometimes do not get hospice that are in their home alone.

And so, I think -- I'm hoping that this will help encourage for us to be able to have hospice more readily available to the individuals that aren't receiving it. Thank you.

MEMBER KENNEDY: Hi. This is Jennifer Kennedy.

Can you hear me?

CHAIR MERKELZ: Yes, Jennifer.

MEMBER KENNEDY: Great. I have a few comments.

While NHPCO does support the concept of an index measure, there are few things within the measure that, you know, we would like to ask for clarification or even just essentially provide some comment.

We always have push back on purely claims-based measures as we don't feel that they're a total representation of quality of

care, and I would like that to be just a statement right out of the gate.

And I do understand the ease of collecting data from claims because it's more readily accessible, but there are a few things that we do have some concerns about.

It looks like the transition measure that came across NQF's desk a couple years ago is now being folded into this index measure.

And if that's going to happen, we would like some clarification on the time frames, particularly for readmission to the hospital after a hospice discharge and then readmission back to hospice, what time frame would that be in.

We previously stated that we do not feel that revocation should be folded in to hospice discharge because that is a decision of the beneficiary to step away from their hospice benefit. They're free to come back to it at any time, but it is their decision.

A couple of other things we're

concerned about is the nursing visits, the length in minutes.

We want to know where that came from. What's the standard for a quality nursing visit? Is it, you know, 60 minutes? Is it 45 minutes? Is it 90 minutes?

So, there doesn't seem to be a standard there that we know of that's in regulation to warrant that.

And we also want to -- for the No. 10 indicator, visits in the last phase of life, that measure is already on deck to be implemented by CMS as sort of a redefined measure of previous visits when death was imminent measure pair.

So, we feel that that indicator is duplicative if CMS needs to go through with implementing the hospice visits in the last days of life measure.

So, we feel that there needs to be some clarification really throughout many of those indicators relating to time frames and just looking at any sort of duplication that may

already be present with either measures on deck or current information that is being collected.

So, those are our comments and we -- oh, one last thing is we really feel telehealth visits should, in the future, be considered for any kind of measure.

We're doing telehealth during COVID and I know that NHPCO is advocating for some telehealth post-public health emergency as well as other provider types.

So, we would like CMS to consider inclusion of telehealth visits as well. Thank you.

CHAIR MERKELZ: Very good. Thank you so much, Jennifer, for that.

Do we have additional comments coming from the public?

MS. PANCHAL: No other comments in the chat box, Kurt. And I don't see any other hands raised either.

CHAIR MERKELZ: Amy, do you want to go ahead and introduce the measure under

consideration? And I believe there's also a video to go with this.

MS. MOYER: Yes. So, I am going to have the developer first give an introduction to the measure, and that does include a video and they have some slides prepared.

I think having that overview of how the measure is constructed and was developed will be beneficial before I dive into the details of the preliminary analysis and the recommendation.

DR. LEVITT: This is Alan. I'm not sure if I could do this to make a couple of comments up front. First of all, thank you for the public comments on the measure.

I had forgotten to introduce -- we have an outstanding program and -- my division, I'm very proud of.

When we review the quality reporting program, inpatient rehab, Ariel Adams is the program lead.

And Christy Hughes is the program lead for the Long-Term Care Hospital Quality Reporting

Program.

And Heidi Magladry with -- along with Casey Freeman, who you'll meet later, are the leads for the SNF Quality Reporting Program.

Joan Proctor, the Home Health Quality Reporting Program, will be present later to hear the comments about that program.

And in the Hospice Quality Reporting Program we have Cindy Massuda. Cindy is a wonderful model as to a program lead.

She really owns the program. She owns the measures within the program as well. It's been a pleasure to work with her.

Cindy has really led the development of this composite measure of hospice care practices and behavior and will discuss the measure now along with T.J. Christian from Abt Associates.

You probably remember T.J. from last year when he presented along with the -- on the visits measure.

So, I'll send it to you, Cindy, and

thank you so much.

MS. MASSUDA: Thank you so much, Alan, for your kind words. And thank you very much, Amy, and everybody on the NQF panel.

I am Cindy Massuda. I am the CMS steward together with T.J. Christian from Abt Associates, the Measure Development Team.

We're here to discuss the Hospice Care Index, which is a claims-based measure that we're proud to bring forward to you.

Next slide, please. So, the Hospice Care Index, which we'll also refer to as the HCI, is a composite index that combines ten claims-based indicators representing several categories of hospice care practice.

The HCI aggregates the scores from the ten indicators into a single total score. The vast majority, about 85 percent of all hospices, score an eight or better on this quality measure, as T.J. will present later.

While a single claims-based metric may be affected by external circumstances in an

unlucky year, a hospice is less likely to fall short across multiple indicators simultaneously.

A hospice's performance across all ten HCI indicators will provide a comprehensive overview of performance, helping consumers choose a hospice, and helping providers identify opportunities for improvement.

Based on our statistical analyses of national hospice performance, each of the selected indicators demonstrates validity, reliability and meaningful distinction between hospices.

The Hospice Care Index both meets quality measure standards and reflects the interdisciplinary nature of hospice.

Therefore, CMS believes the Hospice Care Index will contribute value to the Hospice Quality Reporting Program.

Next slide, please. So, the HCI fills a gap in hospice quality measurement. CMS' Meaningful Measure Initiative seeks to identify valuable measures from a variety of data sources

to provide a representative window and to have hospice care quality through the dying process.

Currently, the Hospice Quality Reporting Program only has quality measures at admission and discharge.

The Hospice Item Set, or HIS, assesses activities at admission and discharge. The CAHPS Hospice Survey assesses the experience of care for patients that died on hospice.

The HCI helps bridge the gap of claims data represented by the yellow arc on this graphic, and reflects care delivered during the hospice stay.

Taken together, the HIS, CAHPS Hospice Survey and the HCI better reflect the impact of care throughout the hospice stay across the multiple disciplines of the care team.

Before I turn to T.J. to discuss the performance results that support this quality measure, we would like to show you a short video that summarizes how the measure brings value to both the Hospice Quality Reporting Program and to

consumers.

Next slide, please. Video, please.

(Video playing.)

DR. CHRISTIAN: Hey. This is T.J. Christian. You can go to the next slide. Yeah, great. Thank you so much.

So, as Cindy mentioned, the Hospice Care Index, or HCI, combines ten claims-based indicators.

So, we actually simulated the data using 100 percent federal fiscal year Medicare claims data.

So, in effect, each indicator has its own numerator, denominator and criterion to identify whether a point is earned in each indicator.

The criteria are based on statistical analysis to determine meaningful thresholds that differentiate hospices.

So, determining a hospice score for the index, the index sums up the points earned for all the indicators.

Scores can range from a 10, meaning all points are earned on all indicators, to a zero on the whole.

So, next slide, please. Okay. Great. So, this graphic displays -- summarizes the relationship between the indicators and the Hospice Care Index score.

So, each indicator can contribute up to one point towards the overall Hospice Care Index score.

So, we solicited feedback on the Hospice Care Index concept and selected indicators from a variety of stakeholders, including hospice providers, family caregivers, and a technical expert panel.

So, the ten Hospice Care Index indicators listed on this slide again reflect comments previously received for areas of interest identified during information-gathering activities that we conducted.

So, we did several analyses to confirm that these recommended indicators demonstrate

meaningful distinctions between hospices that reflect the quality of care.

Next slide, please. So, to meet the NQF testing standards, we tested the Hospice Care Index variability, validity and consistency over time.

These tests were to respectively ensure that the measure can sufficiently differentiate providers in public reporting, variability. So, validity is that the measure's results are consistent with other established quality measures.

And third, consistency, that the measure's scores remain comparable across time periods.

Next slide, please. Great. Thank you. So, first, let's talk about variability. The graph that's displayed shows the results of our initial testing of 4,155 hospices.

So, most hospices, as Cindy had mentioned, tend to score between eight to ten points on the Hospice Care Index, which indicates

that the, you know, the vast majority of hospices do well on the Hospice Care Index earning points on all or almost of the ten indicators.

We also observed that about 15 percent of hospices scored a seven or below on the index. So, this score distribution allows the Hospice Care Index to differentiate between higher-performing hospices and those hospices with more room for improvement.

Next slide, please. Okay. Great. So, this slide gives some results for validity testing. So, we had found a correlation between higher Hospice Care Index scores and a higher percentage of caregivers reporting that they would recommend a hospice via the CAHPS hospice scores.

So, this correlation demonstrates that the Hospice Care Index aligns with caregivers' perceptions of hospice quality.

Next slide, please. Great. And so, now turning to consistency. So, what we did here is by comparing Hospice Care Index scores

calculated from 2017 claims data to data from 2019 claims, which we have used in our kind of previous slides, we found that the Hospice Care Index scores do not -- have not changed very greatly over this -- these two years.

So, the majority of hospices, about 85 percent, either achieve the same score or only had a one-point difference in these yearly scores.

So, what this means is that the Hospice Care Index is relatively consistent over time.

Hospices expect their index scores to represent their performance without large year-to-year fluctuations.

And then next slide, please. Okay. Great. Thank you. So, in conclusion, the Hospice Care Index combines ten carefully selected quality indicators into a single score that patients and their families can really use to compare their hospice options.

These indicators represent aspects of

care quality not currently captured by existing Hospice Quality Reporting Program quality measures.

So, with the addition of the Hospice Care Index, the Hospice Quality Reporting Program will offer a more comprehensive and holistic view of hospices.

The Index will help patients' families and caregivers to make the best possible decisions with the most complete data, you know, when it matters the most.

So, thank you so much for the time. We're certainly looking forward to answering any questions you might have and taking this time to better clarify our measure to you all.

DR. LEVITT: And this is Alan. Just before I turn it back, do you want to wait until -- I mean, I know Jennifer has some, you know, important questions about the measure, whether we want to accumulate the questions before, you know, T.J. and Cindy start responding?

MS. MOYER: Would it help for me to go

through the preliminary analysis before we go to the questions?

(Pause.)

DR. LEVITT: Did I lose everybody?

CHAIR MERKELZ: Amy, do you want to go through the -- yeah, why don't you go ahead and go through the preliminary analysis. Then we can move in to more of the questions and --

DR. LEVITT: Okay. Okay. Thanks.

MS. MOYER: So, as you may have surmised from the description of this measure, this is a composite of ten individual measures.

Hospices start with a score of zero and then, as they meet the point criterion on each measure, their score increases to a max score of ten for the ten measures.

It is largely new information that is not currently available in the hospice program. There is some slight overlap on the hospice visits when death is imminent, as we had heard in the comments.

And the index feature was largely

built in response to feedback that CMS has been receiving over the year about measures in the program.

So, each of the components we looked at individually for supporting evidence, which is what the consensus development process, the endorsement process, would do more in depth when this came through.

So, one thing I do want to caution the group on, it will be easy to get in the weeds on this measure, but we do want to really focus on fit for program and feedback to the developer and CMS.

So, with that said, each of the components in the measure have varying degrees of supporting information and supporting evidence.

Some were based on conditions of participation, some were in response to OIG and MedPAC reports, but all had some supporting information for them.

It does address high-priority areas and summarizes that performance into one result

that should be easy to interpret and use.

The testing, they went over that in the presentation. It did demonstrate reliability and validity.

And because it is constructed entirely from claims records at this time, it is highly feasible of the calculation and gathering of the data for the measure itself. It does not pose an additional data burden collection on hospice providers.

In general, we felt this was an innovative and promising approach and that it provides information not currently available.

The composite design is useful as a summary, but then also provides a breakdown of the performance on the indicators.

And the preliminary recommendation for this from staff was conditional support for rulemaking. And the condition we have placed on it was NQF endorsement because we do think it's appropriate to go through that endorsement process for a more rigorous evaluation of

scientific acceptability and construction of the composite than we're able to give it in this context.

The feedback from the Rural Health Workgroup was they appreciated that scores on this measure are comparable for rural and urban hospice facilities. There does not appear to be a discrepancy between those settings, and that 85 to 87 percent of hospices meet the reporting threshold. So, there was minimal concern that low volume would be an issue for rural hospices on this. In general, they felt it was fairly relevant to the rural population.

