NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
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3:35 pm CT

Man: Hello, everyone. This is NQF wanting to let you know we'll get started in a few minutes. Thank you.

Woman: Okay.

Amy Moyer: (Unintelligible) and thank you for joining us in the Measure Application Partnership PAC-LTC Workgroup Orientation Web Meeting.

I'm Amy Moyer. I am a Director here at the National Quality Forum and I am leading the work of this committee at this first round of MAP. And thank you everyone for taking the time to join us.

One housekeeping item, if you could please make sure your line is on mute if you are not the one currently speaking on the conference call that will make it easier for everyone to hear and enjoy the presentation.

If you are having any issues with the sound or with seeing the slide, please let us know in the chat box. I see a couple of people were having difficulty

hearing. I (unintelligible) the mike now so hopefully the sound is better, but please do let us know via chat if you are able to hear us.

I am going to turn it over to our Co-Chair Gerri to introduce herself and to offer some opening remarks for the committee.

Gerri Lamb: Thanks very much. Glad to be with you all. Welcome, everyone. I'm Gerri Lamb, Co-Chair. And I think I know many of you I am a professor at Arizona State University and a nurse and I also head up our interprofessional center.

In addition to MAP, I also co-chair the Patient Experience Care Coordination and Function Committee at NQF. So clearly love doing this work. So I'm delighted to have all of you here and delighted to have a new co-chair.

I'm not sure if Kurt can join us today but we'll certainly…

Kurt Merkelz: Yes. I'm on.

Gerri Lamb: If he - good, that's wonderful. And a special welcome to new members. We'll be hearing their names and welcoming them in just a sec. And Alan Levitt. Alan, if you are on the call, welcome to you too. It's great to be connecting again.

And I would just encourage everybody to really listen closely to the orientation today. It's really going to help those when we get together in December.

So welcome again and Kurt I'm going to turn it over you to introduce yourself.

Kurt Merkelz: Excellent. Thank you. And certainly I appreciate being part of this group. Let me take care of first order of business, which is the final game tonight since I hail from Houston and in acknowledgement of my NQF friends they're in Washington against the Washington Nationals. So we'll see how the game ends up tonight. I'm a physician …

Woman: (Unintelligible)

Kurt Merkelz: I've been a geriatrician for just about a quarter of a century and have been associated with hospice compasses for the last 13 years. I have been serving as Chief Medical Officer for the last three years with this organization.

My interest specifically within the hospice realm and what I'm embarked on right now is really working to reduce the variability in care delivery, specifically by providing this specific methodology that's focused on what's important to patients looking specifically at comfort, safety, quality of life.

And how we can actually measure our performance. And hopefully that this measure has a general consensus among, you know, individuals involved in this space. And hopefully it's the right measure that can certainly help drive to performance improvement.

As we look at, I think the ideas that we are going to be embracing and you know, where we can possibly advocate for improvement, just some general consideration, thought, just open up that I would like to hear a little bit about is regarding the recent med tech discussion. They will release their value incentive program for post-acute care focus, you know, mostly on skilled nursing facilities, home health and how that value incentive program ties the payments.

So really interested in their quality outcome measures that they are specifically looking at and should this be part of our agenda as part of the MAP and where we can potentially look at these recommendations as they - as a guide or resources, we have our discussion.

Also, whether or not these recommendations that are put out by MedPAC, can they be considered as a guide for us as we look at other measures including within the hospice space and specifically around all calls, hospitalizations and hospice transition which I think is very important.

I had a couple of other just points, just - I'm not sure if they'll come up during the discussion. But to put out there, maybe we can, it's where we are at currently with hope, which was previously hard and should the group be reviewing this.

And just somewhat of an interest regarding the public use file, the public use file and their derive measures and whether or not they are appropriate to be reviewed by the MAP.

So otherwise, I'll look forward to the continued discussion and again thank you for allowing me to be a part of this.

Gerri Lamb: Okay. To Amy, if you'll give me the next slide I'll go through the agenda. So here's the plan for today. We are going to be introducing everybody in just a moment.

We'll be going through the-pre rulemaking approach and the overview of programs under consideration. And as Kurt mentioned, it's really going to be an emphasis when we get together to look at alignment across programs as well as the different programs that we'll be considering.

We'll have a presentation from CMS, Alan will be with us. And then an opportunity for public comment and we'll get prepared for our December get together.

I think with that, Amy I'm passing it back to you.

Amy Moyer: Thank you, Gerri. I would like to introduce the NQF staff, who are working on this project. I am Amy Moyer, I'm a Director. We also help on the project Janaki and Charles, our Project Manager and Jordan Hirsch, our Project Analyst.

And I am going to turn it over to Jordan for a roll call of our workgroup members. Thank you.

Jordan Hirsch: Thank you, Amy. I will go through and read off organizational names. And if you are the organizational representative, please let us know you are here and provide a brief introduction. Thank you.

So on the line, as we've already heard from, we have our Co-Chair Gerri Lamb and Kurt and Merkle is the organizational representative for AMDA the Society for Post-Acute and Long-Term Care Medicine on with us today.

Raj Mahajan: Yes, hi. This is Raj Mahajan. Can you guys hear me?

Jordan Hirsch: Yes, we can.

Raj Mahajan: Okay. I'm Raj Mahajan, I'm an internist in geriatrician of Chicago. I have lived with AMDA the Society for Post-Acute and Long-Term Care for the quality measures for the practitioners in the field and we have a lot of interest

in exploring the possibility of facility based reporting for practitioners in Post -Acute and Long-term Care.

So I'm happy to come back. I think this is my third or the fourth year on the workgroup.

Jordan Hirsch: Thank you very much. The American Academy of Physical Medicine and Rehabilitation?

Kurt Hoppe: This is Kurt Hoppe, I represent the AAPM&R. I am a physiatrist specializing in spinal cord injury medicine at the Mayo Clinic in Rochester, Minnesota.

The interest in our group is understanding how the continuum works for the patients that we serve and how we can make sure that the quality remains as it should be given more and more cost restrictions and resource deprivation for not only our services but for what patients face when they are in the community.

Jordan Hirsch: Thank you. The American Geriatrics Society?

Debra Saliba: Hello, this is Deb Saliba, I'm representing the American Geriatrics Society today. I'm an internal medicine physician with on board certification in Geriatrics. I work at UCLA of the ZA and the reincorporation.

AGS, I remember (unintelligible) clinicians who have an interest in the care of older adults, caregivers, and also researchers and policymakers.

So, looking forward to participating today and really helping to represent the interests of the older adults that we care for. Our clinician members include physicians, nurses, pharmacists and social workers.

Jordan Hirsch: Thank you, Deb. The American Occupational Therapy Association? The American Physical Therapy Association?

Heather Smith: Hi, good afternoon. This is Heather Smith, I am representing the American Physical Therapy Association. I am a staff member there. I'm the Director of Quality and also a Physical Therapist.

I'm delighted to be back with the workgroup. I've been on the workgroup for a number of years. And I will apologize ahead of time I do need to leave the call a little early. But again, looking forward to participate in the workgroup this year. So, thanks.

Jordan Hirsch: Thank you. Centene Corporation?

Christine Hawkins: Hi, this is Christine Hawkins, I am the Regional Vice President over our quality and risk adjustment program strategy for all of our managed care entities across the nation, specializing in government sponsored programs and all lines of business. And of course focusing on delivering high quality care in the outpatient setting but making sure that we have good positive care transitions from the acute care setting.

Jordan Hirsch: Thank you very much. Kindred Healthcare? Legal Counsel for the Elderly. National Hospice and Palliative Care Organization? The National Pressure Ulcer Advisory Panel?

Jill Cox: Yes, hi. This is Jill Cox, I'm representing NPUAP. I am a Clinical Associate Professor at Rutgers University in the school of Nursing and I'm Advanced Practice Nurse with a specialty in wound care, and wound and ostomy care.

And I'll be representing the NPUAP in terms of pressure injuries and pressure ulcers in that space as it pertains to this group. So this is my first appointment to the group and I am very excited about working on this workgroup. Thank you.

Jordan Hirsch: Thank you. The National Transitions of Care Coalition?

Edward Davidson: Hello, this is Ed Davidson, I'm sitting in today for Dr. James Lett who usually attend these meetings and also be attending the meeting in December on behalf of Dr. Lett and talk.

I have an academic appointment in Internal Medicine & Geriatrics at Eastern Virginia Medical School and also a partner in a company called Insight Therapeutics that conducts clinical research in long-term care.

I've been on the board of directors for NTUC for the last several years and have an interest in medication management, during transitions of care to the nursing home.

Jordan Hirsch: Thank you very much. The Visiting Nurse Associations of America? We're moving on to our individual subject matter expert, Sarah Livesay.

Sarah Livesay: Hi everyone. This is Sarah Livesay, I'm an Assistant Dean at the College of Nursing in Rush University in Chicago, where I oversee a number of our D&P programs.

I'm also on the board of directors and an officer for the Neurocritical Care Society. My personal clinical interest is Stroke and Neurocritical Care.

This is my first time on this committee so I'm excited to learn more and contribute.

Jordan Hirsch: Thank you, Sarah and an apology for boxing your last name. Rikki Mangrum?

Rikki Mangrum: Hi, this is Ricky Mangrum, I'm a Senior Researcher at American Institutes of Research in Chapel Hill, North Carolina. I conduct Research and Development in Quality and Performance measures and nursing home care. Most recently working with the state of North Carolina on an initiative to reduce complaints about nursing homes and also led a project recently to develop a uniform definition of emissions of care nursing home.

So this is my second year on the committee and I'm glad to be back.

Jordan Hirsch: Thank you very much. Paul Mulhausen? Eugene Nuccio? Ashish Trivedi?

Moving to our Federal Government Liaison, the representative for Centers for Medicare and Medicaid Services.

(Sam): Yes hi, this is Sam, I'm the Medical Officer in the Division of chronic post-acute care at CMS.

I've been at CMS for six and a half years. In a prior life, I'm at Academic Physician at the University of Maryland in the Internal Medicine Geriatrician in the Department of Medicine in my primary faculty responsibility was really running a stroke rehabilitation unit. And really being involved very much in the rehab world in terms of management and administration in the hospital as well, prior to coming to CMS.

Jordan Hirsch: Thank you. The Office of the National Coordinator for Health Information Technology? Substance Abuse and Mental Health Services Administration?

And anyone - has anyone joined since going over on initial roll call or may have been on mute and not introduce themselves previously. Please introduce yourself now.

Andrew Geller: Hi, this is Dr. Andrew Geller from CDC I believe, I'm a Non-Voting Federal Government Liaison but I'm not on a list.

Jordan Hirsch: Okay. Thank you. We'll make note of that.

Jennifer Kennedy: Hi, this is Dr. Jennifer Kennedy representing the National Hospice and Palliative Care Organization.

Jordan Hirsch: Thank you very much.

Jeremy Furniss: Hi, this is Jeremy Furniss and I am staff with the American Occupational Therapy Association. And I am listening in for our member Dr. Pat Roberts.