We did also receive public comments on this. Four comments. In general, the comments were supportive, but there were some questions on calculation and thresholds.

A recognition that the measures should be meaningful to the consumer and that components of the measure should perhaps be driven by family and patient preferences and may be driven by patient behaviors and questions about how that

fit into the measure.

There was a suggestion to perhaps incorporate survey data broadening the information from patients and bring that into the measure, broadening the provider types included in the measure.

And one comment, which is certainly on all of our minds, was that request for no new measure implementation during the public health emergency of COVID, and questions about the impact of COVID on performance on the quality -- the components of the measure.

So, telehealth visits, different levels of providers, ability to provide visits, those kind of questions.

So, with that, I will hand it back over for any questions.

CHAIR MERKELZ: So, we have -- yeah, go ahead, Jennifer, please. Yes.

MEMBER KENNEDY: So, I just had a couple of questions.

In the discharge -- in the indicator

with the discharge, it looks like we were talking about the previous transition measure, but there were time frames attached to this when there are none in this indicator.

So, it's a little concerning when you have the patients discharge from hospice and is admitted to the hospital and goes back to hospice, but we don't have a time frame in when all of that happens.

DR. CHRISTIAN: This is T.J. I can take that. Thank you so much for the question and I'm sorry if it kind of didn't come across in the charts you're looking at.

We had some more detail specifications that might not have made it out to everyone. So, technically the way that those two, you know, that indicator is being specified is it's within two days.

So, it's simply the rate of people going from discharge from hospice to the hospital within two days, and then -- so, within two days of hospice discharge, and then returning back to

hospice within two days of the hospital discharge.

And I think there was something -- it might have been a little bit different than kind of the previous transition measure.

There was -- we had taken that from -- there was some academic studies that looked at it in that way.

So, we just kind of borrowed the specification in the course of our information gathering. So, that's kind of where it came from.

CHAIR MERKELZ: Thank you, T.J.

Jennifer, you also had other comments regarding revocations not being included as it represents patient decisions --

MEMBER KENNEDY: Right.

CHAIR MERKELZ: -- and some questions regarding the minimal standard -- the minimum standard of time for the visit as well as the duplication of visits in the last day of life.

Alan, I think, was going to comment.

You might want to pass over to Alan at this time.

DR. LEVITT: Yeah. What I wanted to make sure was that we, you know, had T.J. and Cindy address -- I apologize -- the questions that came up, if that would be okay.

CHAIR MERKELZ: Absolutely.

DR. LEVITT: Yeah.

CHAIR MERKELZ: We can -- you know, we can go item by item on some of these. T.J., there was revocations not being folded in as this represents patient decisions. We can certainly leave that more as a comment.

There is -- the question regarding the time element, you know, what -- the minimal threshold, what is considered standard for nursing minutes, where does that come from?

DR. CHRISTIAN: Yeah. Sure. Yeah, happy to address that.

So, effectively the way that that indicator, and many of the indicators work, is I think it's the beauty of the approach is that it's more based on the distribution of time.

So, effectively there's not -- you know, I think we agreed for this measure we don't set a minimum standard.

Rather, whether or not points are given for the indicator for time per day, it's effectively based on the -- kind of the distribution of where the hospice falls nationally.

So, as in most of our indicators, just for an example, we give a point for the indicator if the hospice falls within the top 90 percent of hospices nationally.

And so, the hospices that aren't given a point are those at the bottom ten percent of all hospices nationally.

So, effectively those hospices probably didn't provide the least amount of minutes like in the bottom -- the bottom ten percent of all hospices.

And so, there's not a particular, again, standard. It's more just, you know, who's in that kind of bottom ten percent versus top 90

percent, you know, line.

I was just looking up kind of some our statistics on that while that was going on. And I think in that bottom ten percent is something -- it's like the average rate of providing nursing minutes was like half of what the other 90 percent of hospices were providing.

So, effectively, it's just like these are really kind of more in the extreme. So, again, it wasn't like a -- you know, no, like, you know, minute standard. It was just more relative, is how we define that.

CHAIR MERKELZ: And Eugene also had some comment around this. I don't know if that fully captures it.

He's going into regarding that 90 percent, ten percent thresholds and how those were actually selected.

Is that adequately -- do you feel it's addressed there, Eugene, or do you want to further elaborate?

DR. NUCCIO: Actually, I think that's

someone else's comment. I have the next comment.

CHAIR MERKELZ: I have there, Eugene, are any of the ten measure indicators -- well, you had --

DR. NUCCIO: Yeah, my question had to do with --

CHAIR MERKELZ: Oh, I'm sorry, Rikki. Rikki Mangrum. Could you share some more detail about how the ten measures were selected and how the ten percent and 90 percent threshold was selected?

MS. MASSUDA: Sure. So, this is Cindy.

The measures were selected because they have to meet gaps in care as were identified through, you know, the hospices themselves at different meetings have talked to us about the kinds of issues they wanted addressed.

NQF at these meetings have talked. MedPAC and their reports, GAO, other organizations have raised the kinds of gap issues.

And so, that, you know, and so meeting

our Meaningful Measure Standards of a good gap measure, these were selected along with they show care across the hospice stay. And we really were trying to address issues where we can show care that captures beyond admission through discharge.

And then we wanted to identify measures that, you know, that were considered important by hospices. So, that's how we selected these ten different indicators.

And then the percentile we used based, you know, the 90 percent -- the 90/10 split is a way that gives a good representation of improvement in care in the hospice community.

So, we wanted to give that fair opportunity for hospices to both score well and also give an opportunity for improvement.

CHAIR MERKELZ: Thank you, Cindy. And I think this is a good segue into then Eugene's comment.

Are any of the ten measure indicator components reversed? For example, higher values are bad. Why discharge isn't after 180 days.

MS. MASSUDA: So, this -- you're talking -- the scoring on some is 90 percent or better. On some scores it's ten percent or less.

And which is why the scoring -- each indicator has a numerator and denominator which gives you a percentage, but we end up converting it into a score of 0 or 1 whether or not you meet, you know, a threshold, the 90 percent or the ten, because that then gives parity across all the measures, all the scoring so that if you got a -- it's understood that when you score points when you get to hospices, that most of the scoring eight out of ten, they can recognize whether -- when we look at this from a public reporting perspective, people can understand that a hospice has scored an eight or a nine out of ten or has gotten a perfect ten on these composite measures.

DR. NUCCIO: And so if I can jump in, your -- the methodology of creating a value for each of the indices, the ten indices, is essentially a 0 or 1 based on whether or not they

reach a particular threshold. That threshold might be the 90th percentile or higher or the tenth percentile or lower.

MS. MASSUDA: That's correct.

DR. NUCCIO: Okay. I see T.J.

MS. MASSUDA: He's shaking his head.

DR. NUCCIO: The -- my other question had to do with given the large percentage of pretty high scores, are you viewing this as a measure that's best used as to identify outliers, that is, the hospices with extremely low scores, as opposed to claiming meaningful differences amongst the 8, 9 and 10 group?

MS. MASSUDA: Actually, we're seeing this as a measure that gives a lot of opportunity to the hospice industry.

We are recognizing that there has been a lot -- that these indicators are consistently being raised as gaps in the hospice industry.

I mean, we have the recent Consolidated Appropriations Act of 2021 that, you know, addresses the same GAO and OIG reports that

raises a lot of these same indicators that are in this measure.

And so, we're actually looking to be the opportunity for the industry to view the issues that are consistent that we see year over year in hospice as an opportunity for improvement.

Hospices that perform well on this measure have the ability to do well, you know, in all aspects of hospice care and it really gets us, you know, it addresses the philosophy of hospice, which is something we really value and want to be recognized as part of our quality, you know, well in the Quality Measure Program.

And so, the -- if performance -- and the hospices that do do well in this measure, we anticipate, will probably use it as a marketing tool much like they use the Hospice Item Set and our quality measures currently.

So, we actually see it as a very positive way to encourage improvement as we work with the industry, because that's our goal is to

-- trying to be working in a collegial manner with our hospice partners between the government and, you know, CMS and the hospice industry.

We're very excited about this measure in that regard.

DR. NUCCIO: If I could just make a couple more comments. The -- I'm very supportive of the idea of a composite measure for hospice.

I think that more accurately reflects what they try to do, that it's not just a single or even a small handful, that the ten components make a lot of sense. So, I'm very, very supportive of that.

Just one other question, perhaps, for T.J. And that is, have you identified any discernible differences amongst CMS regions in scores?

I know that the rural/urban folk said that there weren't any differences between urban and rural, but are you identifying geographic differences beyond urban/rural?

DR. CHRISTIAN: Yeah, no, that's a

great question and you're not the first one to bring it up.

And because it was mentioned, we solicited a lot of feedback. We did some engagement with associations in the course of development of this and actually that came up quite often.

There was a lot of, you know, thoughts that there could be some regional patterns. That's something we should accommodate.

So, I guess the short answer is no, we didn't really find any strong geographical variation regionally or kind of even, you know, urban/rural as kind of had been mentioned.

So, that was something we definitely, you know, had gotten feedback and spend a lot of time looking at, but it didn't seem to be a strong pattern in that regard. So, thanks for bringing that up.

CHAIR MERKELZ: Okay. I want to make sure that Jill Cox's question earlier, if she's clarified now, there was some question regarding

Item Index No. 6 and 7, the burdensome transition, Type 1 and Type 2, and clarification on the difference between the two.

Certainly one looks at death after discharge and going to the hospital, and the other one looks at readmission, but there's further clarification, T.J.?

DR. CHRISTIAN: Effectively that's it. So, the first one was kind of churning in and out of hospice. So, going from hospice to the hospital and back again to hospice.

And the second one was, you know, going to -- going from hospice to the hospital, but with the patient's death -- or the beneficiary's death.

CHAIR MERKELZ: And just to -- also, an earlier comment regarding Jennifer, just maybe a clarification. She did question why there was duplication in the visits the last day of life, which is already a measure that we have, why it's also being added into the Hospice Care Index.

DR. CHRISTIAN: Yeah. Sure. You know,

it was specified a little bit different. Like, slightly. I mean, fair point it is, you know, conceptually similar, but, I mean, I don't think we saw that as double dipping, you know.

The current are Hospice Item Set-based composite measure, you know. Same thing goes previously separate measures are included into the composite.

We saw end-of-life visits as really a key, very important, you know, process of care at the end of life. So, it's important for us to include this as well and there have been a lot of -- I thought this kind of thing would be important to add.

You know, again, the formulation is a little bit different, you know. We're using this kind of, as was mentioned, kind of, you know, criterion like bottom and top 90 percent. So, it kind of -- that continues to score a little bit differently.

You know, again, it isn't -- again, there is some conceptual similarity, but it's not

exactly the same thing. So, that was our kind of rationale for including that.

MEMBER KENNEDY: This is Jennifer.

CHAIR MERKELZ: Go ahead, Jennifer, please.

MEMBER KENNEDY: I just want to ask you, because it does -- to the layperson out in the community, it does feel similar.

Is it going to be measuring the interdisciplinary team visits across the board or just, again, skilled nursing and medical social worker on the index measure?

DR. CHRISTIAN: Yeah. So, this one will be --

MEMBER KENNEDY: So, we've got --

DR. CHRISTIAN: Go ahead. Sorry.

MEMBER KENNEDY: I was just going to say, so the hospice visits in the last days of life is really limited to nurse and social work.

Is the indicator in the index encompassing the entire interdisciplinary team, which is what hospice is really about?

DR. CHRISTIAN: No, you're right. So, this would, you know, we're working with claims data here.

So, effectively it would be limited to, you know, just those disciplines that could be measured using claims data.

And while it does leave out some of the interdisciplinary team, you know, I think we saw this as just, you know, one part of the broader quality reporting program.

So, I think we would agree, you know, that's an important nature of hospice and it might be able to be addressed in a different, you know, measure or capacity, but at least for this index, you know, we're sort of working with the data availability that we have.

MEMBER KENNEDY: Okay. Thank you.

DR. CHRISTIAN: Thank you.

MEMBER TRIPP: I think to Jennifer's point and recognizing the limitations that you bring up, T.J., that was a point that was raised by some of the hospice folks that we heard from

from the LeadingAge side as well that -- particularly in thinking about the role of patient preference at end of life and that they are -- who they might want for visits at that end of lifetime might be different than what you're just picking up on the claims measure.