Jordan Hirsch: Thank you. Is there anyone else? Hearing none, I'd like to turn it over to our CMS colleagues for opening remarks.

Alan Levitt: Hi, it's Alan Levitt, I didn't realize that I was doing a welcoming remarks today. But I, on behalf of the agency, I want to welcome the entire workgroup to this year's PAC-LTC, MAP workgroup. And I'd like to thank the chairs, both Gerri, for all the work that you've done before and Kurt who I met as well and I welcome you to your new role as a Co-Chair.

I also wanted to welcome the new NQF staff who are here as well and we've had a very productive discussions over the past seven years that I've been part of the community and I really look forward to continuing discussions. And I apologize, I guess there is no other CMS welcoming person to provide the remarks.

Amy Moyer: This is Amy at NQF. And Alan, we also really appreciate working with you and I'm glad you are here. We like a welcoming a remark.

I am going to provide an overview of the MAP pre-rulemaking approach. So, this will give you an idea of what to expect in the coming months. Right now, next slide, we are at the very tail end of October and having our initial workgroup meetings and the coordinating committee has their web meeting.

So we are going to review the approach and evaluation of measures under consideration and we are going to walk through the program today to help familiarize you with each program and each program measure set.

Moving into November, the world works health workgroup will meet via web meeting to provide perspective on the selection of quality measures. And those of you who've been with us over the last several years, which is a lot of the workgroup, you know that the statutory deadline for the mark is December 1.

We are all working together on a slightly accelerated timeline this year. And CMS is working to hopefully get us the mark ahead of that deadline. As you know our December in person meeting is December 3.

So we will all work to make sure that you get the information you need in advance that December in person meeting. At that meeting in December, you

will receive a preliminary evaluation completed by the NQF staff. Those evaluations are a good starting point for discussions around the measures to help the committee come to the workgroup conclusion.

Our recommendations from the workgroup will then go to the MAP Coordinating Committee in January. The MAP Coordinating Committee examines all of the MAP workgroup recommendations, and looks at cross-setting issues, consistency and makes final recommendations for the programs.

On the next slide, we have a nice graphical representation of all of the stuff so we kind of just went over. So and you can see a little more information along the bottom. We make the recommendation by the individual measures. That goes to the coordinating committee.

They make the final recommendations, and then we issue, there's guidance for the hospital in PAC/LTC programs and that will happen in February. Are there any questions on that workgroup and the process and kind of where we are in the timeline before we can introduce our goals for today's meeting?

All right, hearing none, I will take you through the goals for today's meeting. We are going to review each program as part of the MAP PAC-LTC preview and the structure of it.

We'll talk about the critical objectives of each program. We'll review measurement GAAP area, both that were identified by our colleagues at CMS and that were identified by this workgroup during recycle last year. And then we will open for discussion of any additional GAAP areas that we want to consider throughout the process this year.

There are six programs that are part of the PAC-LTC workgroup. The skilled nursing facility value based purchasing and quality reporting program, the inpatient rehabilitation facility, quality reporting program, long-term care hospital quality reporting program, hospice quality reporting program and the home health quality reporting program.

The next slide is a reminder of the highest leverage areas for performance measurements and core measure concepts that have been identified for the PAC-LTC program.

So getting into the program's themselves on the next slide. Some of the programs are covered under the IMPACT Act and we'll go through those programs first because there are some similarities across different grounds.

The first program is the skilled nursing facility quality reporting program. And like the other three IMPACT Act programs and this program is a penalty for failure to report data that also has a public reporting element.

The data under this program are recorded on the nursing home compare website. The IMPACT Act requires CMS to penalize Skilled Nursing Facilities who do not submit a required quality data by two percentage points.

The scope of the program is all Skilled Nursing Facilities is a prospective payment system and they are all required to submit excluding units that are affiliated with critical access hospitals.

Data sources for this program includes Medicare fee for service claims and minimum data set assessment data. And our goal of this program is to increase transparency so that patients are able to make important trade with them.

And then the next two slides. We have an overview of measures that are in the program. We tried to make these slides a little easier to read this year, but I know that still a lot of information. The slides will be available on the website for download later, which they are a little easier to read than sometimes.

The key thing that I will call out across all of these programs is the addition of the transfer of health information to provider and transfer of health information to patient. You may recall those were two team as that were discussed last year and they have been added to the program.

So high-priority meaningful measure areas that CMS has identified for the skilled nursing facility QRP are making care safer, the healthcare associated infections and the exchange of electronic health information and interoperability measured concept.

On the next slide, we see the workgroup itself identified GAAPs in measurements including measures that include managed care. As we mentioned, the program looks at Medicare fee for service claims, bi-directional measures, quality and safety of care transitions, patient and family engagement and detailed advanced directive.

Given the GAAPs that we just mentioned, does the workgroup has suggestions for any refinements to those identified GAAPs?

Man: Can you show the GAAPs again, please?

Amy Moyer: Can you show that slide? Okay.

Kurt Hoppe: This is Kurt Hoppe. Can you remind me what bi-directional measures are again specifically?

Woman: That was going to be my question as well.

Amy Moyer: Sure, I - well we did not having been on the workgroup last year. Those are measures that kind of close the loop. So for instance, I believe there was discussion of measures of handing off information to the funding information to the next location of care.

But there wasn't necessarily a measure coming back around the quality of the handoff or the quality of the information and Gerri or Alan, you may know them better than I do, it's at discussion.

Gerri Lamb: Amy, that's exactly right. These are really closing the loop is when you have information flowing in one direction is it received and is it returned so that in the Care Coordination Committee, we frequently called these the handshake measures that you had both hands in the process.

So this is I believe, the one GAAP I would expand detailed advanced directives to include and maybe use a broader category of achieving goal can coordinate care. So I, you know, I think with some goal can coordinate care that would encompass advanced directives.

It also includes current activities and care and ensuring that we are identifying goals and partnership with our patients and their caregivers and then we are using that as our guideposts for quality.

Amy Moyer: Thank you for that suggestion.

Kurt Hoppe: This is - real quick. This is Kurt as well. Regarding earlier discussion I recall having regarding bi-directional measures and I'm not sure just pertain to the sharing of the information but I thought there was also some accountability that occurred at both ends from a hospital going to a sniff or from a sniff going to discharge home. There was still some tieback to the original care delivery source.

Amy Moyer: All right. Thank you. I believe that was an intense of having the bi-directional measures but we'll capture that.

Edward Davidson: This is Ed Davidson. I just wanted to - under the quality and safety of care transitions, I'm hopeful that this includes information around medication reconciliation and identification of discrepancies?

Kurt Hoppe: One more question, and this is Kurt Hoppe again. Tell me a little bit about what you mean by measures that include managed care.

Amy Moyer: So I believe the goal there was to include a broader population of patients. With several of these programs the data source -- the Medicare fee for service claims, which would not include the managed care and Medicare Advantage patients.

And so that's kind of a blind spot, if you go off the measures and not having that data included in the force for the measure.

Kurt Hoppe: So, simply including MAP data?

Amy Moyer: I believe so. All right, any other suggestions or feedback on the identified GAAP? All right, we'll move on to the next program.

This is the home health quality reporting program. Similar instructions to the program we were just discussing. The data and measure results for this program are recorded on the Home Health compare websites.

This is also a penalty for failure to report program where agencies that do not submit data will see the two percentage points reductions in their annual market basket percentage increase. Data sources for these programs include the outcome and assessment information time. And again, Medicare fee for service claims.

And the goal in this program is alignment with the mission of the National Academy of Medicine and their definition of quality encompasses the domains of effectiveness, efficiency, equity, patient centeredness, safety and timeliness.

On the next few slides, we have an overview of measures that are currently in the program. And again at the very end you'll see this rule is not finalized, I believe. But they are proposing the inclusion of the two transfer of care - the transfer of health information measures that came to the MAP PAC-LTC workgroup last year.

Meaningful measure areas that CMS has identified for this area are persons and family engagement and carries personalized and align with the patient goals. Communication care, coordination, admissions and readmissions to hospital and exchange of health - electronic health information and interoperability measure account up.

In the next slide, we have the GAAPs that were identified by the workgroup. The workgroup identified patient reported outcome-based functional status or quality of life.

New measures to address stabilization improvement and/or distal outcomes with activities of daily living and a more holistic view of what we care. We'll pause here and see if the workgroup has any suggestions for refinement to those identified GAAPs so we can put them back on the screen for you.

Jill Cox: This is Jill Cox. I just wanted some clarification on holistic view of wound care.

Amy Moyer: You know I might have to go to the workgroup discussion for that.

Jill Cox: Okay.

Amy Moyer: Unless Gerri happens to remember, Gerri…

Gerri Lamb: Amy, I was having the same reaction. I think we are going to have to go back to our discussion notes in the end then bring it back to the group. But thanks for asking the question.

Amy Moyer: No problem.

Gerri Lamb: Amy, just a comment, this is Gerri, I'm at the kind of a placeholder is in the orientation session from last week. We talked a great deal about alignment between settings. And one of the requests to NQF and Sam Stolpe was there and said that he would respond to it.

It's also to create some sort of table for us so that we can look at the alignment and the connectivity between the different settings because I'm noticing that CMS high priority areas, some are consistent, some are different. Some of the tech long-term care recommendations are consistent. Some are different.

But I think for a big picture view of our group, it would be very helpful so that we can have that 20,000 foot level to stay on the same page with each other as well as CMS.

Amy Moyer: Absolutely and we are working on the best way to present that information, but I believe that is something we will be able to share with the workgroup.

Kurt Hoppe: This is Kurt Hoppe again. It remind me what you mean by digital outcomes, is that long-term outcomes or outcomes at the end of the program?

Amy Moyer: I believe that is long-term outcomes.

Kurt Hoppe: Thank you.

Gerri Lamb: Amy, for the meeting - and again I tried to create a lot of extra work but these are really good clarifying questions. Can we possibly go back to the notes from our last meeting and just put in a couple of clarifiers so that everybody knows exactly what the GAAPs are and we can either talk about them, add to them, revise them or whatever?

Amy Moyer: Absolutely. Any other suggestions or questions on this program? Okay. We'll move forward to the next program. Again, this is an IMPACT Act program so similar in structures, different in setting.

The next program is the inpatient rehabilitation facility quality reporting program. These data were recorded on the inpatient rehabilitation facility compare website. And it is also a penalty for failure to the point. And our failing to submit data, it results in a 2% reduction in the applicable inpatient rehabilitation facility prospective payment system.

This applies to all facilities that are in the prospective payment system program. These data sources for us again it's that fee-for-service claims. CDC, national health safety network data and inpatient rehabilitation facility - patient assessment instrument records.

And the goal of this program is to address the rehabilitation needs of the individual including functional status and achievement of the customer return to the community post discharge.

On the next few slides, we have a listing of the measures currently in the program. Again including those transfer of health information to the provider and to the patient from the discussion last year.

The meaningful measure area, CMS was identified for this program is an exchange of electronic health information and interoperability measure concept.