And that -- the importance of the person-centered piece does warrant further consideration of whether we accurately pick stuff up with using the claims data for that for this particular item.

MS. MASSUDA: I agree with you, but the point with claims data, as we've said when we've come before the MAP in prior years, and it's a famous line of Alan's, we have to make the measures with the data that we have versus the data we wish we had.

But obviously as claims -- if it adds other areas of disciplines into the claims, we will look at that. If it adds telehealth, we will look at that and be considering bringing it into these measures.

So, we were -- we're very fluid about -- that's the -- that is one of the benefits, actually, of the claims -- of claims data that we can bring that data in as it's available.

CHAIR MERKELZ: Thank you, Cindy.

Someone had asked a question about how are some of these measures claims-based? I mean, all of this information is reported in hospice claims.

He did ask, though, about hospice revocations. Is it captured somehow, you know, how else is it being captured? He just commented on the importance of the hospice revocation process.

MS. MASSUDA: Yeah. You know what? I'll start with T.J.

DR. CHRISTIAN: Okay.

MS. MASSUDA: So, with the claims-based measures we -- and any of these, we purposely recognize that by bringing it together as a composite, we have -- we overcome issues that can be raised on any one individual measure indicator

here. Any one of the individual indicators.

So, we recognize that people raised issues particularly when we brought the transition measure up in the past about revocation, and so -- but that, when you look at these measures as a -- the likelihood these issues start going away because the issues that you can have on any one measure wouldn't have, as you look at them, have a hospice behaving in multiple ways.

So, the -- you know, some of the limitations that we may have with claims as we bring together multiple of the claims indicators together, start becoming minimized or effectively go away, the arguments that you can make about it go away.

T.J., do you want to add to that discussion?

DR. CHRISTIAN: Yeah, no, I think that summed it up very well. And I guess the only thing to add is just, you know, give reassurance that indeed this is -- everything here is

calculable by claims data.

So, yeah, you know, we really think that claims can be a rich source of information that can be brought to the program. So, we see this as a, you know, good opportunity to bring this information to healthcare consumers.

Again, I would just really kind of echo what Cindy was saying that, you know, every individual indicator for any of their, you know, limitations, given the limitations of the data and what's not captured, what we're trying to do here is look at all of these comprehensively and just kind of broadly at the same time.

So, you know, as Cindy mentioned, if, you know, due to, you know, limitations or bad fortune if a, you know, hospice didn't do well on one indicator, you know, certainly I think what was trying to be done here is look across all the ten indicators so that, you know, where one could be bad luck, in situations where there's multiple, that would be a much more compelling story that shows a kind of consistency across the

various indicators.

CHAIR MERKELZ: Aaron, you asked for further clarification related to the burdensome transitions, Type 1 and Type 2, whether there should be a time frame incorporated which would be possible via claims data.

MEMBER TRIPP: Yeah. The comments that we had gotten related to these was you might see -- what you might be trying to get from those measures might vary.

So, for example, with the Type 1 -- and let me pull up my more detailed notes -- with hospitalization, if you're talking -- you might see a difference with readmission within, like, a short time frame versus a long time frame and whether or not a hospice might be having live discharges that might be indicative of trying to avoid paying for procedures versus somebody who might have -- who might be readmitted to a hospice after a longer stay, which might have indicated that their terminal diagnosis piece might have sort of alleviated.

So, there is -- with it just sort of being open-ended and then similar in Type 2 that there could be factors that a time frame might point to that are different than just sort of having these two as open-ended, and we wondered if that was something that had been considered or not and whether that was, you know, chosen to not have a time frame or if that just hadn't been considered yet.

DR. CHRISTIAN: Hi, this is T.J. I can jump in and clarify.

I'm sorry if it didn't -- so, it may not have been in the paperwork that you see, but we did -- and sorry it didn't get in -- we did have a time frame specified.

It was on the shorter end. So, it kind of speaks to the first example you gave, but we're limiting it to kind of transitions within two days for each of those transitions between hospice and hospital.

MS. MASSUDA: And that's based on the research that's out there that supports that.

DR. CHRISTIAN: Yeah. We took that just from studies that had been published.

CHAIR MERKELZ: Someone asked regarding clarification, whether or not revocations were captured in that burdensome transfer measure whey they are live discharged.

DR. CHRISTIAN: Yeah, no, so we did make a distinction between, like, reasons for live discharge.

I think in our information gathering, I think, you know, I think that the point -- MedPAC had made the point that there's reasons to include kind of live discharge broadly.

So, I think, you know, for that reason and also kind of the point that Cindy was raising earlier, we just, you know, again, it's kind of part of a comprehensive, you know, ten-indicator look. So, you know, we just -- we kept it as all live discharge for all reasons.

CHAIR MERKELZ: Can any consideration regarding adjusting any of the measures based on patient case mix?

DR. CHRISTIAN: Yeah, I can take this, too.

Yeah, so it's not risk adjusted, you know. A lot of it tended to be like a process measure.

So, you know, process measures typically aren't, you know, patient or, you know, case mix adjusted.

Another thing would be the, you know, essentially the algorithm for calculating the measure. Again, we were interested in, you know, really the outliers of the extremes like the top ten percent of the population.

So, you know, in that case, you know, the case mix adjustment would not have a meaningful impact on, you know, on the eventual Hospice Care Index score.

You know, just given that as some of the -- like, for instance, the nursing minutes per day, that group that's not getting the point was providing something like, you know, half the average care as the other group and case mix

adjustment wouldn't make that go away because we're really trying to capture more of the extreme outliers, you know, category where it wouldn't, you know, wouldn't have affected who was in that category or not.

MEMBER GRADEVSKI: Just as a followup comment -- this is Tzvetomir from NPHI -- the area I guess I was most interested in in the case mix adjustment is really the beneficiary -- per-beneficiary spending.

One area is just a general -- what is the general goal there for beneficiary spending? Because from one perspective having higher per-beneficiary spending, at least from a productivity perspective, could be concerning.

On the other hand from a patient perspective, higher spending could indicate, you know, more attention paid to my individual need or more services delivered, i.e., a generally good thing.

So, I'm just generally interested in what is the intent of the -- that individual

measure and I also just wanted to re-highlight the comment I made earlier in the chat, is that there are or seem to be significant differences in the patient case mixes between hospices.

So, some hospices tend to see a significantly high proportion of patients with a terminal diagnosis of cancer and those spending patterns of patients with -- I'm sorry, significantly different than patients with dementia, for example.

MS. MASSUDA: I'll start out, T.J.

DR. CHRISTIAN: Okay.

MS. MASSUDA: And what I was going to say is one of the things about the Index is that we are looking at it as the -- as a composite which allows the measure to be looked -- to not -- - as opposed to getting into the individual indicators that hospices are scoring across all these as a whole.

So, you're not -- so that hospices as we -- T.J. has talked about also -- are being viewed across the entire spectrum so that they

get a score for all ten indicators and that's their score for the index.

So, the individual issues that you can -- that are -- are areas for hospices that can -- for room for improvement, but it's understood to be an overall index score.

T.J., if you --

DR. CHRISTIAN: Yeah. I'm just going to echo, Cindy, what you said. This particular indicator was, you know, it was sort of an easy one to come up with.

It was -- it's been used in other settings. So, it was something we kind of experimented with bringing it in.

You know, again, as Cindy said, you know, it's, you know, this indicator, and really none of the indicators, are, you know, meant for isolation. It's more just a big, you know, holistic picture.

So, it's not so much like having a high rate of spending by itself. It's having a high rate of spending in conjunction with the

same provider providing, you know, lower provision of care across, you know, various indicators again simultaneously at the same time.

So, again, we're just trying to paint -- it's not so much like the individual indicators, but just kind of painting a totality, you know, picture of the hospice with these ten.

MS. MASSUDA: And one of the benefits you see is that the measure does very well in matching up well with, like, the CAHPS hospice willingness to recommend the hospice so that there's a very strong correlation between this measure and the CAHPS score, which benefits very well for supporting, you know, the support for the measure, but also the consumers understanding the measure.

And we've actually worked with the consumer groups who have shown that looking at this measure with this score, you know, the eight out of ten is very understandable to appreciate, you know, what that means about a hospice and distinguishing between hospices.

MEMBER GRADEVSKI: One followup question in terms of distinguishing between the scores.

Have there been any analyses -- a discipline analysis done on what a standard deviation is in the score?

So, you know, is -- what is the significance in scoring between a ten and a nine or is it really the difference between a ten and an eight?

DR. CHRISTIAN: I can take this. We have. So, we did something with CAHPS analyses. I mean, the broader difference in the scores is going to have, like, more of a likelihood of a statistic difference.

You know, again, like I said before, I don't know if we're as interested in the -- kind of like the one-point differences like a ten and a nine just because for any, you know, manner of reasons it could be the, you know, bad luck or just the limitations of the individual data, but it's much more, you know, again, the -- kind of

like our general sense of, you know, the interpretation of the score is that when there is, you know, multiple indicators missed at once, you're really going down to like a, you know, seven, six, like in that area, then the hospice is missing on multiple indicators, and then that will be much more due to, you know, something else besides, you know, bad luck going on.

And moreover that's where we see, you know, as would be expected, you know, much more likelihood to be a high statistical difference between, you know, a ten and those lower scores, as would be expected.

MEMBER GRADEVSKI: Okay. Thank you for that clarification.

DR. CHRISTIAN: Thank you for asking.

CHAIR MERKELZ: Gerri, Janaki, I don't see any additional questions at this time; is that clear?

MS. PANCHAL: Yes. I don't see anything else come in either and no hands are raised.

CHAIR MERKELZ: Amy, at this time, do we want to move to voting on the preliminary analysis?

MS. MOYER: Sure. I think we are ready to do that. And as a reminder to the group when we pull the poll up, the preliminary recommendation is conditional support. And the condition attached to that is completion of the NQF endorsement process.

MS. PANCHAL: Great. Voting is now open for MUC2020-0030 Hospice Care Index Measure for the Hospice Quality Reporting Program.

Do you vote to support the staff recommendation as a workgroup recommendation? Options are one, yes; two, no.

(Pause.)

MS. PANCHAL: I see 18 votes are in. I'll go ahead and lock the voting now. Thank you, everyone, for casting the votes.

We have 16 votes for yes and two votes for no. In terms of percentages, we had 89 percent of the workgroup who voted yes and 11

percent who voted no.

CHAIR MERKELZ: All right. We will move forward then with the adoption and acceptance of this.

At this time, we'll move over into the gaps discussion regarding the Hospice Quality Reporting Program.

CMS has already identified some high-priority meaningful measure areas which include patient-focused episode of care and care personalized and aligned with patient goals.

Additional workgroup-identified gaps include safety, particularly in the area of polypharmacy and medication reconciliation, patient-reported outcomes around symptom management, care aligned with and meeting patient goals, communication of patient goals to next site of care should the patient leave hospice, and coordination of care.

To the workgroup, are there any other identified gaps that should be brought to the attention?

CHAIR LAMB: I'd like to bring forward the one that we were talking about related to hospice and teamwork.

Understanding that many of the individuals, the professions that contribute to hospice outcomes are not represented in claims data, is to kind of look forward to how can we capture the full team and how can we, you know, in the absence of having that in claims data, are there creative ways for us to really look at providers who may not be direct billers?

So, I think it would be great to have that one on the table, perhaps not an immediate priority, but something we do need to look at down the road especially given the limitations of claims data.

CHAIR MERKELZ: Excellent. Thank you, Gerri.

MS. MOYER: I have captured that. Thank you.

MEMBER SALIBA: I think the other concern that I have in looking at this, T.J., is

that it already looks like it's starting to cap out.

And so, in that, you know, the majority -- the overwhelming majority of providers are scoring in what we consider to be the good to excellent range.

And over time, it would be nice to start thinking about ways to better discriminate among -- across the organizations, particularly since it's already highly correlated with -- I'm sure MedPAC was a bit surprised it's very highly correlated with what you're getting from patient -- that summary question from your patients along the way.

MS. MASSUDA: This is -- do you want a comment from us or -- you directed it to T.J. So, I wasn't sure if you wanted some feedback from us or --

MEMBER SALIBA: Oh, sure. I'm just identifying that as future area for support.

DR. CHRISTIAN: Sure. I can take it. Yeah, no, appreciate that.

Cindy, I didn't know if you wanted to say anything else in that regard.

MS. MASSUDA: I was going to give an overview and all I was going to say is in -- when we brought forward some of our other measures like the seven hospice item sets, they did perform in the 85 percent -- I mean, many of those seven measures did perform very well.

I will say one of the things about this measure, and we've looked at that, is that it takes -- it's going -- because the data is very consistent year over year in looking at this data through the claims, it will take hospices some effort to make improvements, which is why we want to be sharing, you know, the ten indicators through the confidential feedback reports that we provide to help the hospices on these -- making these improvements, but we don't -- I mean, the same way it took years to reach much higher numbers in the seven hospice item sets, it's going to take -- it will take a while before this measure reaches any sort of topping out or -- so,

we're not -- so, we do think it will be a measure that will be in the program for many years.

I'll turn it to T.J. for some more details.

DR. CHRISTIAN: Sorry, I lost my mute button.

Yeah, no, absolutely. I guess we, you know, continue to monitor this kind of mindful of the topping out, yeah.

I think -- I mean, in some sense, one of the benefit of this is it's kind of -- it scored kind of relatively. So, it's a little bit of a seesaw.

Hospices get, you know, get points if they do, you know, relatively, you know, if they're doing better in this one, if they're doing, you know, kind of in the bottom ten percent.

So, that will shift along; I think it might help things from, you know, getting too much more topped out, but, yeah, I appreciate the comment and we'll continue to monitor that.

MEMBER SALIBA: I mean, I think I'm thinking about it from a consumer perspective and, you know, if in my market there's only, like, one or two hospices that are scoring below 8, how it's going to help me more than what I currently have available to me in decision-making.

So I'm thinking about it more from that perspective. And we're already facing that. You know, we faced that with some of the other measures as a committee that we look at, you know, that they tend to -- you know, because so many providers do so well on them, are they really adding to the reporting from the consumers' perspective?

DR. CHRISTIAN: Great point.

CHAIR MERKELZ: Yeah, absolutely. Thank you, Debra. I also thought, along those same line, it's kind of like a Yelp review: everyone tells you where not to eat but doesn't help you on what are the good recommendations. Absolutely.

Amy, I want to make sure we capture the other comments in the chat from Sepideh: also including patient/family education as an area of gap. Alice Bell recommending something about perceived caregiver burden and how caregiver burden is managed, impacted through hospice care. Sepideh also commenting on coordination of care and lacking communication and coordination with the primary care and hospital staff. And that also gets cited in what we had discussed last year on communication of patient goals to next site of care when they leave hospice, but absolutely noting it.

I would further add to this regarding telehealth. You know, hospice was called upon significantly in this time period of COVID to be able to provide telehealth visits for patients, especially when we're excluded. And this is not getting captured anywhere, and certainly not getting recognized, I think, is a potential gap right now that exists significantly within hospice.

Gerri, Jan, any other comments or anything else?

MS. PANCHAL: I don't see anything, Kurt.

There is -- sorry, I don't know if you saw, but there's a comment from Jennifer.

CHAIR MERKELZ: Absolutely.

MEMBER KENNEDY: Yeah, I just wanted to thank CMS for putting the work in on this to really develop something that will, you know, show those low performing providers, because, you know, the people who are doing the right thing and giving good quality of care just don't want to be lumped into that group.

MS. MASSUDA: Thank you very much, Jennifer. Appreciate the comment.

CHAIR MERKELZ: Certainly, so much. Thank you to CMS and Cindy, TJ, Alan, for accommodating and responding back to the questions.

Very surprising that we actually are actually on track with time. And with that, I

will pass it over to Gerri to continue with the Skilled Nursing Facility Quality Reporting Program.

CHAIR LAMB: Thanks, Kurt. Great discussion. Okay. So we're moving to our last measure of the day, and it's skilled nursing facility related to health care-associated infections.

Amy, I'm thinking we already reviewed the program so that we can move directly into the public comments on this particular measure. So let's see if we have any public comment.

(Pause.)

MS. PANCHAL: Gerri, there are no hands raised and nothing has come through in the chat either so far.

CHAIR LAMB: Okay. Thanks, Janaki. So let's move on to the measure. Amy, if you would intro the measure for us?

MS. MOYER: Absolutely. So, this measure is a new measure and it's not currently in the program. And it is a claims-based measure

of health care-acquired infections that result in an admission to a hospital from a SNF setting. So, it is looking at HAIs that are severe enough to require that admission, and that's where the claims come into play.

It is based on evidence, and because it's an outcome measure what we're looking for is that SNFs have the ability to reduce their health care-acquired infections. And there are interventions cited that can accomplish that, including education, monitoring, and feedback on infection rates from surveillance programs, and feedback on infection control practices from audits.

The measure does address a quality challenge. I think this is something that's on a lot of people's minds and was actually one of the CMS-identified priority areas for the SNF program.

There is some minor overlap with existing measures in the program. The SNF program does include hospital readmission

measures. Those are, largely, all-cause or more preventable readmissions, whereas this one is really very targeted for health care-acquired infections and that readmission back to the hospital.

There are also some other measures in different PAC/LTC programs around health care-acquired infections. But this measure has the benefit in that it focuses on severe infections and is the only one capturing this in the SNF setting.

As I mentioned, the measure is claims-based, and so gathering the data and calculating the measure does not impose any additional data burden on SNF providers.

The measure has been specified and tested. They performed a split-half reliability test, and then also face validity and the testing of convergent validity.

And, let's see. The Rural Health Group appreciated that this measure is being introduced in a pay-for-reporting program, which

allows providers to gain experience with the measure and with the result without being penalized for performance right out of the gate. They further stated that they recognize reducing health care-acquired infections in SNFs is very important. And with 86 percent of the SNFs meeting the reporting threshold of 25 cases, there was, hopefully, a minimal issue of low volume for rural SNFs. Overall, they thought this was appropriate for use in a rural setting.

The preliminary analysis recommendation on this is conditional support for rulemaking. And the conditions placed on that is completion of the NQF endorsement process. Again, a review of -- really, a deep dive into the specifications, testing, and evidence of the measure.

This measure, we think, adds a lot of value to the program. There's variation among the measure scores, which is helpful for patients to use and will help SNFs become safer and more efficient in patient care.

In terms of public comment, we had two comments, generally supportive. It's questions of -- in some ways related to quality improvement. So, whether there would be segmentation by type of infection to help SNFs improve; the recommendation to use NHSN instead of claims data for this; a recommendation to track all health care-acquired infections in SNFs, not just those requiring readmission. Some concern over accuracy of coding and attribution for the measure. And then, finally, a concern that an unintended consequence would be that this provides a disincentive to transfer patients out of the SNF to the hospital and that it could result in worse patient care in that way.

That is my summary of the measure. I will turn it back over the Gerri.

CHAIR LAMB: Thanks, Amy.

So, let's see, does anybody have any comments or questions?

MS. MOYER: My apologies. We also have some slides from the developer on this one.

I missed that.

DR. LEVITT: Yeah. Is that okay, Gerri and Kurt? I don't want to interrupt.

CHAIR LAMB: Definitely. Definitely. Go into that.

DR. LEVITT: Yeah. Okay. Well, again, I'll do the intro here. This measure came, actually, out of a request from our leadership about two years ago. I think it was after yet another adenovirus outbreak in nursing homes. Was there a way that we could look, using claims data and a no-burden approach to looking at overall health care-associated infection rate or infection rate within a nursing home, or within the SNF population within a nursing home -- could that be a measure that we could develop? Not for a specific type but, really, to look at kind of the overall rate of infection.

And so that was our target at the time, and we actually ended up, as we describe in the slides in a few minutes, you know, holding an expert panel on it. You know, we spent a lot of

work trying to say, well, how could we conceptualize and use claims and try to find a reliable -- and ending up being a very valid way of being able to look at this that would be a truly meaningful measure?

And so, you know, I was recently asked the question whether it could be done. My answer was: I think so. And so we went ahead and started doing this. And in the meantime, then, Casey Freeman came along. Casey has long experience in terms of caregiving within the nursing home and SNF world. Casey started,, actually, as a nursing assistant, then became a nurse and nurse practitioner and providing care there. And then we were able to convince her to join us at CMS and use that experience to actually become part of our program. And I was able to convince her to come and really help lead the efforts for this measure.

So Casey's going to -- hopefully, she's able to come along and present this measure. I'll be able to also, hopefully, answer

questions as well. And we do have the Acumen team that helped in terms of developing this measure as well to answer, perhaps, any technical questions that, you know, help to clarify things as well.

So, Casey, you can take it away.

MS. FREEMAN: Thank you, Dr. Levitt. Good afternoon, everyone. I'm very excited to partnering with each of you to further the development of this HAI measure. Our team did create a small presentation, so if we could move to the first slide.

We'd like to highlight two key elements of this measure. We want to touch on its rationale and its purpose, its specifications and testing, and some other stakeholder feedback that we have already received that helped to inform this measure. We've also included a slide with our references. And we're very excited because we have just concluded a new COVID-19 analysis that we're sharing for the first time today.

Next slide, please. As Dr. Levitt said, we began this journey of measure development more than two years ago. CMS's Meaningful Measures Framework identifies HAIs as known quality gaps. So we conducted an environmental scan and found the Office of Inspector General estimated that one-fourth of all adverse events amongst its residents was due to HAIs. More than half of those HAIs are potentially preventable. Most stem from poor processes of care, such as the lack of handwashing, the way that nursing assistants and staff handle laundry, the improper use of personal protective equipment, and sharing of equipment between patients. Additionally, COVID-19 studies are revealing higher patient spread due to poor infection control.

When this data was briefed to leadership, the SNF HAI measure concept became our team's top development priority. And to note: improving health care-associated infection outcomes was our priority prior to the COVID-19

pandemic beginning. This measure is important because a very vulnerable population of patients are contracting infections from the health care they are receiving, and many of these infections are preventable.

Next slide, please. With this in mind, we set out to develop a measure that would produce actionable data by identifying health care-associated infections occurring during SNF care. Because, again, we went the SNFs to focus on improving the care processes that we spoke of earlier: having excellent handwashing hygiene, handling linens properly, making sure patient equipment is cleaned appropriately to prevent infection.

Our team also wanted to bring focus to more than just the breaches in care processes. We also wanted to target early identification of infection. We wanted to encourage the aggressive management of infections. We want SNFs to treat in place, to use the most appropriate antibiotics, and to work with their infection

preventionists to track and treat infections, and to have good are coordination with acute care providers. To meet this goal, we decided to only include HAIs occurring during SNF care that require hospitalization.

We also needed a measure that allows comparison between SNF providers and does not add assessment burden. And this measure does all of those things. By using Medicare fee-for-service claims, this measure will estimate the risk standardized rate of HAIs that are acquired during SNF care and result in hospitalizations.

Next slide, please. The specifications speak to how this outcome measure meets all of these goals. The HAIs are identified using the principal diagnosis code and the present on admission indicator on the hospital -- I'm sorry, on the re-hospitalization claim within the incubation window.

To be clear, this measure only includes residents hospitalized for the treatment of an infection as the primary reason for

admission to the hospital. Incidental infections are not included.

For example, a resident admitted for a hip fracture or a stroke who's found to have a concurrent UTI or a concurrent upper respiratory infection would not be included in this measure.

Knowing that appropriate attribution is critical for this measure, we implemented an incubation window that was recommended by our TEP and aligns with the CDC's health care-associated infection incubation window.

To further address attribution, the SNF HAI definition includes chronic infections, infections with long incubation periods, HAIs that are treated during emergency department visits and observation stays, and preexisting infection by applying a reinfection time frame.

This measure is risk adjusted to level the playing field to control for differences in resident casement such as sex, age, prior hospitalizations, co-morbidities, and clinical conditions and treatment.

And when this measure is calculated, the final HAI rate allows for peer comparison by category. SNFs are designed as better than, no different, or worse than the national average.

Next slide, please.

Our team is very encouraged by the stakeholder feedback that we have received so far and have used this feedback to inform the SNF HAI's measures ongoing development.