On the next slide, the GAAP identified by the workgroup last year was appropriate clinical prescribing and use of opioids.

We'll go ahead and stay on the slide, the CMS workgroup has many suggestion from a refinements of the identified GAAP.

All right. Hearing none at this time, we'll move on to the next program. The next program is the Long-term Care Hospital Quality Reporting program.

Data and measure results from this program are recorded on the long-term hospital compare website. It is again a two percentage point reduction in the applicable annual payment updates for facilities that failed to submit data.

And the data sources include the fee for service claims. The CDC, National Health Safety Network Data and the Long-term Care Hospital Continuity Assessment Record and Evaluation Data Set. This program goal is furnishing extended medical care to individuals with collectively complex problems.

Again, the next few slides are a summary of measures that are currently in the program, including the transfer of information measures from last year on that process.

The meaningful measure areas that CMS has identified for this program are personal and family engagement, functional outcomes and exchange of electronic health information and interoperability and measure concept.

On the next slide, the workgroup had identified one GAAP for this program and that was the measure around the availability of palliative care.

Palliative care (PHP), if the worker has any suggestion for refinement to the identified counts. Okay. If you're already known at this time, we will move forward with the Non-IMPACT Act programs that are part of PAC/LTC. There are two programs. And the first of this is a skilled nursing facility value-based purchasing program.

This is a pay-for-performance program, not a pay for recording. And this program began awarding incentive payments in 2018. The payments are made to Skilled Nursing Facilities based on performance on a hospital readmission measure.

So based on submission on those measures, CMS scores the Skilled Nursing Facilities on both improvement and achievement. And then facility has

earned incentive payment multipliers, negative or positive fees or payments based on their performance. And the score that's used to determine that payment multiplier is the higher performing of either the achievement or improvement scores.

The goals of this program are transforming healthcare is paid for by moving to rewarding better value and outcomes and innovations instead of paying for weekly based on volume. It is also linking payments to performance on a readmission measure.

On the next slide, we have some background on this program. It was started in 2014, Protecting Access to Medicare Act. And that legislation has mandated that CMS specify in all cause, all conditions, readmission measure. And a resource use measure that reflects resource use by measuring all condition risk-adjusted, potentially preventable 30-day hospital readmission rate.

So it's a unique thing to this program is that the measures were specified as part of the legislation. On the next slide, they have a summary of those two measures for the program. And we don't have any GAAPs identified for the program from the workgroup because we did not discuss that program last year. And some others are identified statutorily which is through the rulemaking process.

The last but not least program is the hospice quality reporting program. This program is also a penalty for failures report information. The data are recorded on the hospice compare website. Hospitals that fail to submit data are subject to 2% reduction is the applicable annual payments update. The data sources for this program are the hospice items and the CAHPS Hospice survey.

And the program goal is addressing pain and symptom management for hospice patients. And meeting their patients and their goal while remaining primarily in the home environment. On the next slide, you'll see a list of measures that are currently in the program. There's only one side of measures for this program. They are all here.

And then on the next slide, CMS is meaningful measure areas and they have identified as high priority for this, is communication and care coordination. And on the next slide, we have the GAAP identified by the workers of last year, which is care delivered in line with the patient's goals.

We will pause here to see if the workgroups has any questions or refinements to that account.

Kurt Merkelz: Yes. Hi, this is Kurt. I would add in some look into more safety measures on specifically potentially around Polypharmacy and MAP reconciliation and also something along the lines of patient-reported outcome, specifically towards symptom management.

(Jill Cox): This is (Jill Cox). I don't know whether this would be appropriate or not as far as the GAAP. But patients who are in hospice and a home hospice or at hospice facility, if they are transferred back into an acute care facility, clear communication of the goals of care, I just know that as a practitioner - I don't know if that's appropriate for this. But I know that clear communication was one of the overarching goals.

Amy Moyer: You know, I will write that down. I think there was some discussion around that on the workgroup last year.

(Jill Cox): Oh okay, it's okay.

Amy Moyer: I think it was actually around a different measure. It wasn't looking at that as a measure goal so we will capture that.

Kurt Merkelz: This is Kurt again. Something still along the lines of a value, incentive type of evaluation looking at hospice transition along those lines. Maybe less than seven days, something like that a time factor about hospice utilization.

Jennifer Kennedy: This is Jennifer Kennedy. I don't know if this is goal but timely referral, sort of ties in with that. I think what you're saying, Kurt.

Kurt Merkelz: I would agree. Yes.

Woman: Okay. So, timely referrals into the hospice program?

Jennifer Kennedy: Yes.

Amy Moyer: Okay. Thank you. Any other suggestions or refinements on the GAAPs for this program? Okay. Hearing none at this time, I am going to transfer the discussion over to Janaki, who will walk us through the overarching theme from last year's workgroup meetings.

Janaki Panchal: Hi, good afternoon everyone. This is Janaki Panchal, Project Manager here at NQF. And we will look over the overarching theme for the MAP PAC/LTC workgroup. And there are two main overarching theme.

The first is improving care coordination and care transitions. And the second is in showing meaningful information for all stakeholders.

Delving deeper we'll look at what is included in each of the two overarching theme. The first is including care coordination and care transitions, which is essential to improving post-acute and long-term care. As patients in among their home, the hospitals, and post-acute care and long-term care setting as their health and functional status change.

Another focus under this theme is health information technology that could play a big role to improve quality and minimize burden of measurement. Although the adoption of electronic health records and PAC/LTC studies often lack behind other care settings, greater standardization could help improve transitions and the exchange of information across providers.

Another focus is timely transfer of information to the patients and providers can ensure that we have the medication and equipment needed for a safe and effective transition of care.

And lastly, patients have varying degrees of degrees of health literacy and emphasis is on health care providers, should ensure that patients understand the information on their medication including the timing and dosage and when to discontinue use.

The second overarching theme is ensuring meaningful information for all stakeholders, which highlights the need for measures that are more patient-centered and address aspects of care that are most meaningful to patients and families. And here in this aspect, there is a need to engage patients and families into quality improvement efforts.

There's also emphasis and measures that produce information as granular as possible so clinicians and providers can act on that information. And patient-level data can improve, can help identify root causes of quality issues versus

facility level information can become challenging to act on. And lastly, the information from claims-based measures can be delayed, which can be difficult in making timely improvement.

Moving on to MAP Rural Workgroup review of the MUC. So first, we'll look at the Rural Health Workgroup chart. And Rural Health Workgroup will play a more active role in this cycle.

The MAP Rural Health Workgroup will provide their perspective on the measures under consideration the MUC list for setting specific programs. And they will also help address priority health, rural health issues, including the challenge of low case-volume in updating the rural-relevant core measures set.

So the Rural Health Workgroup, we'll look at five aspects of the workgroup will consider to provide feedback to the settings specific workgroup. And the five aspects are summarized here. The first is relative priority and utility of MUC measures, in terms of access cost or quality issues encountered by rural residents.

This I think is data collection and/or reporting of challenges for rural providers. So it is the methodological problems of calculating performance measures for small and rural facilities. Fourth is the potential unintended consequences of inclusion in specific program. And the last is GAAP areas in measurement relevant to rural residents and providers with specific programs.

This next slide looks at how the Rural Health Workgroup will be sharing their feedback with setting specific workgroups. They will provide their feedback through two main mechanisms. The first is through measure discussion guide, which will summarize the Rural Health Workgroup discussion of the MUC.

They will also share voting results that quantify the Rural Health Workgroups production of suitability of the MUC for various programs.

And secondly, we will have an in-person attendance in rural health workgroup liaison at all three pre-rulemaking meetings in December. Are there any questions before we move on? Hearing none, so now I'll turn it over to Alan Levitt to talk about the CMS presentation on feedback loop.

Alan Levitt: Okay. Thank you, thank you. Okay. Next slide, that's great. Thank you again. This is Alan Levitt. As I mentioned before, I'm the Medical Officer in the Division of Chronic and Post-Acute Care at CMS. And this is my seventh year as I mentioned representing the agency and this is actually the fourth year of our feedback loop presentation being done at the October webinar.

I want you to turn in our next slide. The feedback loop was based on discussions I had with the Workgroup members back in December of 2015, where I was requested by the members that they receive feedback on those measures that we had previously reviewed particularly in how workgroup discussions have been or have not been incorporated into our rule proposals and also into the current work of our Quality Reporting programs.

And we initially had the first feedback loop presentation at the October 2016 meeting. And it was very successfully received and so we've continued to do it up until today. Let's go to the next slide. Last year, there were nine measures that were reviewed by the workgroup at the in-person meeting.

Eight of them were the impacted mandate is a specimen-based transfer of health information measures. Two of them for each post-acute care setting. The setting is being, as we've talked about just before home health, inpatient rehabilitation facility, long-term care hospital and skilled nursing facility.

For each setting, we presented one transfer of health information to provider measure and there was also a transfer of health information to patient measure. The ninth measure that was considered that MUC 18101 was the claim space transitions from hospice care followed by death or acute care measure that was for the hospice quality reporting program.

We'll go to next slide. It was mentioned on the previous slide, we did review last year, the transfer of health information measures. And they received conditional support for rulemaking for each of those eight measures pending at NQF endorsement as last year's workgroup meeting. The assessment-based measures were mandated under the IMPACT Act.

And as was noted from the slides before, we're proposed and adopted in the three fiscal year rules for inpatient rehabilitation facility, long-term care hospitals and for skilled nursing facilities. And it's been proposed in the one calendar year rule for the home health quality reporting program. And the final rule is yet to be published this year.

As recommended by the workgroup, we also do plan to submit this measure in the future for NQF endorsement. We'll go to the next slide. The transition from hospice care followed by death or acute-care measure was not supported by the workgroup with a potential for medication at last year's meeting. Recommendations from the workgroup included to first - we considered the exclusion criteria.

There was lots of discussion on patient choice as well as the reliability of claim factories to support that reason for life discharge. Some workgroup members also did not support the use of claims as a data source for hospice measures. Since for this particular outcome measure that would require risk

adjustment, it would use up to one year of prior claims thereby excluding Medicare Advantage patients from the measure.

Some workgroup measures recommended that this specify the measure to find a better, separate the two outcomes, deaths and hospitalization from each other as well as there is also the consideration whether we should be looking at the timeframes that we had originally established for measuring these outcomes.

Since the meeting last December, this measure was not proposed in last year's rule as was recommended by the workgroup. And we are continuing to work on them with our measure contractor on exploring with specifications of the measure, taking into account the workgroup recommendations.

Go to the next slide. Other highlights from our rulemaking, even this year. And please note again that in home health these are proposals that are not finalized. It included the adoption of some additional standardized patient assessment data elements that are required under the IMPACT Act. These new data elements included those in categories of constitute function mental status, special services, treatments and interventions, medical conditions and comorbidities, impairments and, also as I noted on the slide, your social determinants of health.

The social determinants of health data elements were done in collaboration with our colleagues in the Office of Minority Health here at the agency. And they included items as I've listed on the slide such as race and ethnicity, preferred language and interpreter services, health literacy, transportation and social isolation.

We also modified rulemaking in four of the five quality reporting programs. Changes in the specifications of the discharged community post-acute care measure. And what we changed was we are now excluding a baseline nursing facility residents from the measure. This was a topic of workgroup discussion a few years ago when the measure was first considered into our quality reporting programs.

And so again, we've taken feedback we got from the workgroup as well as through public comments in terms of looking at the measure, retesting the measure and finding that retesting the successful. That's why we went ahead with re-specification proposal and finalized it in three of the four rules so far.

And finally, although we too continue to believe at the collection of quality days and our program should include all patients regardless of payer so that would include managed care, as it was described on the first slide.

We did not finalize all-payer proposals that were in two of our rules. We need to continue to work through the administrative operational training challenges that are implementing all-payer data collection as well as we do also accounts for the burden that would be related to implementing this policy. But it's still something we really are interested in doing in the future.

Go to the next slide. And as a reminder, as it was noted by Dr. Veceza in the all-MAP call if you attended that last week. We continue to follow the agency, the Meaningful Measures Framework to identify the highest priorities for quality measurement and improvement.

Meaningful Measures focuses efforts on these same quality areas through the eight objectives that are listed here on the slide, including addressing the high-impact measure areas that safeguard public health, making measures patient-

centered meaningful. Making measures whenever possible outcome-based, fulfilling each program statutory requirements, minimizing the level of burden for providers.

Making measures that where there is opportunity for improvement. Addressing measure needs when possible in a population-based payment. We've gone through turn of payment models. And then finally, where possible aligning measures across programs are also with other payers.

Next slide. Thank you. As I said in my presentation, I guess, I can take questions now or at the end of the meeting.

Gerri Lamb: Alan, this is Gerri and it's always good to have you on these calls. Going back to the Meaningful Measures objective, you know, I was on the call last week and your colleague, I thought, made an articulated call for not only addressing Meaningful Measures but particular - which I thought particularly focus on alignment across setting the goals and so forth.

As you think about the December meeting, which is, you know, at least in my view Alan it's been a really excellent time to have these discussions. What would you suggest in terms of thinking preparation that our committee members can do? And particularly the people who are new to this process, what thoughts do you have on that?

Alan Levitt: Again, alignment is something we've been, you know, very interested. Obviously in the post-acute care world, it was statutorily mandated of us. But we were certainly the right community to be able to - first be able to align our measures, which we've done within those quality measures domains as outlined in the IMPACT Act.

Again we're interested in, well, how can we continue to make alignment of understanding the operational issues that are associated with it, particularly in terms of data sources that are available. And that's one of the biggest challenges we have is we have all different types of data that's available, that's collected in different settings in different ways.

Each setting they have different resources available in terms of their IT resources in their infrastructure that are there, the ability to have electronic medical records. And so, you're kind of ticking all these pieces together and saying, well, how can we align measures even if they may not necessarily be exactly the same way that we're collecting the measures?

And so we really want to now try to - how can we expand what we've been doing in post-acute care, at least within before IMPACT Act settings and how do we expand that outward? Part of that is, well, if we're interested in the use of standardized assessments, for example, and different sorts of assessment items, whether or not the use of those items could one day be expanded to be used in these other settings particularly for the types of patients who are very similar to the patients within the PAC world.

And so if we are able to expand those, use of those items again the expansion of measurement would be easier. Short of that, well, less domains with seem to work or be able to be looked at or measured across settings. And then how could we make if they could exactly be measured the same way at least at this time? How could we take the disparate decent data sources and kind of pull them together to make similar types of measurements?

You know, we can't do everything at once. So there may be simpler things that we could do, certainly transfer of health information, the same health

information that is coming one way to go the other way and so that those are kind of, I guess, some of the lower hanging fruit that we could look at.

But then also in terms of the same patient safety issues, whether it's healthcare associated infections, whether it's falls, whether it's pressure ulcers. Again, same types of patients, whether they are in a post-acute care setting or if they are admitted to the acute-care hospital, they're still at risk for those same issues going on.

And so trying to get maybe from the committee, prior to the session of kind of what sort of measurement topics are measured, domains may be most important to look at, so that we can kind of concentrate our resources in the best way. I don't know if that helps at all Gerri.

But it is something - I mean, literally, we're talking about this all the time. So we're glad that for you to always talk about it as well because we're interested. Did I lose you?

Gerri Lamb: Not me, I was listening, totally rapidly Alan.

Alan Levitt: Okay, okay, okay.

Gerri Lamb: You know, what - and please, everybody on the committee jumped in. What's really intriguing to me is, of course, our first priority is to look at the MUC measures.

But in last week conversation, I think there was, you know, a very concerted movement to encourage all of us to really look at exactly what Alan was just talking about which is the hospital group, the hospital MAP, the clinician MAP, the rural group is all getting together.

And part of this work is to look at making it meaningful for patients families, clinicians, all stakeholders. And how do we do that across setting while we're looking at specific MUC items?

So that, you know, I think the challenge and the joy of this is really to look at the MUC items at the same time that we look at the bigger picture of Meaningful Measures than alignment. So I'm really looking forward to those discussions.

Does anybody else have anything to jump in? This is just a great opportunity to engage with Alan, as we're preparing for this meeting.

Alan Levitt: If I could just grab in again even if you're, you know, thinking right now as to what, you know, think about it over the next, you know, few weeks so that way we can talk about it also in the in-person meeting, as well.

Rikki Mangrum: So, this is Rikki Mangrum and a lot of what you talked about really resonates with me. And I do work in another field of health care in which there is sort of a broad desire to align care and coordinate care in such a way that from the recipient point of view, the patient, the family, whoever that might be, there's sort of No Wrong Door for care.

And one of the questions for me is should there also be No Wrong Door for quality measures. And so one of the things that I'm really struggling with right now is the increased number of programs and the increased number of distinctions between inpatient rehabilitation and hospice and long-term care hospitals.

And I think for a lot of consumers of healthcare, none of that makes any sense. I think it makes less and less sense to me, the more time I spend talking with patients and families as well.

So always in the back of my mind is this idea that when we talk about care coordination, we should also be talking about measure coordination, instead of always siloing our discussion even when we were talking about the identified GAAPs. I sort of, had a question in the back of my mind is why some of the GAAPs are only listed for one program, they're really GAAPs for all the programs?

Anytime you're exchanging information, for example, there should be some kind of bi-directional measure. But we're used to thinking of care in specific ways and so we only called it out in the program where that seems to make the most sense to us. So those are the ideas that your discussion about running around in my head.

Gerri Lamb: Thanks Rikki. That's exactly the kind of conversation that I think really makes our meetings robust.

And again we have the opportunity to really talk to this process influences, so I would just encourage everybody to think about what's important to you in the settings, across the setting, taking into account, you know, that we do have this opportunity to really look at this more broadly and influence the direction that it takes.

Amy, it seems to me, I guess, folks are ready to move on.

Amy Moyer: All right. Thank you everyone for that discussion. I definitely made some notes of things that we can bring out that we have additional discussion time

in the meeting with in-person, which is effectively may have. Next on our agenda item is, is Janaki a public comment?

Janaki Panchal: Yes. So, we'll open the call for member and public comments. Is there anyone on the call would like to make a comment? You can also chat the comment via chat box. We'll give everyone a couple minutes to see if they have any comments?

All right, hearing none, so we'll move on to the next step. Next slide please. So we'll look at upcoming activities and timeline and what to expect moving forward. The release of the MUC list, we're anticipating that will happen by December 1 and based on then the MUC list is released, we'll open that up public comment period one. But the timing will be based on the release of the MUC list.

Following that, we have rural workgroup meetings on November 18, 19 and 20. And then in-person meetings in December, PAC-LTC Workgroup in-person meeting is December 3. You will be receiving more information through our meetings department regarding travel and accommodation. And we'll follow up with you as well on that.

And then following that we'll have public comment period two, which will be December 18 through January 8, 2020. System resources and links for your reference, if you have any questions, let us know, and it looks like, that's it.

Are there any questions before we wrap?

(Jill Cox): Yes. This is (Jill Cox). Just one question. The previous slide that you just showed with the resources, would you be able to email that to us for info?

Janaki Panchal: Yes. So, it's included in the slide deck that's attached to the calendar invite but if you're not able …

((Crosstalk))

(Jill Cox): I didn't realize that the slide deck was available on as a download.

Janaki Panchal: Yes. It's a PDF attachment…

((Crosstalk))

(Jill Cox): Okay. Thank you. Yes, I didn't see it.

Janaki Panchal: No problem.

(Jill Cox): Okay.

Janaki Panchal: (Katie), if could you just say a few words about what folks can expect given that not everybody was on the orientation last week. So we expect the MUC list to be out no later than December 1. And my understanding is that we will all get the staff review of the MUC list.

And then we will have we discussed on so I'm expecting them that once the MUC list comes out that's going to move pretty fast. And people will need to do their reviews to be able to come to the meeting and help us facilitate the discussion. Is that right?

(Katie Cannon): Yes. This is (Katie Cannon) and that's exactly correct. So one of the things as you mentioned, the MUC list will be release by December 1. And that since the meeting will be in September 3 and it's going to be pretty, pretty

quick turnaround. We as always try to get five business days, meeting materials five business, ahead of time.

It will include the staff seminary analysis, as well as the elite discussion assignments as we've done in years prior with them, we'll be discussing assignments. And if people want to opt out well they're of course allowed to. But we send that out with the assumption that unless you tell us you do not want to be able to discuss it, you will be one for the in-person meeting.

So we are hoping it's an all materials out to the committee members a weekend in advance. But as you mentioned, it is dependent on the MUC list release.

Janaki Panchal: And the week prior is Thanksgiving?

(Katie Cannon): Yes, it is. Yes.

Janaki Panchal: Okay, okay. Yes. So our goal is to get panelists out by the 25th, 26th obviously depending on the MUC list release. Any other questions?

So we have our project page and workgroup SharePoint site listed here as well. All the material will be uploaded to the SharePoint site. We will send an email out with the link as well when we send out the meeting materials.

And lastly, the project inbox is listed at the bottom of the slide. And this is just more information regarding our NQF conference, which will be taking place, March 23 and 25. Next slide please. More information on the following slide, as well.

Great. If there are no other questions, we can end the call. Thank you everyone for taking the time to join the call. If any questions do come up, please feel free to email us. So, is there anyone talking? Okay.

I'll turn it back to Gerri to see if there is any last words, Gerri?

Gerri Lamb: Was that for me, Janaki?

Janaki Panchal: Yes. Gerri, you're correct. Yes.

Gerri Lamb: Okay. So first I'll start. So just thank you everybody for participating. We'll look forward to seeing you in December. And certainly, if you have any questions about, you know, the process or what we're going to be doing or being lead discussing, please reach out to NQF staff. They're wonderful and they will respond quickly.

So, see you in December. Have a great holiday.

Man: Yes. Thank you. Thank you all for participating.

Janaki Panchal: Thank you.

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