This feedback includes guidance provided by the technical expert panel in 2019 at the onset of measures development, which included recommendations from our CDC colleagues on identifying the time windows and the types of health care-associated infections to include in this measure, and, most recently, the feedback from our public comment period held this summer.

Next slide, please.

As the measure development team, we appreciate the high standards that NQF requires for endorsement and we always strive to develop a best in class measure. With that in mind, we're

pleased to share this measure's testing results, which match other NQF-endorsed measures. The SNF HAI measure has high reportability.

After examining the total number of SNFs that would meet the 25 stay requirement over a 12-month period, fiscal year 2019 data revealed that 84.9 percent of SNFs meet this criteria. So, again, this indicates high reportability.

Using the same fiscal year 2019 data, we found this measure identifies risk-adjusted scores ranging from as low as 2.34 from our nation's best performers to SNF HAI rates of 17.59 from our nation's worst performers.

This data shows variability and confirms a performance gap that should be addressed. Our testing shows this measure is reliable. Using both fiscal year 2018 and fiscal year 2019 data, we conducted split-half testing to assess the internal consistency of the measure using Spearman's rank correlation to assess the correlation between HAI rates of two randomly assigned groups.

The average correlation from 20 iterations was .5, which was moderate reliability which matches reliability scores in other NQF-- endorsed measures.

And finally, the C-statistic of this model is .72, which shows good model discrimination. So this is a valid measure of SNF HAIs.

Next slide, please.

Lastly, our team wanted to share some exciting findings from a new analysis comparing the SNF HAI rates calculated from fiscal year 2019 data with the currently reported rates of COVID-19 in nursing homes today.

This information was not available to share with our stakeholders during the TEP or the public comment period. So we're really grateful for the opportunity to share it with you. A key takeaway from this analysis is that poorer-performing SNFs with higher HAI rates also have a higher number of COVID-19 cases.

This data is represented in Table 1

with the SNF providers divided into five equal groups. The data shows our best infection control performers are in the first Quintile.

They have the fewest health care-associated infections and the fewest number of COVID cases per 1,000 residents and they display the very best ability to keep COVID completely out of their buildings.

The higher the quintile of the HAI rate on the table, the higher the number of COVID-19 cases and the less likely the SNF will remain COVID-free during the pandemic.

Table 2 represents the same data from fiscal year 2019 but the SNF providers are divided by bootstrapping into three performance categories: better than, same as, and worse than. And, again, the data shows that SNFs who performed poorly on the SNF HAI measure have higher rates of COVID-19 in their facilities today.

Once again, the SNF HAI measure can predict those SNFs more likely to have COVID-19

outbreaks, which means this measure is performing exactly as we want it to. This measure uses the best available low-burden claims data to measure each SNF's ability to prevent and appropriately manage health care-associated infections.

And because this measure captures those universal factors that impact infection control across all SNFs irrespective of the type of health care-associated infections, the measure was able to differentiate those SNFs more likely to have a worse COVID-19 outbreak.

And as a reminder, the data used to determine a SNF HAI rate was for fiscal year 2019, which predates the beginning of the COVID-19 pandemic.

We believe that if adopted in the SNF QRP this measure could predict those SNFs that might once again be more likely to have higher rates of infection from future pandemic.

And on behalf of our team, I want to thank you for investing your time reviewing this valuable measure. Alan and I and our team are

here to answer any questions you have, and at this time I'd like to turn the discussion back over to the committee chairs.

DR. LEVITT: And just if I could just interrupt, just go back to the table for a second just to kind of --

MS. FREEMAN: Oh, I'm sorry, Alan.

DR. LEVITT: No, I'm sorry. Just to explain something.

You know, first of all, I mean, there's, obviously, an understanding that, you know, prevention -- there is -- we believe there is likely a piece in terms of the COVID outbreaks or the degree of the COVID outbreak that's occurring within the skilled nursing facilities that likely is due to factors within SNFs' control.

I mean, obviously, there are things that may not be there. And when we actually first did this analysis we first did it actually on fiscal year 2018 data because we were still waiting for the 2019 data to come along.

And we found -- and this was earlier in the pandemic, probably, you know, around the summer time when there were a lot of facilities that didn't -- you know, were COVID naive, and we were impressed with results that you really saw, in many ways, the same thing as you would see in Table 1.

And we said, well, let's keep looking and seeing, we're going to now -- let's take a different data set. Let's now wait and look at fiscal year 2019. Let's see what's happening, you know, as this pandemic continues to, unfortunately, become nationwide and see what's happening.

And, again, you know, from a reliability standpoint using the 2019 data, we really are seeing the same thing even as the percents of SNFs that may have no COVID goes down because, you know, they're few and far between but you're still seeing with the average number of cases how that's continuing to progress based on the HAI rate, which really did give us a lot

of validation that this really is a meaningful measure, that this is a measure that, you know, we are looking at.

We are taking claims data. We are looking at a particular aspect of the HAIs, which is actually the transfer of those residents who went out for an HAI because it's kind of looking at a severity of the HAI that would require that to go out.

And not only is it really a measure that can -- you know, looking at the performance within a SNF but it has predictive ability to it. It's really a meaningful measure.

I know I use the -- I apologize. I get passionate sometimes and I used the war analogy this morning, talking about COVID vaccination, which I probably -- I should not have used.

But this measure really is radar. It is radar that really could be used to help to, you know, for SNFs to use for their own internal quality improvement activity but then also to

help identify those who may be at greater risk for pandemics which were totally unpredictable.

There was no -- you know, there's no reason, you know, COVID and the transmissability of COVID in terms of a particular HAI prior to this how do you predict that. But if you look at a measure that's a global HAI together within a SNF that this is what such a measure can do.

I apologize for taking away from the chairs. Now I'll pass it back to you.

CHAIR LAMB: Thank you, Alan. Thank you, Casey. That was very helpful and we're honored to get data right off the presses here. So thank you for that as well.

I think we're going to open this up for questions for you as well as possibly NQF. But maybe if we start with some of the questions from the public comments that you have not yet answered.

You've answered several of them in this presentation related to the rationale for tracking the one -- the infections that lead to

hospitalizations.

Two questions that have come up are the issue of how the nursing homes might use this for quality improvement. This is intended as a global measure.

When they translate this into so how can we deal with this, the question I think that came out in public comments was is there a possibility or a plan to segment these by infection that is leading to hospitalization.

So I'll stop there and get that answer, and then I'll give you the other question.

MS. FREEMAN: Sure. Thanks, Gerri.

Yes, we did look at whether or not we should segue that, sort of differentiate between UTIs versus sepsis versus skin infections, and what we found was that the data really supported if we provide this global look at all infections it allows the SNFs who, I guess, in November, actually the 28th, based on legislation, is now required to have an infection preventionist.

So we were very excited to know that this data can become a tool for the infection preventionist who can then use it to look at the observed rate and also the risk adjusted rate to be able to track those SNFs -- I'm sorry, track those cases within the SNFs but also track those cases that require transfer to the hospital because, again, we don't just want the SNFs to concentrate on UTIs or line infections.

We really want them to please look at hand washing which, you know, the current studies show are only at 45 percent for nurses going in and out of the building, in and out of rooms, and only 60 percent going in and out of isolation rooms.

So we really want that infection preventionist, which is now required as a part of the conditions of participation, to use this data as a tool to really help strengthen their internal infection prevention and infection control program.

So thank you for the question.

CHAIR LAMB: Thank you.

The other question that we got is, and this is a clarification, this indicator is Medicare fee-for-service only and does not include Medicare Advantage. If that's accurate, how many people are we not tapping into and comments about the implications of that.

MS. FREEMAN: Sure. Thank you.

So when we think through how this data is going to be utilized for facilities, we believe strongly that, again, that infection preventionist is going to look at the rate of HAIs and their skilled population and then strengthen their infection control procedures across the whole facility so we believe that will not only benefit Medicare patients but all patients within the SNFs because, again, when we educate staff and when we try to encourage vigilance in hand washing, we make sure linens are appropriately handled, folks are wearing protective equipment, those things will be implemented throughout the entire facility, not

just targeted at SNF patients.

DR. LEVITT: Do we have the -- do we have the reportability? I was trying to find that quickly. Do we have the reportability of the measure we're using?

MS. FREEMAN: The reportability is 85 percent.

DR. LEVITT: Right. Right.

MS. FREEMAN: Eighty-five percent.

DR. LEVITT: Right.

CHAIR LAMB: Alan, do you want to clarify that, what that means?

DR. LEVITT: Well, again, so if it is -- because we are -- you know, we are limiting our data set here. We're, obviously, taking a -- what is really the best, most reliable data that we can then use in terms of the necessity to be able to risk adjust material and stuff.

So when we're doing that, as you mentioned, Gerri, you know, the down side is, obviously, well, first of all, does that reflect care throughout all, you know, the residents in a

nursing home.

In this case, you said we believe that it does, that -- you know, that, you know, whether somebody is a Medicare fee-for-service versus, you know, different insurer or whatever that would reflect such care.

The second issue is really what about reportability. Does that, you know, not allow certain SNFs to have enough cases to be able to report on this measure, and that's why I asked the question of Casey again to clarify that.

CHAIR LAMB: Thank you.

Let's open it up. Other questions, comments, about this measure?

MS. PANCHAL: Hi, Jerry. There was a question from Ed.

CHAIR LAMB: Ed?

MS. PANCHAL: Yes.

CHAIR LAMB: Do you want to -- Ed, go ahead.

MEMBER DAVIDSON: I think you have already addressed that and that was the fee-for-

service versus Medicare Advantage. It sounds like you're losing about 15 percent, roughly, and Medicare Advantage falls into that box.

But while I'm speaking, just for clarification and completeness, even though I think this is unavoidable, does potentially unnecessary or inappropriate antibiotics use fall into the unintended consequence category?

MS. FREEMAN: Thank you so much for the question.

DR. LEVITT: Do you want me --

MS. FREEMAN: Sorry. Sorry. I was having trouble getting off mute.

Again, when we think through the legislation that was passed in 2016, that required the second phase to have an antibiotic stewardship program.

We finally timed into phase three, which has, again, the infection preventionist, and one of the roles of the infection preventionist is to look at antibiotic stewardship programs and to ensure that they're

following up with local labs to make sure the most appropriate antibiotics are being used and to make sure that the attendings within the nursing homes are able to have access to that information and are selecting the most appropriate antibiotics.

So we're excited to see how this measure will help inspire and strengthen those stewardship programs.

DR. LEVITT: And if I could just add, we are always concerned about the unintended consequences of our outcome measures and actually Gene's probably snickering in the background.

We actually are our worst critics in terms of trying to say, well, what we are doing or asking, you know, what potentially could be unintended consequences and then what, you know, should we be monitoring.

I think one of the questions that came up earlier is well, will SNFs, for example, not want to transfer their residents and keep them. And again that's, you know, something that we

will need to monitor.

We'll need to monitor mortality rates, actually, within the SNFs and see if that has any effect. Will SNFs prematurely just try to discharge residents out because they want to be within an incubation window that would allow them to go out.

So once again, you know, we have data already, you know, knowing where -- rates of transfer based on date.

These are things we kind of really have to know up front to be able to look at in our monitoring and evaluation of any measures we adopt in the program, particular a measure like this.

One thing to point out is, again, that some of the building block of this measure was really based on readmission measures from SNFs which are already adopted in the SNF value-based purchasing program, for example.

And so some of those, I guess, perverse motivations are already, you know, built

in there to those measures that, again, we will need to continue to monitor.

I mean, it is something we really have to monitor in all of our outcome measures in terms of potential consequences and, you know, be open to considering them and looking at them.

CHAIR LAMB: And I'm glad you asked that because that was also one of the public comments. So that was very helpful.

We've got a couple questions here I think that goes back, Casey, to what you've already looked at, which is this is a global measure. So to move this into prevention, and I think you addressed it.

So please just kind of briefly repeat it if you did. We have a comment about the difficulty preventing the HAIs unless we know which ones are more prevalent and what the data show. We also have a question about follow-up on quality improvement efforts depending on the infection.

So I guess the questions are coming

around, given this is a global measure, what's the translation into really dealing with specific infections that are leading into the hospitalization.

MS. FREEMAN: Thank you for the question.

So I guess the first thing I'd like to say is this measure does exclude certain infections.

So we don't have chronic infections. We don't include infections with long incubation windows and we also apply a reinfection time frame so that SNFs aren't held accountable for infections that they were treated for and, you know, acquired somewhere else or acquired in a hospital, treated in the hospital, and then came to the SNF with those infections sort of in a resolving state.

So we do work hard to make sure that attribution is appropriate and we're not including infections that couldn't have been prevented.

With that said, we do believe that the infections included in this measure can either be prevented or managed in the SNF. In our public comment document, we did have some stakeholder comments that was very meaningful related to C. diff and we do recognize and appreciate that C. diff could potentially cause a hospitalization.

With that being said, we believe that it can be managed in a SNF when it's found early, when there are preventative protocols put in place when patients are initially put on the antibiotics to help prevent C. diff from occurring.

So we believe that having a measure that looks at global infection control because the data shows that hand washing really has such poor compliance in general, and when our surveyors go into buildings they have a very specific guideline that they use to walk through how they're going to evaluate and judge a facility once a year on infection. And infection control violations is still the highest, the most

frequently given tag for nursing homes.

So there is so much room for improvement that we believe without targeting specific infections we can still make great gains.

And, again, when you look at the correlation between the SNF HAI measure from data prior to COVID and then the COVID numbers, it really shows that those facilities that are struggling with COVID struggle with all infections.

DR. LEVITT: It really is the global looking at things, you know, having an infection preventionist. Infection preventionist, part of the role really should be is knowing what infections are going on within that SNF -- you know, what types of infections, where are they happening. You know, are there particular outbreaks within those areas.

SNFs -- in terms of the staff education that goes on, in terms of the ability to effectively kind of manage and monitor and

have antibiotics stewardship, these are global issues that are involved in terms of infection control and management that we're talking about here that go across all -- you know, all types of health care-associated infections.

Whether it's a urinary tract infection or a bloodstream infection, those sorts of fundamental aspects that are really under a SNF's control are what we're trying to deal with here.

CHAIR LAMB: Just so that, you know, that you're aware, that seems to be a common question that's showing up in the chat.

DR. LEVITT: Yeah.

CHAIR LAMB: I think that you both answered it, you know, comprehensively.

We do have two more. Is there going to be a way for SNFs to compare their data to comparable sites, according to things like region, facility size, and so forth?

MS. PANCHAL: And, Gerri, I feel I just wanted to make a note that Alice Bell has her hand raised as well. So --

CHAIR LAMB: I saw that, yeah, and we'll go to you, Alice, right next.

MS. FREEMAN: So thank you for the question.

We actually felt so strongly about this measure and its ability to help improve infection control within SNFs.

Today we did publish dry run reports for all SNFs from fiscal year 2018 and '19 data, and those dry run reports include the performance year, the dates of that time span, the number of states that were included in the measure as well as the number of observed cases as well as the risk-adjusted rate and a national observed average.

So this will be able to compare their observed rate, their risk-adjusted rate as well as the national average.

Dr. Levitt?

(No response.)

CHAIR LAMB: Okay. And, Alice, thank you for your patience. If you would come on here

and ask your question.

MEMBER BELL: Sure. Thank you so much, Gerri, and thank you, Casey and Dr. Levitt. And this question may constitute such an exception that it doesn't significantly impact the data.

But I was just curious, given that we're using hospitalization as kind of the measure of severity of infection, two factors. Thinking of other variables that may lead to hospitalization, are there any regulations state by state that would limit a SNF's ability to manage certain infections that may force them to hospitalize a patient that, you know, may not need to be hospitalized in another geographic location. That was the first.

And then the second being those patients who are hospitalized because the patient or the family member demands hospitalization, not because the SNF has an inability to manage the infection.

MS. FREEMAN: Alice, that's a great --

those are two great points. We did not look at whether or not -- because it's claims based and we just know that they're admitted. We don't know what the mechanism of the admission was, whether it was driven by the attending or driven by the family.

What we do know is that emergency room staff felt the need to admit the patient. So I think that that's something that we would love to dig in deeper and look at to really appreciate the comments.

And with regard to state by state regulations, I don't want to -- I don't think I'm experienced enough to answer that. I only know that, you know, we have conditions of participation, which -- within Medicare and we require SNFs to be able to give IV antibiotics. Some SNFs have ventilators.

So I definitely think that it would be a great variable to look at for those SNFs that don't provide ventilator care whether or not they have an increase in admissions related to

pneumonias and things like that.

So a great point. I wish I had a better answer. I'm just not familiar enough with the state regulations at that level.

MEMBER BELL: No, that's very helpful. Thank you so much.

MS. FREEMAN: Great. Thanks, Alice.

CHAIR LAMB: I don't think we have any more comments or questions. So I think we are ready, Amy, for the vote.

MS. MOYER: All right. And as a reminder, as we get the slide ready to go, the preliminary recommendation -- the preliminary analysis for this is conditional support and the condition placed on it is that the measure go through the NQF endorsement process -- successfully completing the endorsement process.

MS. PANCHAL: Thank you, Amy.

Voting is now open for MUC2020-0002, Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization Measure for the skilled nursing facility quality reporting.

Do you vote to support the staff recommendation as the workgroup recommendations? The options are, one, yes; two, no.

I see that we have 14 votes in. We'll wait for a couple more seconds to see if any additional votes trickle in.

Seventeen votes in. Is there anyone else who is still trying to get their votes in. All right. I'll go ahead and lock those votes.

We have -- voting is now closed. We have 17 votes for one, yes, and zero votes for no, and that means 100 percent of the committee voted for yes.

CHAIR LAMB: Thank you, Janaki. In all the years I've been doing this I don't know that I've ever seen 100 percent vote. So, clear agreement.

Okay. We are now moving into then the gaps discussion. So would anybody like to propose a gap? Let me just give you an overview for reference.

The previous gaps that have been

identified in the CMS high priority areas are related to what we just covered: healthcare-associated infections, exchange of electronic health information and interoperability, and we in the work group have previously identified care coordination and involvement of patients and caregivers, bidirectional transfer of information, quality and safety of care transitions, patient and family engagement, and care aligned with and meeting patient goals.

So additional gaps that you would like to recommend?

(No response.)

CHAIR LAMB: One more call. Gaps.

Okay. Not hearing any then, we have completed our MUC voting portion of the day and I'm going to turn it over now to Kurt to talk about gap discussions.

CHAIR MERKELZ: Thank you, Gerri, and as pointed out, there is no measures under consideration for our pre-rulemaking for the value-based purchasing.

Amy, do you want to give an overview of the program?

MS. MOYER: Sure. I am actually going to let Alan kick this off. You may notice this is not a program we have had a lot of discussion about previously as part of MAP PAC/LTC, and part of why we're discussing it today was this program was updated as part of the Consolidated Appropriation Act of 2021.

So late-breaking news and changes. And Alan's going to walk us through that Act and some of the changes.

DR. LEVITT: This is all my fault, actually, bringing this. I asked for this to be on the agenda.

I think we have informally -- I've asked, especially when we have had some free time in the past or extra time to, even though this program -- just as a reminder, this SNF value-based purchasing program was mandated by PAMA back in 2014 and it was mandated essentially as a single measure program.

And one of the discussions I brought up here before, even though we are tasked with this program we, obviously, you know, are limited by statute, are still kind of interested, well, what sort of measures potentially could, you know, could be included if they ever expanded this program.

And so we have talked about this before in the past, and, again, last month in the midst of the 5,600-page Consolidated Appropriation Act of 2021 bill there were three pages that were part of that bill that was looking at an expansion of this program, which is something I think we have all been looking at for a while to essentially take the program from being what it currently exists at to being in a more expanded form.

And, hopefully, I've joined -- hopefully, I've asked for Lang Le, who's the program lead of SNF VBP. I don't know if he's joined yet or not. But, hopefully, he's listening as well.

But the reason I asked us to add this to the agenda was to begin the discussion because, as you know, I believe in the partnership and I believe in getting the feedback up front in terms of well, now we have been offered this opportunity to finally expand this program -- you know, what we'd be looking at.

In a nutshell, what we're being allowed to do through this legislation, which is all within a may. So it's not like the IMPACT Act where, if you remember, we were forced to -- you knew these measures applied, these measures by this date, so to speak. And so we were kind of within a certain constraint.

What they're allowing us to do here is to add, essentially, up to 10 measures in this program and it's within a may structure beginning on or after October of 2023, and the 10 measures they were looking at primarily in areas of functional status, patient safety, care coordination, patient experience of care and then the ubiquitous other measures as deemed

appropriate by the secretary.

And the way we really looked at this program is that even if it's a SNF VBP program and we have had discussions already with our office of general counsel is that we believe that this program should also reflect kind of the depth and breadth of the care that's provided within a SNF or really within a nursing home.

So it really could, you know, potentially extend not just for the SNF population or SNF services but also for the long-term care population, as well.

And so that's kind of how we're looking at it and envisioning these things. In terms of the types of measures that we're looking at in general, we have measures already that have been adopted within the SNF QRP that have come through you, that have come through the committee.

We also have measures that have been publicly reported on nursing home compare or the nursing home quality initiative. Some of them

are also included then in the calculation of Five-Star, which you heard about as well, and they're a combination of short stay and long stay measures, as well.

There were also other measures that we have actually discussed here that may not have yet been proposed or adopted in the SNF QRP. An example is CoreQ measure, which we -- the committee of several years ago we brought was for a measure that, you know, Dr. Gifford came and the committee supported that measure.

It hasn't yet been proposed or adopted in the SNF QRP. But, again, that's a potential measure. Again, that's been reviewed, the measure that looks at the experience of care. Again, that's a potential measure. We have talked about PROMs measures, patient-reported outcome measures here as well.

So kind of we're given a -- it's an open slate but in some ways we really want to also look at if we're going to be using a set of a maximum of 10 measures to kind of include depth

and breadth population, taking all these characteristics.

You know, what sort of measures should we look at? And so that's kind of what I wanted to open to discussion here so we can -- you know, we can really start so that, you know, as we start, you know, proposing and adopting measures into this program it's measures that we both, you know, believe should be measures that are part of this.

CHAIR MERKELZ: Thank you for that, Alan. Certainly, this is -- you know, the work group has not had the opportunity in the past to previously discuss gaps within this program. We can certainly afford to go into further discussion regarding these type of gaps in other areas to be looking for in more detail.

Any comment from the work group?

CHAIR LAMB: You know, first, I appreciate you bringing this to us so that we can think about it. One thing that comes to mind is the approach that we just reviewed with the

hospice index, which is conceptually to try and kind of cross the quality continuum from safety, you know, at different points in time, transitions of care, and when I -- you know, interestingly enough, the hospice measure has 10 indicators, which is what's a good cross section that really speaks to value and high-quality care across the SNF and to choose measures accordingly.

You know, co-chairing the patient experience and function I would expect that there needs to be functional measures in there. Those are absolutely critical to SNF care, care coordination, all of the issues that show up in the research related to hospital readmissions and losing ground when people come back to the SNF. So I would want to see a cohesive kind of coherent set of 10 measures that really give us a good sense of quality in the SNF.

MEMBER MAHAJAN: This is Raj. I just wanted to get a few words in. My only concern with a composite measure that will have almost

double digit diverse measures is the -- you know, it dilutes how individual measure might be addressed.

You know, going back to Five-Star system, we had the points there and the score so people could pick and choose on how to be more effective, you know, and again, from overall quality improvement, just ground rules, people can only address two to three top items at one time.

If you try to address everything it becomes a little difficult. So and I think during our last in-person meeting there were at least five or six high-priority or low-hanging fruit identified and if I were to, you know, throw that in there I'm not sure how far, Alan, you all are into having decided that there will be 10-ish measures to make a composite measure.

I just find it hard for facilities to then get a direction with how they come up with a score that, you know, gets them to that composite value. So we are going from one -- just one

measure on readmission to 10. Even with one it was kind of hard to get them onboard.

You know, again, this thing will evolve over time, but I think what we have learned in this pandemic, infection control, staffing, and exchange of information has been kind of like the top thing, staff retention being the most important thing other than infection control, which is obvious.

So I would personally suggest we stay focused. We add a few measures but not 10. Two, three, four should be the max.

MS. PANCHAL: Gerri, we have three hand raises. We have Terrie followed by Mary and then Alice.

CHAIR LAMB: Okay. Why don't we just go through it and, Kurt, I think you and I are in this together so let's start with Terrie.

Janaki, who are the other two people?

MS. PANCHAL: Mary, and then Alice.

CHAIR LAMB: And then Alice. All right.

Terrie, if you would go first.

DR. BLACK: Right. Yeah. Thank you for taking my question.

So, you know, in my past roles within NQF I've been on the leadership consortium. I've been on a shared decision-making action team. One thing that keeps coming up in terms of, you know, patient and family engagement and what's important to patients, and oftentimes even within my own clinical role and practice there is a bunch of clinicians or work groups coming up that what we think is important to patients.

So I guess my question is what, if any, opportunities are there to ask patients what is important in terms of meaningful data and how do we arbitrarily come up with 10 because of the hospice indicator or the PSI-90.

You know, to me, it seems like there should be several key elements that are posed to patients and families to say what would be meaningful to you in terms of value and what is -- if you're trying to make a decision on this

metric what are things that you'd want to know.

And I agree, Gerri, being a rehab nurse function is very important. Patient experience is very important. But, you know, there might be other things that while we think is very important, patients or their families might not put as much weight on.

So I keep hearing this, we need the patient's perspective. But yet, I'm not seeing how that input is taking into consideration some of these quality measures.

So thank you.

DR. LEVITT: Yeah. If I could just -- you know, let me just clarify just for a second.

First of all, it's a great point and I think it's something we're in the very early stages here now of trying to figure out, you know, what to do based on this legislation, and taking perspectives not just from here but also including perspectives from, you know, residents and families and taking all of that into account is going to be really important.

The legislation -- just to clarify, the legislation allows us to include up to 10 measures within a -- you know, this VBP program. We were envisioning, you know, trying to take, you know, a mixture of what's been successful already, you know, in terms of measures that have already been specified.

Some of them, you know, likely have been NQF endorsed. You know, to take time as a mix that would include -- and, again, as legislation said, you know, please, you know, strongly consider these are the categories we want you to have, you know, measures from.

Those don't all have to be from those categories, but to have those. It's hard to mix those things, giving an example like function. We all agree function is very important. However, again, there are -- you know, what does function mean?

We have the SNF residents. The goal is really in many of those residents to improve the functional status. A lot of them are there

with different goals.

For the long stay residents within a nursing home, the goal is to maintain function or not to lose function. And so, again, same kind of global domain but, really, two different, you know, measures that are getting involved and, you know, how do we end up mixing these things.

And so it doesn't have to be a maximum of 10. It can be -- you know, it can be adopted in any sorts of way or approaches to it. But, you know, it's really getting the sort of feedback as to, you know, the types of measures, you know, where should we really be looking to really get that sort of feedback.

I apologize for having to interrupt.

DR. BLACK: No. No. Thank you for that and, again, I think we -- if we would, with this group, just a response to that, you know, I think in this group we could very much come up with a composite and, again, if we presented that to the public or to the lay person it could be a very different group.

So I just think, you know, rather than just trying to fit something into what we have done in the past, you know, I think we just need to consider patients and caregivers in this in terms of what's meaningful to them.

CHAIR LAMB: Thanks, Terrie.

Mary?

MEMBER VAN DE KAMP: Thank you. Not to be repetitive but maybe affirmative, I think, Gerri, you said it with your sentence of patient experience and then, Terrie, totally support your thought on family engagement.

To determine value, I think that term is very subjective and therefore I think it does need to have a personal component to it, and a lot of what I've heard on many of these gatherings is that value always has a cost effectiveness and I totally appreciate that if you look at the value of the dollar and the results and the outcome.

But I think it's been easier using claims data to be heavily focused on the

financial as it is -- as you've articulated, Dr. Levitt, how hard it is to bring a nonclaims-related measure to the table.

But I think function relative to the goal of the patient as well as finding ways to really look at the patient's goals, we have had a lot of focus on that; are we meeting the goals and how does that fit.

So I think I also like a composite score. Recognizing that -- whether it's 10 or 5, it allows for a balanced view of taking the considerations.

But I challenge us and I so appreciate the opportunity early in the initiative to have the discussion about how you really do address the value that's not so easily measured in the claims data.

So no specific answers, but support Terrie and the conversation around patients' experience and function in ways that really look at the patient value as well as the cost effectiveness.

CHAIR LAMB: Thanks, Mary. And I just would note that there are several comments in the chat emphasizing the importance of that stakeholder group. So I think, Alan, you've spoken to that that group will be involved.

Alice?

MEMBER BELL: Thank you, and I support everything that's been said thus far, and the one thing I would add, and Dr. Levitt, I think you touched on this a little bit, but we tend to look at function at a point in time or multiple points in time, and I think the concept of consistency and sustainability is so important.

So how we figure out looking at even points in time post-direct intervention and how we look across time and setting for beneficiaries to look, really, at consistency and sustainability because a patient often reaches a point of performance and that's almost an indication that they're done, and we find that many of these patients it's just the predictor of the next slide or decline, and so we just have to

think about that component.

CHAIR LAMB: Other comments?

MS. PANCHAL: Gerri, we have Rikki's hand raised as well.

CHAIR LAMB: Rikki?

Rikki, we're not getting sound.

DR. MANGRUM: Can you hear me now?

CHAIR LAMB: Yes.

DR. MANGRUM: Oh, okay. Sorry, wrong microphone.

One of the thoughts that I was having during the preceding conversation, I think those of you who know me know that I worry a lot about the patient's perspective and caregiver's perspective and how we include that. And thinking sort of aspirationally about how we could apply the value part of this thinking there, I begin to wonder whether there isn't room somewhere in these programs to include a consideration of costs that are paid by patients and their families.

So what is the co-pay burden on the

individuals and their families, and even more expansively to think about the many other costs that families often accrue whether it's expensive parking fees or so on.

So, again, I'm trying to think loudly outside the box and imaginatively. But I think in the many conversations that I have with patients and caregivers that is something that is very strongly on their mind and it affects what they're able to do.

CHAIR MERKELZ: Absolutely. Thank you, Rikki. I'm thinking as well as provider services so much is needed after discharge from a skilled nursing facility level to maintain and continue to succeed in the home through such services as provider services that aren't generally going to be captured anywhere. That's predominantly an out-of-pocket expense.

You know, part of it also, I think echoing what everyone said, I really like what Gerri stated as well. Very interested in, potentially, capturing rolling up both health-

related and nonhealth-related goals that patients could, potentially, establish and put in place specifically for return at home.

We know a lot of what we want patient -- what patients want to achieve after discharge. They want disease managed. They want to be safe. Medications have to be reconciled, and looking at quality of life from a -- potentially, from a health-related and nonhealth-related goals and goal setting would be something, I think, would be very interesting as well.

And burden. I think burden on the caregivers and how we could potentially capture that burden would be important for this group, certainly, from a value-based component.

Anything else, Janaki or Gerri, please?

CHAIR LAMB: Just to comment, it strikes me that that would give us the opportunity to expand how we think about care coordination.

So many of our care coordination

measures are based on exchange of information across systems, and I think what, Kurt, you were just mentioning really pushes the envelope, which is in a lot of situations people are leaving these settings, going home, totally dependent on family members and caregivers, and their ability to manage all of those services with or without support has a huge influence on readmissions. So just looking at communication and readmissions doesn't tell that story. So I totally support what Kurt just said.

Okay. Any last comments on the value-based purchasing and, again, Alan, thank you for bringing that to this group and allowing us to share our thoughts on it.

DR. LEVITT: Everybody please continue to think about this and, again, you know, one of the challenges -- I think I talked about this before -- is, you know, we all have great ideas in terms what we would like to see.

The question always ends up being, well, how do you operationalize it, you know,

into a measure that then can, you know, differentiate performance between providers, which is really what's, you know, trying to be looked at within such a program.

And, you know, so keep thinking about it and thank you for your interest and, you know, this is the beginning and, you know, we want to try to get this right.

And thank you particularly for the suggestion that, you know, really the conversation shouldn't just be here. It should be, you know, with, you know, residents and families and, you know, really try to get opinion as to what sort of measures would they really find most meaningful for them to be part of such a program as well.

So thank you, in particular, for that.

CHAIR LAMB: Thanks. Okay. So we're going to move into our last topic of gaps, which is home health quality reporting, and Amy, if you would intro us.

MS. MOYER: Absolutely. So we did not

have any measures this year for this program. But we do want to still provide input and feedback to CMS on any potential gaps in areas we feel could benefit from additional measurement.

This is a pay for reporting and public reporting program, and home health agencies that do not submit their data will have their annual market basket percentage increase reduced by 2 percent.

Program goals are alignment with the mission of the National Academy of Medicine and, namely, effectiveness, efficiency, equity, patient centeredness, safety, and timeliness of care. We did want to just spend a little time on this program as well.

CHAIR LAMB: Thanks, Amy.

So here's your opportunity. Just to start the conversation, we talked a little bit about home health before and COVID and the need to consider home health and hospice in the COVID measures down the road, and you have some of the priority areas, again, care coordination that we

have mentioned, patient goals, functional status, and wound care.

Other things that you would like to have on our consideration list related to gaps?

DR. LEVITT: We did have one question about the capturing wound care holistically. Yeah.

Just trying to get a better understanding as to, you know, what's the -- what does the committee mean by that and what type of measure could potentially be developed regarding -- you know, regarding that gap?

CHAIR LAMB: Would anybody like to speak to that?

(No response.)

DR. LEVITT: We do take your word seriously, by the way, if you haven't noticed. So that's why we ask.

DR. MANGRUM: Does anybody remember what we talked about last year?

(Laughter.)

MS. MOYER: I am looking through my

notes right now.

CHAIR LAMB: I remember somebody was really passionate about that. So I'm hoping that passionate person is here to fill us in.

MEMBER SALIBA: I don't remember being passionate about this but, Alan, we do have a plastic surgeon here in Los Angeles that has done some work looking at issues about present on admission and, you know, a wound being reported in one setting but not another at times of transition.

So I don't know if that's relevant to this. But she's published some papers and I think actually presented some of that data at CMS before.

But, you know, basically, she just showed that one site shows that it's present on admission but the site that discharged them doesn't show it at all in administrative data, and sort of trying to figure out ways to effectively track that.

But I don't know if that's what that

particular bullet is about. Does that ring a bell with anybody?

DR. LEVITT: I can just tell you that, you know, one of the challenges we have in these national programs is taking an important domain and saying, well, because we have had -- we had an improvement in surgical wounds that was part of a measure of the home health quality reporting program and, again, the problem is is numbers.

And so, you know, in order to be able to, you know, have a measure to be meaningful there have to be enough patients that are in enough home health agencies that would be in the denominator in order for, you know, such a measure to be useful.

And that's been one of the challenges here is that, you know, there are not as many agencies, for example, that may be caring for enough of these sorts of patients to make it meaningful. I mean, obviously, you want to be able to capture something like this. But that is the flip side, yeah. That's our challenge.

MEMBER SALIBA: Well, I think -- I think the other challenge -- sorry to come back to this now, Alan, some of the conversation around this.

It's also that this concern that, you know, how frequently is the home health provider in the home and in control of the wound. It's sort of the attribution issue that came up here versus the family caregiver or the other paid caregivers who are doing the day to day management of the wound.

I think that also came up. But you're right. I mean, it's a numbers -- part of it's -- particularly if you look at, say, stage four, three or four is my -- is suggested numbers, yeah.

CHAIR LAMB: That's helpful, Deb.

Amy, would it be possible to go back to our notes from last go round and fill in any pieces in case we're not remembering kind of all the pieces of this discussion, which, you know, we may not be?

MS. PANCHAL: Gerri, we have a hand raised from Gene.

CHAIR LAMB: From Gene?

MS. PANCHAL: Mm-hmm.

CHAIR LAMB: Gene, please go ahead.

DR. NUCCIO: Just a couple of items.

One, it says long-term tracking and functional status. I'd argue that creating a change in functional status measure might be integrated, that is, looking at functional status across a number of functions and the change created by the agency might be more valuable than simply whether or not an agency created any improvement in any single functional status item might be useful.

And the second, it's sort of in conjunction with the first two bullets there and that is to look at the value of the promise instrument and that is patient-reported outcome, and perhaps triangulating the results from PROMs with what the clinicians say about the patient and perhaps what the caregiver says about the

patient.

So raising the level in both of these, sort of raise the level of sophistication in the measurement QRP items.

DR. ANDERSEN: This is Dan Andersen. I would just add that, you know, looking at this and occurring measures on the next couple slides what I don't see reflected is any focus on HAIs or infection prevention.

I'm actually thinking that the measure we just discussed for the SNF program, you know, if and when implemented would be a good candidate for alignment in this setting, as well.

DR. LEVITT: Thank you for that segue, Dan.

One of the things, again, we didn't discuss today but, you know, when -- actually, when thinking of this model of whether a claims-based infection or claims-based measure of health care-associated infections or the like that would require hospitalization, even if we initially first developed this within the SNF setting, if

successful -- like, it looks like it really is successful -- could apply to other settings whether it actually could be home health within a global measure, ESRD within a global measure.

A long stay nursing home population, because even though many of them are Medicaid patients within the nursing home, a lot of them have Medicare.

And so, again, these are things actually that we are looking at that, you know, again, if this concept and the approach is appropriate, again, how could it potentially apply exactly like you just described within home health.

DR. ANDERSEN: Alan, I would argue as well that it means the PAC long-term care settings, these kind of injurious HAIs leading to hospitalizations could probably be taken a step farther and use those assessment tools to risk adjustment rather than just rely on our claims to some kind of hybrid method down the road. I know that's -- we were looking at that on mission up

front and I think it showed promise.

DR. LEVITT: Yeah. Yeah. We're an open book right now in terms of potentially, you know, how to deal with these different things.

And to be honest we are also -- you know, Casey and I were involved -- just so you know, we developed a claims-based measure. I know we're going to back to a measure we already conditionally supported, but just to tell you, I mean, you know, we're continuing to look at everything.

We're already -- you know, we have been in discussions with Digital Bridge with the CDC whether or not, you know, as we get much more familiar with electronic recordings similarly of health care-associated infections, how could we potentially make a digital measure using the same sort of concepts that we use with claims that way, too.

So, you know, we're always trying to look at -- you know, it may be fine for 2021 but, you know, what is it going to look like two or

three years down the line.

MS. PROCTOR: Hi, this is Joan Proctor.

CHAIR LAMB: Joan, did you have a comment?

Yeah, go ahead.

MS. PROCTOR: Yeah. I was just going to kind of echo the things that Alan was going over here. You know, I think -- I think one of the overarching comments we got back was the surprise that we didn't have any measures on our radar -- I mean, on our map, measures under consideration for our individual program, and just wanted to reassure everyone that our work continues in this area in not only developing things that are cost setting but developing things that are specific for home health.

We definitely are interested and looking forward to getting the additional feedback that you -- clarifications you're going to give us relative to the wound care and holistic and, of course, you know, we have done

some of the work here on terms of patient engagement with our transfer of health that is in our program and across settings.

And I think one of the things that, you know, I was a little bit surprised just now with the definition about long-term tracking of functional status because I thought that last year's comments, and that probably we could get some clarification on that, but I thought last year's comments was relative to the long-term stay patients who are kind of like maintenance patients because that's something we have heard, you know, in rule making and stuff and feedback from the industry I found interesting.

So, you know, as we're looking back and going through this process and taking a look at the transcript and stuff, could we get some clarification on not just that but also the long-term tracking.

Appreciate it.

MS. MOYER: All right. I will talk on the long-term tracking. My recollection of that

was, and this is not just for home health, but the ability to kind of track it as patients move in and out of different settings and across the settings versus just kind of the shorter surveys that we were doing. But I will verify that.

CHAIR LAMB: And one thing to add that I think came up for hospice that also is relevant to home health is -- going forward is how telehealth is used and the relative -- you know, and this would be a good one in terms of bringing patient experience and preferences in is that relative balance between the in-person and the use of technology and what's the right fit for patients, and I think we spoke about that in hospice. Also relevant here. So any other comments? Jennifer?

MEMBER KENNEDY: This is Jennifer. I would just -- thank you for saying that because there is no way right now that hospice can capture the patient's voice. The TEP survey is filled out by their loved one or their caregiver. So we have no way to capture patient experience

than themselves who receive the care. So I would love to see something like that.

CHAIR LAMB: Thanks, Jennifer.

Any other final comments related to gaps in home health?

MS. PANCHAL: Gerri, Alice -- Alice's hand is raised, as well.

CHAIR LAMB: Go for it, Alice.

MEMBER BELL: Sorry again. Just for clarification on the long-term tracking, I would agree that I think what we were speaking about was, again, more of that sustainability issue and tracking over transitions of care and looking at the impact of a transition of care on loss or promotion of functional performance.

CHAIR LAMB: Great. Janaki, are you seeing any other hands?

MS. PANCHAL: Oh, aside from Amy.

MS. MOYER: As we were working on the COVID measures and looking across programs, I was struck by the lack of any immunization measures of this program.

I see we have one for the patients, and I think earlier someone raised some of the concerns about tracking of data or getting that data for home health.

I wasn't sure if that -- if you all view that as a gap or if that's just normal.

MS. PROCTOR: I think we did consider it a gap. I think one of the things that we have dealt with, though, is the removal that came along recently really had to do with us.

You know, there were changes in the guidelines and it threw what we did have in our program out of compliance with those guidelines. But I don't think it's something that's off of our radar. It's definitely something I'm noting here as a concern that you guys are bringing forward in that.

CHAIR LAMB: Thanks, Joan.

Okay. I'm going to turn it back over to Kurt for a public comment.

CHAIR MERKELZ: Yes, at this time we open up the floor for public comments based on

the day's conversations.

And Janaki, you'll let us know if there's anything coming in.

MS. PANCHAL: Nothing. I don't see anything so far, Kurt. No hands are raised and no comments in the chat box.

CHAIR MERKELZ: All right. Well, Janaki, at this time I'll turn it back to you then.

MS. PANCHAL: Great. Thank you so much. Our next slide, please.

So as we wrap up our meeting today, we will just quickly look at some of the next steps and then I'll turn it over to Gerri and Kurt to kind of give a summary and a recap of the day.

So what you see here is just a high-level overview of the MAP rulemaking approach and some of the milestones that we have. In April through August, we go through nominations.

In September, we have our MAP coordinating committee strategic meeting and then our MAP orientation meeting where -- meeting

where you -- some of you might have attended that.

In October, we had a workgroup orientation meetings where I'm sure some of you attended that, as well. In December, MUC list gets released. We are currently in that early to mid-January time period where we have our virtual review meetings.

In late January is when we have the MAP coordinating committee virtual meeting to finalize the recommendations from today's meeting, and February 1st is when the final report goes to HHS, and then March is the rulemaking report is published.

Next slide, please.

To give some of the more concrete dates and guidance that we talked about, after -- following this meeting we have a public commenting period and work group recommendations which will open on January 12th and it will close on January 20th.

Following that will be the

coordinating committee in-person meeting, which will be on January 25th and then the final recommendations will go to CMS on February 1st, like I said, so those are some of the key dates that are coming up in this month and early next month.

Next slide, please.

Sorry, next slide, please.

I'm not sure. Maybe -- Ray, are you able to proceed next? Oh, there we go.

So this is the end of our work group meeting today and we have some contact information for the project team as well as -- the first thing here is linked to the project page.

This is a public page. All of our materials should be on this page as well as upcoming events and even the materials that are there should be on the project page.

The second -- the second link that you see here is to the workgroup share point side. This is only visible and available to the

workgroup members. This is not open to the public. This is only visible to the work group members.

So most of the material gets posted here as well as so you can reference back to it, and if you have any questions or concerns or you need to get in touch with the project staff, our -- the project inbox email is listed there as well. It's mappac-ltc@qualityforum.org.

Any questions before I hand it over to Gerri and Kurt?

(No response.)

MS. PANCHAL: Okay. Back to you, Gerri and Kurt, to just provide a summary and a recap.

CHAIR MERKELZ: I'll start off because I know Gerri can be more eloquent than myself at this time.

But I certainly want to thank CMS and NQF for this opportunity. I'm really impressed with the robustness of the discussions and the measures that came before us. I mean, looking

specifically at, you know, health care-associated infections and, you know, very reportable and actionable measure, you know, what we're looking at from a public health emergency and quickly moving the dial on something that's so important as COVID vaccination.

And I think the composite from a hospice care index, although, you know, it certainly really blurs the line between integrity and quality, it does really get to the concepts behind data and making data actionable, which for hospice has very often been amiss.

Claims data, very useful. Really excited about the next direction and how we're using claims data but just as a reminder with the --- certainly with the meaningful measures of keeping patient and family perspectives at the height of what we do.

So often as we look at quality we look at what the system expects and what the system delivers, and we really need to keep our eyes on what the patient really expects and what the

patient receives.

So let's not, you know, lose sight of that most important group as we continue our measure development work.

Gerri?

CHAIR LAMB: Thanks, Kurt.

Just a couple things to add, which is that we'd like to acknowledge the NQF staff. We have gone through five measures and if you noticed we accepted each of the preliminary recommendations.

So thank you for the quality work that you've done, extensive work that you've done. Amazing, as usual.

And, of course, as Kurt is saying to CMS, thank you for the very clear message of partnership with NQF as well as our committee work, also to acknowledge the CDC folks and the Abt folks who have been on this call.

And then to each of our committee members on long-term care, post-acute long-term care, you hung in the whole day. I also want to

acknowledge every one of you and I think everybody on the committee was a discussant and you were all prepared.

Kurt and I know you were prepared, and we didn't need to get there but thank you for all that preparation. It made it a much richer conversation and I'm sure you shared many of the things you were concerned about.

So thank you. I'm hoping that in the end of this year we will get to see each other again face to face, God willing, and please take Alan's encouragement this morning to all of us, which is this is a very difficult time, a very important time.

Get those vaccinations, wear your mask, social distance, and just do all the great work you're already doing. Thanks so much, and I think -- Amy, I don't know if you had final comments.

DR. LEVITT: Can I say one thing? I apologize, guys, I also, I just wanted to reiterate, you know, obviously, next year,

hopefully we can all be together again and, you know, despite all the challenges, how well this meeting was run today, and I think that's a testimony to everybody, first of all, on the work group.

I hope you all felt that you had a chance to participate and, certainly, it really appeared that you did. Thank you to the chairs, you did it once again. Kurt and Gerri did a great job in terms of really including everybody within the discussion. And particularly, thank you to the NQF staff.

This was a challenging year. You know, we -- you know, we brought measures with your understanding, you know, in terms of the COVID vaccination measures and you allowed us to -- you know, to bring it because we really do value the partnership and you gave that sort of understanding and gave that context to all of this and then even such things as the VBP model to be able to add that as well.

It makes me feel proud of the work

that we do and it really does reinforce. I mean, you know, this has been a challenging year. But I think one thing we really have all learned together is that we need more of this, that, you know, we need this sort of partnership to really help continue, first of all, to rid ourselves of, unfortunately, what's happened with public health emergency but really to move health care forward. Let's not go back to the way it was. Let's move things forward and moving forward together.

Thank you. Thank you so much for allowing me to be part of this.

MS. MOYER: And I will just echo everyone. Thanks. I thought we set a very challenging agenda for all of you today and you just handled it gracefully. So impressed.

So we got through everyone and on time, and it always -- the quality of the discussion and the feedback I just -- I appreciate that so much.

We could not do this without the many people who volunteer to come together and share

their time on our work group. So I just -- I appreciate it just so very much from all of you.

I also want to say we had a phenomenal team working in MAP this year and I appreciate all of you as well. This was very much a team effort.

So thank you all, and I hope you have a wonderful week.

(Whereupon, the above-entitled matter concluded at 5:37 p.m.)

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CERTIFICATE

This is to certify that the foregoing transcript

In the matter of: MAP Post-Acute Care and Long-Term Care Workgroup

Before: NQF

Date: 01-11-21

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter