

NATIONAL QUALITY FORUM

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MAP POST-ACUTE CARE AND
LONG-TERM CARE WORKGROUP

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TUESDAY
DECEMBER 3, 2019

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The Workgroup met at the National Quality Forum, 5th Floor Conference Room, 1099 14th Street, N.W., 5th Floor, Washington, D.C., at 9:00 a.m., Gerri Lamb and Kurt Merkelz, Co-Chairs, presiding.

PRESENT:

GERRI LAMB, Co-Chair

KURT MERKELZ, Co-Chair

JILL COX, National Pressure Ulcer Advisory Panel

EDWARD DAVIDSON, National Transitions of Care
Coalition

KURT HOPPE, American Academy of Physical
Medicine and Rehabilitation*

JENNIFER KENNEDY, National Hospice and
Palliative Care Organization

SARAH LIVESAY, Subject Matter Expert*

DHEERAJ MAHAJAN, AMDA - The Society for
Post-Acute and Long-Term Care Medicine

RIKKI MANGRUM, Subject Matter Expert

EUGENE NUCCIO, Subject Matter Expert

JOHN RICHARDSON, National Partnership for
Hospice Innovation

PAMELA ROBERTS, American Occupational Therapy
Organization

DEBRA SALIBA, American Geriatrics Society

HEATHER SMITH, American Physical Therapy
Association

ASHISH TRIVEDI, Subject Matter Expert

FEDERAL LIAISONS:

REENA DUSEJA, CMS
ANDREW GELLER, CDC*
ELIZABETH PALENA HALL, ONCHIT
ALAN LEVITT, CMS
MICHELLE SCHREIBER, CMS

NQF STAFF:

SHANTANU AGRAWAL, MD, MPhil, President and CEO
TAROON AMIN, Consultant
JORDAN HIRSCH, Project Analyst
AMY MOYER, Director
ELISA MUNTHALI, Senior Vice President, Quality
Measurement
JANAKI PANCHAL, Project Manager
SAM STOLPE, Senior Director

ALSO PRESENT:

T.J. CHRISTIAN
KYLE COBB
ALRICK EDWARDS
JESSICA FRENCH, Public Participant*
CRAIG JEFFRIES, Public Participant*
HEIDI MAGLADRY
CINDY MASUDA
JOAN PROCTOR
BROCK SLABACH

* present by teleconference

C-O-N-T-E-N-T-S

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

(9:09 a.m.)

MS. MOYER: All right. Thank you, everyone, for joining us for the MAP PAC/LTC meeting in our new space. I'm excited to be leading this work this year and I'm glad so many people were able to join us in person and on the phone.

I do have a couple of housekeeping reminders as we get started today. First, can everyone access Poll Everywhere? We will be using that for voting.

Anyone who can't raise your card and we can have someone come around. But I'm seeing a lot of nodding in the room, terrific. The meeting materials are all available at public.qualityforum.org so you can see them there.

Something I noticed last night, if you open the materials it opens in your browser window. And if you're like me, you may then close it and close out of it. You can right

1 click, open it in a new tab and then you'll have
2 it open there and still be able to go back to the
3 meeting site. I found that helpful.

4 If you wish to speak and you're in the
5 room, please put your tent card up as is MAP's
6 tradition. I think we're all old pros at that.
7 And if you are on the phone we are monitoring the
8 chat and the raised hand function so that you can
9 participate as well.

10 Restrooms are just past the reception
11 desk. The doors are unlocked now. You will be
12 able to get back into the meeting space. Women's
13 on this side and then men's is on the far side.

14 Those of you in the room, if you could
15 take a moment to please mute your technology and
16 if you have speakers on your laptop turn them
17 down.

18 Those of you who are on the phone, if
19 you could keep your lines muted unless you are
20 actively speaking, that will help everyone be
21 able to hear and keep down the background noise.

22 And I am now going to turn it over to

1 our co-chairs, Gerri and Kurt, for some welcoming
2 remarks.

3 CO-CHAIR LAMB: Good morning,
4 everybody. Glad you're all here. I'm Gerri
5 Lamb. I know many of you. Welcome to our new
6 members as well. And actually, welcome to the
7 new NQF digs. I'm glad you all found your way
8 here.

9 I understand some people went to the
10 old offices. There was a little bit of, you
11 know, nostalgia there. So, welcome to you all.
12 I'm delighted to have a new co-chair this year.
13 Kurt will be introducing himself in just a sec.

14 Would also like to welcome our CMS
15 colleagues here, Alan and Michelle and Reena, are
16 you also -- and Reena. And as well as our
17 measure developers and folks here so we're
18 looking forward to your comments as well. I'm
19 going to turn it over to Kurt for his welcome.

20 CO-CHAIR MERKELZ: Excellent. And
21 again, also extend that welcome to everybody.
22 Very exciting to be here. I know some of you,

1 many of you all in the room.

2 And I think it's a great opportunity,
3 privilege to have this discussion take place. As
4 many of you all know, I'm very personally
5 committed to improving the way we look at quality
6 in care in the Post-Acute Care network and then
7 personally, my father having just passed just
8 less than two months ago in hospice.

9 It's always recognizing that we're
10 trying to design the care that we will actually
11 need in our lifetime. So, again I think it's a
12 wonderful privilege. I thank everybody for being
13 present and look forward to the discussions as we
14 go throughout the day. Thank you.

15 CO-CHAIR LAMB: I'd like to just take
16 a moment too, to just check the folks that we
17 have online. And we'll be introducing everybody
18 in just a moment.

19 Five of our members, we believe, will
20 be joining us online today. So, we'll have to
21 take that into account as we're having discussion
22 and remember to invite them into the

1 conversation. Janaki, are folks online?

2 MS. PANACHAL: Yes. It seems like we
3 have most of them online. But when you do the
4 introductions we can call.

5 CO-CHAIR LAMB: We'll check, okay.
6 And then we're very fortunate to have Brock
7 Slabach, I'm going to get this right, Brock,
8 Slabach.

9 MR. SLABACH: Slabach.

10 CO-CHAIR LAMB: Slabach. I got the
11 last half right just not the first, Slabach.
12 Brock represents the rural, he's a rural liaison.
13 And as we're reviewing the MUC measures Brock
14 will be commenting on the rural committee's
15 comments on it.

16 Brock is not a voting member, I don't
17 believe, for this. But he will be here as our
18 expert liaison. And so, then with that I'm going
19 to pass on to Elisa.

20 MS. MUNTHALI: Yes, thank you, Gerri,
21 and thank you, Kurt. Good morning, everyone. My
22 name is Elisa Munthali. I'm the senior vice

1 president for quality measurement at the National
2 Quality Forum.

3 And I wanted to welcome you and thank
4 you all for serving on this workgroup. And so,
5 what we're going to do today hopefully will not
6 take long.

7 But it's a little complicated. We're
8 going to divide the workgroup into the
9 representation that you sit on the committee of
10 the workgroup.

11 We have both organizational
12 representatives and subject matter
13 representatives. The majority of the workgroup
14 is made up of organizational reps.

15 So, I will start with introductions
16 and ask you to disclose anything that you
17 disclosed to us in a very abbreviated manner in
18 written form. So, we'll start in the room first.
19 We'll start to my left and go around clockwise
20 and then I'll call on the organizational reps on
21 the phone.

22 So, in case you cannot remember if you

1 are an organizational rep, this first time around
2 the room will be everyone with the exception of
3 Kurt and Gerri, Sarah, Rikki, Paul, Gene, and
4 Ash. And then on the phone, I think Paul is on
5 the phone and everyone else should be in the
6 room.

7 So, for the organizational reps we did
8 ask you one question because we expect you to
9 bring the perspective of your organization or
10 your stakeholder viewpoint. And that is if you
11 were making anything in excess of \$10,000 as it's
12 related to the post-acute long term care work.

13 So, we are going to ask you to
14 introduce yourself. Please tell us who you are
15 with and let us know if you have anything to
16 disclose. And so, I think we start Heather. Is
17 that you?

18 MEMBER SMITH: Yes. Good morning.
19 I'm Heather Smith. I'm with the American
20 Physical Therapy Association and I've been on
21 this workgroup for a number of years and I'm
22 pleased to be back this year. I have nothing to

1 disclose.

2 MEMBER ROBERTS: Pam Roberts, I'm part
3 of American Occupational Therapy Association and
4 I am employed by Cedars-Sinai in Los Angeles, and
5 I have nothing to disclose.

6 MEMBER MAHAJAN: Raj Mahajan. I'm
7 with AMDA, the Society of Post-Acute Long Term
8 Care. I, earlier on this year, took on the
9 position as chief medical officer at one of the
10 EHR companies. I don't think that's a conflict
11 but I just wanted to disclose that.

12 MR. SLABACH: Well, I'll disclose and
13 I'm not sure if I'm supposed to. I'm Brock
14 Slabach, Senior Vice President at the National
15 Rural Health Association.

16 I'm the rural liaison to this group of
17 the newly formed Measures Application Partnership
18 on rural measures. So, we've reviewed a lot of
19 the measures that will be discussed today and
20 have our comments in response. I have nothing to
21 disclose.

22 MEMBER COX: Hi, my name is Jill Cox.

1 I'm the organizational representative for the
2 National Pressure -- now called Injury Panel.
3 And I have nothing to disclose as well.

4 MEMBER DAVIDSON: I'm Ed Davidson. I
5 represent the National Transitions of Care
6 Coalition and I sit on the board of that
7 organization.

8 I own a company that conducts
9 pragmatic clinical trials in post-acute and long-
10 term care and currently am receiving funding from
11 two vaccine manufacturers to study the flu
12 vaccine.

13 MEMBER SALIBA: I think I'm the next
14 person. I'm Debra Saliba. I am a geriatrician
15 and I'm representing the American Geriatric
16 Society.

17 I also do research related to post-
18 acute and long-term care through the UCLA Borun
19 Center, the Veterans Administration and the RAND
20 Corporation.

21 MEMBER RICHARDSON: I'm John
22 Richardson for the National Partnership for

1 Hospice Intervention. We represent non-profit
2 hospices and I have nothing to disclose.

3 MS. MUNTHALI: Thank you very much.
4 So, I'm going to call on the organizational
5 representatives on the phone. Kurt Hoppe, are
6 you with us?

7 MEMBER HOPPE: Yes, I am. I am Kurt
8 Hoppe representing the American Academy of
9 Physical Medicine and Rehabilitation and I have
10 nothing to disclose.

11 MS. MUNTHALI: Thank you very much.
12 Danielle, are you with us? We weren't sure if
13 she would be able to attend. So, thank you to
14 all of the organizational reps.

15 And so, now we're going to transition
16 to the subject matter experts. And that includes
17 your co-chairs. Your disclosure of interest
18 included more lengthy questions about activities
19 as were related to the Post-Acute Long-Term Care
20 Workgroup.

21 Just a couple of reminders. You sit
22 on this workgroup as an individual and you do not

1 represent the interest of anyone who may have
2 nominated you or your employer.

3 We're interested not just in paid
4 activities as they're related to the Post-Acute
5 Long-Term Care Workgroup, but also those that are
6 not paid. Also, just because you disclose does
7 not mean you have a conflict of interest.

8 We do this process in the interest of
9 openness and transparency. And so, we'll start
10 with Gerri and then Kurt and then I'll call on
11 everyone. Gene, did you have a question?

12 MEMBER NUCCIO: No.

13 MS. MUNTHALI: Oh, okay.

14 CO-CHAIR LAMB: I'm Gerri Lamb. And
15 I disclosed that I do consulting on case
16 management and care coordination and I also
17 receive royalties on books related to care
18 coordination.

19 CO-CHAIR MERKELZ: Good morning,
20 again, Kurt Merkelz. I'm the chief medical
21 officer for Compassus and I have nothing to
22 disclose.

1 MS. MUNTHALI: Thank you. I think
2 Gene would be next.

3 MEMBER NUCCIO: I'm Eugene Nuccio,
4 University of Colorado Anschutz Medical Campus.
5 I'm the SME on home health. My research work in
6 the past has been funded by CMS, CMMI and MedPAC.
7 And I also sit on the board -- excuse me, on the
8 NQF Scientific Methods Panel. I have nothing
9 specifically to disclose.

10 MS. MOYER: Ash, you're going to be
11 next.

12 MEMBER TRIVEDI: Okay, Ash Trivedi
13 from Novartis. I have nothing to disclose.

14 MS. MUNTHALI: Okay, Rikki.

15 MEMBER MANGRUM: Rikki Mangrum. I'm
16 a senior researcher at American Institutes for
17 Research. I have conducted research for CMS and
18 CMMI on measures. I also have conducted research
19 for AHRC that is measure-related.

20 And I also disclosed that I am
21 currently the Chair of the Quality Measures
22 Committee for AMDA, the Society for Post-Acute

1 and Long-Term Care Medicine.

2 MS. MUNTHALI: Thank you very much.

3 I think we have all of our subject matter experts
4 in the group. So, we'll go to the phone to see
5 if Sarah is with us.

6 MS. LIVESAY: Hi, this is Sarah
7 Livesay. Can you hear me?

8 MS. MUNTHALI: Yes, we can. Thank
9 you.

10 MS. LIVESAY: Hi, good morning. This
11 is Sarah Livesay. I'm an assistant dean for DNP
12 specialty education at Rush in Chicago. And I'm
13 an acute care nurse practitioner.

14 And I will disclose that I've worked
15 in a couple different functions as a consultant
16 for inpatient organizations that are seeking
17 certification.

18 MS. MUNTHALI: Thank you, Sarah. And
19 so, finally we have Paul. Paul, are you on the
20 phone? I don't think Paul has joined us yet.

21 We're also very fortunate to have
22 federal liaisons be a part of our committee.

1 They are not voting members of the committee and
2 we would like at this time for them to introduce
3 themselves in the room.

4 I think we have somebody from CDC who
5 is on the phone. But we'll start with our CMS
6 colleagues here. So, Reena and Michelle and then
7 Alan.

8 MS. DUSEJA: Good morning. My name is
9 Reena Duseja. I'm the chief medical officer of
10 the Quality Measurement and Value-Based
11 Incentives Group.

12 I just wanted to thank all of you for
13 your time today in giving us guidance.

14 MS. SCHREIBER: Hi, I'm Michelle
15 Schreiber. I am the director of the Quality
16 Measurement Value-Based Incentives Group at CMS.
17 And I thank you for your partnership with us.

18 MR. LEVITT: I am Alan Levitt. I'm
19 the medical officer in the Division of Chronic
20 and Post-Acute care at CMS. And I have nothing
21 to disclose.

22 MS. MUNTHALI: And Elizabeth from

1 ONCHIT, I don't know if she is here
2 participating. Andrew Geller from CDC is on the
3 phone. If you could introduce yourself.

4 MR. GELLER: Yes, good morning. I'm
5 Andy Geller. I'm a medical officer in the
6 Medication Safety Program at the CDC.

7 MS. MUNTHALI: Thank you so much. So,
8 before I turn the meeting over to my colleagues,
9 we just wanted to remind you at any time if you
10 remember that you have a conflict, we want you to
11 speak up. You can do so in real time or you can
12 come to any one of us on the staff or your co-
13 chairs.

14 Likewise, if you believe that any of
15 your colleagues is acting in a biased manner, we
16 want you to speak up. So, thank you.

17 MS. MOYER: So, I have a lot of thank
18 yous for staff who have worked hard to put this
19 meeting together. I'd like to introduce those
20 who aren't in the room.

21 First, I'm Amy Moyer. I'm the
22 director of Quality Measurement here at NQF. I

1 have spent a lot of time sitting in your chairs
2 in these meetings. But this is the first time
3 sitting in this chair.

4 So, thank you all for joining us. We
5 also have Taroon Amin, Janaki Panachal and Jordan
6 Hirsch who have done a ton of work in getting
7 everything ready, and Shantanu Agrawal.

8 So, our meeting objectives today are
9 to review the measures under consideration and
10 make recommendations to the MAP Coordinating
11 Committee. And since we have two measures and we
12 have you all here, we would like to take
13 advantage of the expertise in the room to have a
14 robust discussion around strategic directions for
15 the programs as well.

16 And our agenda will flow, we'll go
17 through the measures first. We'll have opening
18 remarks from CMS. And then we will have the
19 strategic discussion at the end so we make sure
20 we do all the voting and get all of the quorum
21 items done first.

22 I will turn it over to Michelle for

1 opening remarks from CMS.

2 MS. SCHREIBER: So, Amy, thank you
3 very much and to all of you thank you so much for
4 your participation and your input. This is a
5 very important process for CMS and we take it
6 very seriously.

7 Before I start I would like to
8 recognize a few folks. First, to say thank you
9 to the NQF staff and welcome to your new digs.
10 Actually, this is my first time here. I have to
11 tell you I miss those microphones. On and off.

12 PARTICIPANT: We can just put one
13 there for you.

14 MS. SCHREIBER: Beautiful space. So,
15 congratulations on the successful move. Second
16 of all, I would like to say thank you to our
17 contractors. If you guys could just raise your
18 hands so people know who you are.

19 We work very closely with our
20 contractors to help develop these measures. And
21 please feel free to reach out to them at any
22 point in time.

1 And finally, if I could ask the CMS
2 staff to all raise your hands. Again, we have a
3 very dedicated group of staff. This is from the
4 Post-Acute Care Division.

5 They are experts in these areas of the
6 programs and the measures of post-acute care.
7 So, please feel free to reach out to any of them
8 at any time. They know far more than I do
9 actually certainly in this particular area.

10 And we would be delighted to answer
11 your questions or engage in any conversations.
12 So, thank you to you guys for being here today.

13 MS. MUNTHALI: For anyone who is on
14 the phone, if you are not speaking, if you could
15 please mute your line. We can hear some
16 background noise. Thank you.

17 MS. SCHREIBER: I want you to know
18 that your input makes a significant difference.
19 So, people have asked we come, we debate, we make
20 recommendations so what happens?

21 And the truth is this really does make
22 a difference to CMS. Last year, which was my

1 first MAP, I had been at CMS for a grand total of
2 one year and three weeks, fingers counting, we
3 did actually remove measures that the committees
4 weren't in favor of.

5 We made modifications to other
6 measures. And so, it does have a profound
7 effect. You are an important group of experts
8 and stakeholders and we really couldn't do this
9 without all of you. So, thank you for your
10 participation.

11 Because we only have a couple of
12 measures, as was pointed out, we are going to
13 take this opportunity because we have such
14 experts in the room to talk a little bit about
15 directionality and strategic planning for post-
16 acute care and really for measures in general.

17 So, thank you for that opportunity.
18 We really do appreciate that. Now, all that
19 being said I do want to remind the group though
20 that this is, you know, a committee that makes
21 recommendations but they're not binding to CMS.

22 And in the end CMS does have the final

1 say. So I just want to be clear about that up
2 front.

3 A key part of the CMS strategy, and I
4 will tell you it is written in our strategic
5 goals this year, is outreach and partnerships
6 with the various associations, the societies and
7 patients.

8 So again, I can't emphasize enough for
9 you that these partnerships are very valuable to
10 us. We're trying to bring consensus. We're
11 trying to bring alignment. We're trying to bring
12 patient empowerment and reducing burden to our
13 clinicians so that we can drive more value across
14 the healthcare system. Some of you may have been
15 participating in the Deputy Secretary of Health
16 and Human Services Quality Summit.

17 We are awaiting, actually, the final
18 recommendations for that. We look forward to it.
19 It's supposed to be out some time this month, as
20 a matter of fact.

21 And so, we will continue to see what
22 recommendations there are from a large multi-

1 stakeholder group to drive quality and make
2 changes to what is being called the Quality
3 Measurement Enterprise.

4 We don't know what those
5 recommendations will be. But I do want to
6 acknowledge that has been ongoing because we get
7 asked about that frequently.

8 We are very committed to partnership
9 and we are very committed to transparency. So,
10 these sessions as we've pointed out, have fewer
11 measures. Actually, there are two.

12 But Alan reminded me yesterday, it is
13 not quantity, it is quality. When I asked him,
14 Alan, can I really count, there's only two? But
15 it is still the quality of it.

16 We're going to take a few minutes this
17 morning to talk about measures. And in, what we
18 would really like to get at is many of you are
19 familiar with the Meaningful Measure framework
20 that was developed a couple of years ago at CMS
21 and we'll review that quickly.

22 But in particular, we're interested in

1 your thoughts as we start crafting what we're
2 calling Meaningful Measures 2.0. In other words,
3 what's the next version of what Meaningful
4 Measures should be?

5 Do you agree with the strategic
6 priorities that are currently on our plate? Are
7 there gaps and we're missing something? And I
8 think for the post-acute care world, this is
9 especially important because, as many of you know
10 or have sensed in the past, post-acute care was
11 possibly left out in some of these cases.

12 And how can we ensure that post-acute
13 care is being integrated into the entire
14 continuum of care because more and more patients
15 are being either discharged from the hospital or
16 they're not even going to the hospital before
17 they get to a post-acute care setting.

18 And it's absolutely vital that all of
19 these are connected across the continuum. So, we
20 look forward to some of your thoughts about
21 Meaningful Measures 2.0.

22 So, if we can bring up our slides.

1 There we go on the introduction to the Meaningful
2 Measures initiative. Reena and I are actually
3 going to share this part of the presentation.

4 So, CMS's primary goal really is to
5 improve the health of patients in the United
6 States. And, yes, for Medicare beneficiaries.
7 But we also know that CMS is the largest payer.

8 What we do really has a ripple effect
9 to all patients in the United States, quite
10 honestly. And our goal is to make sure that
11 we're providing the best, safest, highest quality
12 and most value -- in other words, affordable
13 healthcare that we can.

14 But we also know that within the
15 quality measures framework there has been a lot
16 of discussion, certainly over the past year or
17 so, that the measurement world has also created
18 burden.

19 And the administrator has taken this
20 very seriously and embarked upon what is called
21 the Patients Over Paperwork, which is really
22 demonstrating CMS's commitment to a patient-

1 centered care and to reducing burden for the
2 provider so that providers have more time to be
3 spending with their patients which is exactly
4 what they should be doing.

5 This has motivated us to be looking at
6 our regulations and to be really looking at every
7 one of our measures. And you'll hear from Reena
8 in a few minutes that we've made significant
9 reductions, actually, as we have evaluated our
10 measure portfolio.

11 On the next slide you can see CMS --
12 well, I don't know about you, I can't see it.
13 I'm hoping maybe in your book somewhere you can
14 see it because I certainly can't read that far.

15 But you get the idea of CMS's
16 strategic priorities that place patients in the
17 center and everything revolves around that. With
18 the three big themes from CMS of -- I can't read
19 this, I hope I've memorized it.

20 Empowering patients, unleashing
21 innovation and focusing on results. Thank you.
22 I do know this. With that there are 16 key areas

1 that have been the major thrust of CMS.

2 Price transparency, you've heard a lot
3 about that. Interoperability, you've heard a lot
4 about that. Those are things that CMS really
5 believes in.

6 Transparency in particular. The
7 administrator is very committed to transparency
8 and I think you're seeing evidence of that and
9 you'll continue to see it as some of the compare
10 sites, for example, are made to look a little bit
11 more user-friendly.

12 Hopefully you'll be seeing that in the
13 next series of months. But in terms of quality
14 measurement, it really is about alignment and
15 getting the right measures so that we can empower
16 patients to be making the right choices.

17 On the next slide, thank you, I spoke
18 a little bit already about, thank you. Alan is
19 going to make this so that I can actually see.
20 We spoke a bit about the Meaningful Measures
21 initiative that started in 2017.

22 And its goal really was to try and

1 identify the highest priority areas that we would
2 focus our measures on that, again, same thing I
3 had been talking about, improved outcomes for
4 patients, reduce the data burden, and focus on
5 our measurement system to align with what is most
6 meaningful.

7 And many of you, I think, over the
8 last couple of years have seen these cards or
9 have seen what CMS's Meaningful Measures
10 initiative really is.

11 On the next slide, there we go, we
12 recap a little bit that these are some of the
13 crosscutting themes that were very important to
14 the Meaningful Measures initiative. And they
15 include addressing high impact measures, making
16 sure that we're patient centered, outcomes-based
17 as much as possible.

18 But I have to put my personal
19 promotion in here that there are important
20 process measures and we should not neglect them.
21 It fulfills, obviously, all of our statutes.

22 Much of our program development is

1 based in law, and it's based on what Congress has
2 really mandated for us to do, and we have to stay
3 within those guardrails.

4 Minimizing the level of burden
5 identified significant opportunities for
6 improvement. So, in other words you've probably
7 seen us starting to reduce some of the topped out
8 measures because there isn't as much opportunity
9 to continue to improve there.

10 Addressing population needs. One of
11 the key strategies for CMS, as all of you I'm
12 sure are aware, is driving organizations into
13 value-based payment programs with a goal that was
14 set out by CMMI in the Learning Action Network
15 several years ago really encouraging and pushing
16 so that at some point in time, I think the goal
17 for the next year or two was 80 percent of
18 healthcare was in some kind of value-based
19 arrangement.

20 And ultimately, I think the goal is
21 really to move care payment models into value-
22 based arrangements. There is a strong belief

1 that we have to align the payment incentives with
2 quality to really have the quality that we're
3 looking for, to really move the quality needle.

4 And finally, aligning across programs.

5 I want to pause there for a moment because we've
6 been doing a tremendous amount of work around
7 alignment, because one of the criticisms of too
8 many measures and it's confusing and I have to
9 report a million of them and I will say that's
10 true.

11 I was the former chief quality officer
12 at the Henry Ford Health System. Many of you
13 have heard my little story that on my wall I had
14 675 measures that our organization had to report.

15 And some of them were just one-offs on
16 the other one. But this one wanted it this way
17 and that one wanted it that way. And that
18 creates burden in and of itself.

19 So, we're working very hard on
20 alignment. We've been working with the VA and
21 the DoD to be aligning our measures across
22 basically HHS and the federal government with the

1 VA and the DoD, we've been working with AHIP,
2 America's Health Insurance Plans, to be
3 identifying a core set of measures to be used by
4 all payers so that all payers would agree these
5 are the measures we're going to use in a specific
6 area.

7 And so, we are working really very
8 hard across the continuum and across all payers
9 to try to align and streamline measures. So,
10 these are some of the crosscutting initiatives.

11 But as we talk about the future, some
12 of the crosscutting initiatives, we think, need
13 to continue to be upgraded. For example, what
14 are we doing about electronic measures? Is this
15 something that we're placing as a high priority,
16 and you'll hear the answer is yes.

17 It's near and dear to my heart. But
18 this is one of the reasons that we're reframing
19 Meaningful Measures as to what that looks like in
20 the future.

21 The next slide, thank you, this is
22 really helpful. This is the card. I do know

1 this card and have memorized it. But you can see
2 there are six important domains.

3 One is promoting effective
4 communication and care coordination, something
5 that is near and dear to all of your hearts, I
6 know. Two is preventing and treating chronic
7 disease, again, something that this committee is
8 very importantly engaged in.

9 Third is working with communities to
10 promote best practices of healthy living. I
11 would wrap that up into a word called wellness.
12 Four is affordability.

13 Five is safety, reducing harm in care
14 delivery, because we know that still is an
15 important problem despite many years of work in
16 this area. And then finally, last but definitely
17 not least, is ensuring that the patient and the
18 family is engaged as partners in their care and
19 have a meaningful voice in all care that we do.

20 And under these six domains there are
21 19 specific areas that we chose as, really, the
22 highest priority areas. This is what we're

1 looking at to reassess.

2 This is what we would like your
3 feedback on, and it can be today or it can be as
4 you think about it and go back to your
5 organizations and think what might be important
6 to you. Please feel free to reach out to us.

7 Drop us an email. Send us a note.
8 Give us a call because we want to ensure that
9 Meaningful Measures 2.0 is reflective of the
10 broader community and we really are focusing on
11 the most important initiatives.

12 Next slide. I'm going to turn to
13 Reena for a second to talk about some of the
14 Meaningful Measure areas and she can share with
15 you some of the statistics about how we have
16 changed our focus.

17 MS. DUSEJA: Thanks, Michelle. So,
18 wanted to share a little bit about what we did in
19 terms about how we launched Meaningful Measures
20 in 2017.

21 And you'll see through our rulemaking
22 we actually propose and finalized removal of

1 measures across our care settings. And we've
2 done a deep dive over the last two years to see
3 what has that impact been across our cohorts
4 within our group in particular.

5 And so, we've been doing our internal
6 exercises and we wanted to share some of that,
7 because I think it's profound in terms of what
8 Michelle spoke about, with our administrators
9 really focused on around patients over paperwork
10 and thinking about the burden issue, but also
11 getting to the measures that really matter and
12 are less meaningful.

13 So, when you look at the hospital
14 setting, for example, over the last two years
15 after we initiated this framework we've seen,
16 actually, a 40 percent reduction in metrics in
17 the hospital inpatient programs.

18 This, like, duplication of measures in
19 some of the hospital based programs. And some of
20 them actually, you know, we kept, for example,
21 patient safety across a couple of those programs.

22 But a 40 percent reduction is

1 substantial if you think about it over the last
2 two years. In MIPS, for the clinician-based
3 settings, we also have done a lot of work in
4 terms of removing measures.

5 We had heard that many of the measures
6 within our MIPS program are low bar, process
7 oriented. And so, the focus has been to move
8 toward outcome based measures.

9 And that actually has also translated
10 to a little over 20 percent reduction in the
11 MIPS. And as you may be familiar, we also
12 proposed and finalized the framework for MVPs,
13 which are MIPS Value Pathways, which is going to
14 allow us to continue to refine what measures
15 should be going into these pathways to really
16 drive to our value.

17 In the post-acute care setting, you
18 know, we've had statutory requirements. So, you
19 know, with the IMPACT Act we've had to actually
20 have metrics that are either standardized or
21 across a variety of domains and we've done that
22 through previous rulemaking.

1 And hospice care is where we actually
2 saw the most reduction. And we finalized, I
3 believe, over 40 percent of removal of metrics in
4 hospice care.

5 But I think, you know, and
6 particularly I think while we're focusing on the
7 reduction I think the most important message is
8 the measures that remain and how they're driving
9 toward actually improving care.

10 And, you know, one of the things that
11 we're really excited about in the post-acute care
12 space is that we're going at patient-reported
13 outcomes and looking at functional status. And
14 you'll see that in some of the things that, as
15 well as, you know, communication of care and care
16 coordination.

17 Last year we brought to you, for those
18 in the workgroup that might remember, metrics
19 around, you know, requests for health
20 information, critically important. You know, we
21 have two rules that came out this year and one in
22 interoperability.

1 And so, we're continuing to think
2 about how do we actually transfer information so
3 we're not duplicating services, for example,
4 across settings? I'm an emergency physician by
5 background.

6 So, I will tell you I know that I'm as
7 good as the system I'm in, in terms of the
8 vastness of information I have, right. And so,
9 we're really trying to get at this
10 interoperability piece and we're focusing on the
11 strides in the post-acute care space.

12 Thanks to a lot of the team actually
13 also within our group as well as working with our
14 partners. And so, I think, you know, those are
15 real wins.

16 The other things that we've been
17 working on and I think you'll see more of and,
18 Michelle, I'm going to hand it over to you in a
19 moment, but talking about future directions about
20 how did we get to actually patient reported
21 outcomes and what are things that, cost settings
22 that might get to functional, you know, status?

1 Are they able to do their ADLs? How
2 do we get to patient experience in a way that,
3 you know, is reliable and valid? And on top of
4 that, how do we measure cost?

5 We're doing a lot of work on that
6 space in the MIPS side of things. And we do have
7 MSPB in many of our programs, the Medicare
8 Spending Per Beneficiary cost measure in the
9 post-acute care space.

10 But I think, you know, continue to
11 think about what's meaningful as we pair those,
12 when we're driving toward value for quality and
13 cost is continued work that we're doing for
14 Meaningful Measures.

15 So, I will now hand it over to
16 Michelle to talk about what we're thinking about
17 for Meaningful Measures 2.0 and we'll open it up
18 to some discussion, I think at the end.

19 MS. SCHREIBER: So, on the next slide
20 we can see what really, keep going, thank you,
21 what is our plate as some of the key areas is not
22 only identified by the administrator but that we

1 have heard across the country for areas of focus
2 that we want to make sure in Meaningful Measures
3 2.0 were included.

4 But this is the opportunity for you to
5 look at these and pause, and think, are there gap
6 areas from your point of view that you think
7 should be on here? The first, as Reena talked
8 about already, is patient-reported outcomes.

9 We think that if we were to open this
10 area to patient-reported outcomes actually I
11 think it might revolutionize measurement, quite
12 honestly, as we start hearing in a more robust
13 way from our patients, do we really know what it
14 is that they're thinking?

15 Knowing what they think is important.
16 And I think we need to be doing that. The
17 problem with patient-reported outcomes right now
18 is, frankly, they're kind of clunky.

19 They're outside the normal work flow
20 of most organizations. Organizations are
21 sometimes feeling like they have to hire people
22 just to outreach to patients to get the results

1 put in and then they have to find them.

2 So, what is a better operational way
3 even of doing those as well as just
4 philosophically making sure that we're engaging
5 patients. So, we are putting a fair amount of
6 work into this.

7 The second is electronic clinical
8 quality measures, eQMs. But I want to actually
9 broaden that a little bit, because what we're
10 really talking about are measures that are based
11 on data sources.

12 And it isn't always just a pure eQOM
13 which draws from the electronic medical record.
14 But it could draw from census information, for
15 example, especially if you're looking at
16 disparity and the area where you have a lot of
17 deprivation indices.

18 So, this I think is broader than just
19 electronic quality measures from the EMR, per se.
20 We're doing a lot of work around this though.
21 So, it dovetails with CMS's and ONC's focus on
22 interoperability and how we make sure that we're

1 exchanging information in a very transparent and
2 open way.

3 You've seen the regulations about
4 prohibiting data blocking, for example, and
5 ensuring that providers actually are listing
6 their sort of electronic signature address so
7 that we can ensure that we're transmitting
8 information.

9 We have at least three of our quality
10 measures that have been developed in FHIR-based
11 standards. So, the new standardized language of
12 transmitting clinical data, it's built on HLA-7.

13 But it's sort of the new model, the
14 standardized model for the transmission of
15 clinical information that we are partnering very
16 closely with the organizations who are developing
17 the FHIR standards. And as I said, we are
18 testing some of them already.

19 And I think you will be seeing the
20 future world of more and more of our measures
21 being electronic, a FHIR-based standard. The
22 other thing when we talk about electronic

1 measures is what are some measures of the
2 interoperability?

3 What are some measures of making sure
4 that organizations are actually using these
5 tools? For example, are patients getting and
6 reviewing their notes? Are patients getting and
7 looking at their lab tests in a timely manner?

8 Do they have access to patient
9 education materials? Is this helpful to them or
10 is this not? And how do we address whether or
11 not we're missing a population in the digital
12 divide who don't have perhaps access to these
13 tools and aren't using them?

14 And I think for the elderly that's
15 particularly important. Although I must say some
16 of the best electronic users are actually the
17 elderly population. I am surprised by that
18 sometimes.

19 My 95 year old mother who -- by the
20 way, I'm sorry about your loss. My mom passed
21 away a couple of months ago too so I'm very
22 sympathetic. But she was a great user of her

1 iPad which, you know, we can't just dismiss the
2 elderly in using electronic tools.

3 So, this will be a huge focus going
4 forward of CMS. And I will go out on a limb,
5 even though this is public, and say that we will
6 likely commit to all of our measures being
7 electronic in some way, shape, or form at some
8 point in the future.

9 I cannot give you a date. I recognize
10 in the post-acute care setting that you are, you
11 know, perhaps passed over a bit in meaningful
12 use. You didn't get the same kind of progress
13 that hospitals and physicians got.

14 And so the uptake of robust electronic
15 medical records is different in the post-acute
16 care setting. So, we need your advice on, as we
17 move forward in this direction, how can we best
18 incorporate that fact, actually, but at the same
19 time bring the post-acute care world along here
20 too because clearly this is going to be the
21 future.

22 There is no other way of getting

1 measures that can be both at a population level
2 and a granular level to the individual patient or
3 provider, that can provide timely feedback almost
4 immediately, if not at the point of contact, that
5 can leverage the opportunities for artificial
6 intelligence or big data analytics.

7 There is no other way to do it than
8 electronic, and we need to be moving in that
9 direction.

10 Obviously another focus is opioids and
11 the avoidance of harm. Some pain measures across
12 CMS have been eliminated because of the concerns
13 of whether or not this was part of the unintended
14 consequence that led to the opioid epidemic.

15 And so, how do we develop appropriate
16 measures and avoid harm but at the same time make
17 sure that we are managing pain which is so
18 important? Nursing home infections and safety
19 measures have actually taken on a very
20 significant spot at CMS.

21 Some of this is around the regulatory
22 world because of concerns of nursing home safety.

1 So, this has risen to the top of the list
2 including things around infection and, frankly,
3 abuse.

4 Some of this is in the regulatory
5 conditions of participation world. But some of
6 this clearly is important in the measurement
7 world, and how are we looking at those places in
8 particular.

9 Maternal mortality has risen to the
10 top. This is something that the administrator
11 feels very strongly about, and should, because it
12 is a sad commentary that the United States has
13 the highest maternal mortality of any
14 industrialized nation.

15 And frankly, CMS, not Medicare, but
16 Medicaid, pays for almost half of all deliveries
17 in this country. And so, this is obviously a
18 very important metric for us.

19 Sepsis, the leading cause of, in some
20 cases, readmission, one of the leading causes of
21 mortality, one of the most expensive disease
22 states. We have sepsis measures but they are

1 difficult, untimely, and hard to collect. So,
2 transforming our sepsis measure.

3 And then a couple of -- that aren't on
4 there, but cost being very important as we move
5 to a value-based world, and we have many cost
6 measures that we are developing. But this is
7 really, you know, people say you have to
8 prioritize. You have to strategize.

9 You have to give us your top areas of
10 what you're working on. I am showing you what
11 our top areas are right now to work on. And
12 we're looking for your input of what are we
13 missing.

14 Considerations for future meaningful
15 measures. I think I've spoken about most of
16 them. Developing more APIs, the FHIR based
17 standards, interoperable electronic registries,
18 harmonizing measures.

19 You know, some of this I have to say,
20 is not sexy work. It's looking at, you know, the
21 granular, you know, elements in the data library
22 and making sure that they're correct and

1 standardized.

2 But it's super important because you
3 can't compare a provider in California to a
4 provider in New York unless you standardize those
5 and we know that they're robust and valid and
6 scientific, that they've been through NQF
7 endorsement.

8 So these are some of the
9 considerations for the future. In our
10 discussion, because we have 20 minutes left,
11 actually, on the agenda, which we can choose to
12 use, but we would like to know from you a couple
13 of things.

14 One is we keep hearing there's too
15 many measures, too many measures, too many
16 measures. Is that what you're feeling? Do you
17 see gaps from things that I am telling you, are
18 what is on our agenda as our highest priority
19 items?

20 Are there gaps from your point of
21 view? How can we ensure that post-acute care is
22 part of this transition into electronic data

1 sources or measures?

2 And I will pause at that and actually
3 turn it to the co-chairs to perhaps open up a
4 discussion.

5 CO-CHAIR LAMB: Sure. So, let's have
6 a discussion, here's your chance. If you would
7 put your name tag on its side so that Kurt and I
8 can call on you. But go for it.

9 This is a chance to kind of set the
10 stage for our strategic planning this afternoon,
11 the gaps and alignment discussion. So, Raj.

12 MEMBER MAHAJAN: So, I don't know if
13 Liz wanted to say a few words before I go on my
14 rant.

15 MS. HALL: Go ahead.

16 MEMBER MAHAJAN: So, between last year
17 and this year I think I disclosed that I went
18 ahead and started working with the EHR company.
19 And the biggest thing is, and people have heard
20 me talk about this for almost five years, this
21 all looks good and we all know it needs to be
22 done. People in this room feel very strongly

1 about it.

2 But when it comes to the actual users
3 they have no idea or even interest. So on the
4 hospital side it's the same thing.

5 There was meaningful use defined and
6 interoperability was part of it, and care
7 transition, sort of really heavy in their
8 measures and standards and all of that down.

9 But when it comes to post-acute long-
10 term care we're talking mainly about SNF and
11 CCRCs or LPCs as they call them. The few vendors
12 that are still standing really don't have this,
13 you know, this is probably they have 99 problems
14 but this is not one of those problems.

15 And so, you know, to call the local,
16 he's from New York, right, East Side, okay. So,
17 I think that divide needs to be somehow
18 shortened.

19 And so, I went on that site to take,
20 you know, pick one of the vendors that earlier
21 was talking about it. So, there's really no, in
22 their commercial world there is really no ROI on

1 this work.

2 So, I just and I think we talked about
3 this in the past too --

4 MS. SCHREIBER: I'm sorry. I don't
5 mean to interrupt you. But can you clarify for
6 me no ROI on what work, on transforming measures?

7 MEMBER MAHAJAN: So, we are part of a
8 group that is actually working on, it's called a
9 PACIO Project which is Post-Acute Care
10 Interoperability Workgroup. And we have picked a
11 couple of topics.

12 The function status, cognitive status
13 as developing the prior standards were around and
14 implementation guides, et cetera. But for this
15 to come out in a meaningful way you have to have
16 the actual software vendors or technology
17 solution companies be there participating and be
18 willing to provide that.

19 And so, I still feel that there's a
20 huge lack of interest from that community to be
21 actively participating in that. And so, is the
22 actual, the facility providers.

1 And so, I think the duty to address
2 that and how we -- with that important piece of
3 this whole puzzle be at the table, otherwise we
4 can do all this and, you know, but it's not going
5 to go anywhere as to adoption from the end users
6 and showing what it can show us as an outcome.

7 MS. SCHREIBER: So, can I just ask a
8 question?

9 MEMBER MAHAJAN: Yes.

10 MS. SCHREIBER: So, if CMS moves in
11 this direction and demands measures being
12 submitted electronically is that incentive enough
13 or not?

14 MEMBER MAHAJAN: So, that's the
15 reverse incentive, right. So, that's the stick
16 approach. So, I mean that industry all along has
17 been, you know, that's what they live off, is
18 everything, so with that industry is working this
19 off regulations.

20 Everything about infections, patient
21 rights, nothing has been, you know, promoted in
22 the carrot form. It's always been the sticks.

1 So, I don't know how many more sticks can we give
2 them.

3 CO-CHAIR LAMB: Other questions?
4 Anybody online have any questions? Michelle, I
5 have a question. One of the priority areas is
6 patient-reported outcome measures.

7 And I'm delighted to see that. Can
8 you talk a little about some of the issues that
9 CMS is looking at in terms of how do we capture
10 patient preferences?

11 One of the priority areas is patient
12 goals. And I'm coming at this from my hat co-
13 chairing Patient Experience, Care Coordination
14 and Function Committee, the Measurement Committee
15 where we're seeing a lot of function measures
16 come through but we're not seeing patient
17 experience goals coming through.

18 So what are you seeing that will drive
19 this?

20 MS. SCHREIBER: That's actually a
21 great question, thank you. It gets to, you know,
22 what IHI always says, it's not what's the matter

1 with you, it's what matters to you, and how are
2 we capturing that to make sure that we are then
3 meeting what matters to you?

4 And I don't have an answer because I
5 don't know that we have something right now.
6 I'll look to Reena to see. But I think that's
7 really an important insight. Thank you.

8 MS. DUSEJA: Yes. And we have had
9 people come and approach us about how do you
10 take, for example, the narratives that are out
11 there --

12 MEMBER NUCCIO: Could you speak up,
13 please?

14 MS. DUSEJA: Yes. So, I think, you
15 know, to the question about how do you get to
16 patient preferences and be able to capture that
17 in a way that's meaningful, there has been some
18 innovation around thinking about, like, taking
19 the narratives that are out there on these
20 websites like Yelp and being able to apply some
21 software to be able to unearth some of the
22 quality trends for patient preferences.

1 And give a gauge of, like, what is the
2 quality of care at a facility. But, you know, in
3 terms of the decision making between a provider
4 and a patient, I think this gets to shared
5 decision-making.

6 And we have certainly, in the past,
7 had considered measures in other settings around
8 these measures. You know, the challenge is
9 burden in terms of the construction of these
10 measures.

11 I'll give you a great example. There
12 was a measure that came to the MAP a few years
13 ago for the Hospital Workgroup on Informed
14 Consent. Some of the staff from before remember
15 this.

16 But the concern was, like, there was
17 so much burden associated with being able to
18 collect that, to really get at that patient
19 preference and understanding before they go to a
20 procedure. So I think we recognize that it's an
21 important area, but we're also trying to figure
22 out a way to do this in a way, maybe electronic

1 means would be the -- you know, because this is
2 where we're hoping we can reduce the burden but
3 still get at, to the patient preferences.

4 MR. LEVITT: Again, we did have the
5 NIH, came and gave a presentation because of our
6 interest in PROMIS and trying to incorporate
7 PROMIS into our programs. And the way we've kind
8 of established our programs is obviously we've
9 gone by the statutory mandates that have come
10 along.

11 And certainly we've set up in -- for
12 our post-acute care settings, assessment
13 instruments and collecting standardized
14 assessment data related to that.

15 And those assessments are done by the
16 assessor on the patient or resident with the hope
17 that we would be able to build those types of
18 assessments to be more patient-focused and so
19 that those same types of items or measures,
20 however you want to define them, would then be
21 able to be reported in a different fashion
22 ultimately.

1 And I think one of our hopes is to
2 work with you to try to do that together and to
3 try to build that in a way that is not
4 burdensome.

5 But again, it is something that we
6 remain interested in and want to move forward and
7 bring forward in a way that doesn't have such
8 additional burden that there really isn't much
9 meaning to the provider.

10 CO-CHAIR LAMB: Thank you. We're just
11 going to go around. Rikki.

12 MEMBER MANGRUM: So, I love this topic
13 and I could talk about patient-reported outcome
14 measures all day. But I'll keep my comments to a
15 couple things that have been preying on my mind
16 for the last couple of years as patient-reported
17 outcome measures have gotten more attention.

18 And I'll disclose that I worked on the
19 PROMIS contract for five years in a rather
20 peripheral role. But it does have a soft spot in
21 my heart.

22 But I'm also aware that there are

1 certain fundamental weaknesses in the way all of
2 our oldest patient-reported outcome measures were
3 developed. A lot of them were selected according
4 to the priorities that clinicians had actually
5 selected, rather than patients.

6 And then patients were brought in and
7 there's been this sort of constant friction
8 between what clinicians need, what payers want
9 and what patients want. And I think like this is
10 our big work in measurement for the next five,
11 ten, 15 years, however long it takes to figure
12 out where the alignment is.

13 And one of the things that I've been
14 wondering and thinking and engaging my
15 measurement developer colleagues with for a while
16 now is do we really need to think about burden
17 and also reliability and validity a bit
18 differently than we have?

19 Have we been missing something along
20 the way? And one of the things that I noticed in
21 nursing homes as well as with patients is that
22 burden, perception of burden, is actually

1 relative.

2 It's not an absolute thing. If the
3 measure is something that is actually really
4 important to me I will fill out 50 questions
5 gladly.

6 If it's not, it's irritating, and I
7 start to skip questions and I start to, you know,
8 do all the bad things that make measures less
9 reliable. And then in terms of reliability and
10 validity we think a lot about, you know, being
11 able to differentially measure, to measure change
12 over time.

13 But that's not always the most
14 important thing to a patient or even to a
15 clinician. And maybe some of these measures,
16 particularly around patient experience, should
17 sort of be pass/fail.

18 So those are the thoughts that I have
19 and would love to see, and I think it would also
20 help bring -- to me there's a disconnect between
21 the big diagram with patients in the center and
22 then when you actually get to the list of the

1 priorities for Meaningful Measures.

2 The patient starts to disappear in
3 that list. And I think going back to the board,
4 drawing board with some of our basic concepts
5 about measurement and really investigating and
6 thinking and discussing whether there are
7 elements that are missing, whether there are
8 alternative approaches that would be of value
9 would be important for the field.

10 CO-CHAIR LAMB: Deb.

11 MEMBER SALIBA: So, a couple of things
12 I wanted to -- originally I raised it for a good
13 reason, but I do want to add to what Rikki is
14 saying about patient-reported outcome measures
15 and the fact that even providers that complain
16 about the burden of data collection when we -- I
17 remember going to a group of providers at one
18 time and saying, okay I get it, you want less.

19 And they said, no, we want useful.
20 And we -- you know, we would rather collect more
21 questions and get something that helps us do our
22 job better than collect a few questions that

1 don't really help.

2 So, I do think, you know, there is a
3 careful balance. And originally I had wanted to
4 comment on your comments about the EMR, again
5 thinking about this need for balance.

6 I am currently on a national project
7 to adopt a new electronic medical record. And
8 one of the things that vendors are currently
9 doing is really leaning on auto-populate
10 approaches in order to be compliant with
11 regulatory expectations.

12 And there is a huge burgeoning in the
13 in the length of these notes, to the point that
14 they are not -- they are just useless, frankly.
15 As a clinician, when I open my chart, I'm no
16 longer seeing what was really relevant to that
17 provider that evaluated that patient. What I'm
18 seeing is what was relevant to the EMR designer
19 looking at regulatory design perceived.
20 Sometimes it's not even real. But it's perceived
21 regulatory requirements as thought was important
22 to be documented.

1 And it keeps being auto forwarded
2 intentionally and it's being sold to providers as
3 something that decreases their burden because it
4 auto-populates the whole thing. And it cuts
5 across all disciplines.

6 Nursing notes have now really reverted
7 to completely being checklists. So, you get the
8 scales, the Braden Scale, the Norton Scale. Then
9 they are auto-populated and no one is paying
10 attention to the content of it. So, when we look
11 at the EMR we see that someone did an assessment
12 and they get ticked off, you know, get a check
13 box in that category. I'm not sure what the
14 solution is. But if we revert to a system that's
15 completely reliant on electronic quality
16 measures, we would be exacerbating that. So,
17 it's that balance.

18 It makes perfect sense to try to use
19 the EMR to do the things that because it's there
20 and it can be a really important tool. But when
21 we become -- if we shift to where we're
22 completely relying on those measures, I'm afraid

1 that we'll just get a fair amount of noise in
2 that process.

3 CO-CHAIR LAMB: Gene?

4 MEMBER NUCCIO: I want to echo my
5 support for the PROMIS and also the use of
6 patient goals. I think the instruments that CMS
7 has been using that include patient goals as part
8 of it is going to be helpful.

9 I did want to raise another issue, and
10 perhaps it's under the electronic quality
11 measures. And that is the availability of large
12 and growing data sets, notably Medicare Advantage
13 data.

14 I think there needs to be a real push
15 to integrate Medicare Advantage data into our
16 easily attainable data systems for analysis
17 because we're losing a growing population and a
18 growing subpopulation within the elderly as more
19 and more people revert to a Medicare Advantage
20 where you apparently can get everything in the
21 world, according to Joe Namath, integrated and
22 whatever.

1 So, Medicare Advantage data need to be
2 incorporated quickly into the data system. And
3 for a new thing and a new item that I did not see
4 on the list, perhaps it's on there, is an
5 emphasis -- or, not an emphasis but an awareness
6 that we need to start seriously measuring mental
7 health conditions in our adult population -- our
8 elderly population.

9 Now, I understand that post-acute care
10 includes more than just elderly. But opioid
11 addiction has perhaps some intersection with
12 mental health issues.

13 And certainly as people grow older
14 with the population of people with Alzheimer's,
15 dementia or some sort of problematic mental
16 condition is clearly growing. So, I would add to
17 mental health to that list.

18 CO-CHAIR LAMB: Thank you. Pam is
19 yours up?

20 MEMBER ROBERTS: I would definitely --
21 you took the words out of my mouth. I would
22 definitely encourage looking at Medicare

1 Advantage data certainly in this part. But I
2 think also with the patient reported outcomes and
3 use of the EMR, I think we also need to think
4 it's great if we collect these quality measures
5 and they're in there, but we have to do something
6 with them. So, if we don't do anything with them
7 so, you know, do we have the clinical decision
8 support? And I've seen it in some EMRs where you
9 actually get information sent to the doctor or
10 the clinician and they see it and they actually
11 can act on it right there.

12 And really, if we're really going to
13 make change in quality it's not only collected
14 but we have to do something with it.

15 CO-CHAIR LAMB: Any other comments,
16 questions? We'll have plenty more time this
17 afternoon. Kurt?

18 CO-CHAIR MERKELZ: Yeah. I'll just
19 start with the comment that both Deb and Rikki
20 and actually everybody has touched on regarding
21 your patient-reported outcome measures. And
22 really Rikki's point about change over time, very

1 commonly I find measures that are most important,
2 certainly as we look at the serious illness
3 population, are that population which is excluded
4 from the measure process.

5 And especially as we look at change
6 over time this is a population -- and most of our
7 world is not a population that actually improves
8 in their capacity. So, there is a frequency in
9 over-development of measures that show
10 improvement in a deficit or an improvement
11 necessary and many of the ADLs or IADLs. And
12 what's really needed for the serious illness
13 population is that their needs are met. Not that
14 they themselves can achieve what the deficit is.
15 But the deficit needs to be achieved.

16 Looking at that construct I think is
17 something that I have yet to see. And I think
18 it's very much needed and very much needed for
19 the serious illness population as we look at
20 their outcomes.

21 And I would just echo again what Raj
22 said at the start of the discussion regarding

1 vendors needing to be at the table in discussion
2 about EMR systems, certainly with what we utilize
3 from an EMR as far as communication outward even
4 in communication internally, the way the systems
5 are set up have become so large because of the
6 auto-population. They are so lengthy in notes
7 that even within an organization I don't have
8 visibility into what other care plans are being
9 developed. And there's no communication between
10 a social worker's and the nurse's care plan notes
11 within our own system, as far as even going
12 outside that system.

13 CO-CHAIR LAMB: Liz?

14 MS. HALL: So, I just wanted to follow
15 up on the discussion and thank Raj and some of
16 the vendors for working with us, coming to the
17 table because we are, as Raj mentioned, starting
18 to work in this FHIR space and really need the
19 vendors to work with us. And they have been
20 participating with us on a regular basis. And
21 so, we are continuing that work. We're very
22 encouraged by it. And it's not just, you know,

1 that communication between -- with the
2 clinicians, but this is a new kind of endeavor
3 really for the PAC vendors. And so, we're
4 certainly building, I think, and trying to
5 education and bring folks to the table and
6 understand that standard development process and
7 build infrastructure that we're going to need to
8 get to this, the eCQM world that we're talking
9 about right now.

10 CO-CHAIR LAMB: Other comments?

11 Please keep these comments in mind, especially as
12 we go to some of our discussions about
13 priorities. You've all raised some, I think,
14 critically important questions, comments,
15 suggestions that we don't want to lose as we move
16 forward.

17 I just want to check before we start
18 moving into rulemaking. Can those of you towards
19 the back of the room, are you able to hear okay?
20 I have to go along with Michelle. I miss that
21 push of the button.

22 (Laughter.)

1 CO-CHAIR LAMB: You know, I come here
2 what twice a year and it's like it's sort of
3 memory of, you know, click and it's just very
4 strange. But you're hearing okay all the way
5 back? Thank you. Okay, Amy, I think you're on.

6 MS. MOYER: I personally miss the
7 power of the voting clicker. It's like, there
8 was something about that.

9 So, I'm going to provide an overview
10 of the approach to decision making and then
11 Janaki will walk us through the voting.

12 So, MAP uses a three step approach to
13 decision making. First, we will provide an
14 overview of the program and how it is structured.
15 And our official next step is reviewing the
16 measure briefly.

17 We're going to incorporate Alan into
18 that since he knows the measures better, perhaps,
19 than even we do. And then we will ask the
20 workgroup to evaluate the measures under
21 consideration for what they add to the program
22 measures.

1 So in your materials and if you are
2 not using the discussion guide it's a fabulous
3 resource. It's kind of everything at your
4 fingertips. And you can move around in the
5 document.

6 But in there you will see the
7 preliminary analysis that the staff has conducted
8 for each measure under consideration. We've
9 developed these based on an algorithm from the
10 measure selection criteria. We have the
11 algorithm here for reference in the slides. I'm
12 not going to walk through it in detail. But it
13 is there if you want to see it.

14 The analysis is meant to kind of offer
15 you a summary and a succinct profile of each
16 measure. And it serves as a starting point for
17 the workgroup's deliberations.

18 This is what we looked at and came up
19 with for the measure, the workgroup charged with
20 making the final recommendation to the
21 Coordinating Committee. You may agree with this,
22 you may disagree with this. That's why we're all

1 here.

2 So, I will walk through the decision
3 categories. I believe you also have these
4 present for reference in the printed material.
5 There are four possible decision categories.

6 These are arrived at by using the
7 algorithm. There is support for rulemaking.
8 Support for rulemaking means this measure is
9 ready to go as is. It means everything we're
10 looking for we think it could go into a program
11 tomorrow.

12 The next category is conditional
13 support for rulemaking. This category means we
14 like the measure, we think there is a lot of
15 promise here, there is a couple of things we
16 would like to see. One of the common conditions,
17 and you'll see this today, is there is a
18 preference for NQF endorsed measures in the
19 program. So, frequently there will be a
20 recommendation of conditional support and the NQF
21 endorsement.

22 So, the Committee could also add other

1 recommendations as well. So, those are the two
2 recommendations we would use if we support the
3 measure and we think it looks pretty good and
4 ready to go into a program.

5 There are two additional
6 recommendations we could make. One is do not
7 support for rulemaking with potential for
8 mitigation.

9 That is where we like the direction,
10 we like the concept of the measure but we feel
11 there needs to be some significant rework. I
12 don't know that we see this often. But perhaps
13 it's a measure that's not specified at the level
14 of the program or not tested at the level of the
15 program. And so, we would want to see some
16 additional work done before the measure would be
17 implemented into a program.

18 The final category is, do not support
19 for rulemaking. That means we feel the measure
20 is just completely off target. We don't feel
21 it's salvageable. We just don't agree with the
22 concept.

1 So, those are the four decision
2 categories that we can make recommendations for
3 on the measures. Any questions on those? All
4 right. Then I'm going to hand it over to Janaki
5 to talk about how we vote.

6 MS. PANACHAL: Thank you, Amy. I'll
7 just go over the voting principles and process
8 briefly. So, in terms of quorum and consensus we
9 need 66 percent of the voting members of the
10 Board to be present either in person or through
11 phone to cast votes and to conduct voting.

12 We have 74 percent so I think we're
13 good on the quorum part. But we do ask for Board
14 members to please stay at your table or on the
15 phone if you're on the phone to make sure that we
16 have quorum throughout the voting process and the
17 discussions as well.

18 For consensus, we define consensus as
19 greater than or equal to 60 percent of the
20 workgroup voting for the recommendation. For the
21 voting process, going over the voting process
22 now, for every MUC measure we will first review

1 the results of the preliminary analysis that Amy
2 talked about. And then we have assigned lead
3 discussants for every measure. So, the lead
4 discussants will share their reflections on the
5 measure.

6 Following that, the Co-Chair will ask
7 for clarifying questions and have a discussion on
8 the measure. The Co-Chairs will then compile all
9 the questions and potential discussion items and
10 then ask for appropriate parties to respond to
11 those questions.

12 Following that, once discussion has
13 been concluded we will start the voting process.
14 We will first vote on whether or not the
15 workgroup agrees with the results of the
16 preliminary analysis as the workgroup
17 recommendation.

18 If we achieve greater than or equal to
19 60 percent of votes that say, yes, that will
20 conclude the voting on that measure and the
21 result of the preliminary analysis will be the
22 workgroup recommendation.

1 If the workgroup does not agree with
2 the preliminary analysis, then we will move
3 forward with discussion on that MUC measure.
4 After the discussion has concluded we will then
5 vote on the four categories that Amy talked
6 about.

7 So, we will start with the first
8 category which is the support rulemaking
9 category. And if we get greater than or equal to
10 60 percent of the voting that will be the
11 workgroup recommendation. If we do not get -- if
12 we get less than 60 percent then we will move to
13 the second category which is conditional support.
14 And we will move down the categories, all four
15 categories.

16 If no category gets greater than 60
17 percent, the result of the preliminary analysis
18 will be passed on to the Coordinating Committee
19 and the measure will be flagged for their
20 consideration.

21 In terms of some commenting
22 guidelines, we will take comments before

1 discussion and voting and remarks for the
2 specific program. So, we will open the line for
3 that before we start discussing the program.

4 PARTICIPANT: Before we move on I just
5 want to emphasize while we've walked through a
6 lot of the voting process a lot of what we found
7 is in the richness of the discussion around the
8 recommendation. So, all of that will be
9 incorporated into the recommendations as it goes
10 to the Coordinating Committee.

11 So, while we may land in the same
12 place as a preliminary recommendation the
13 preliminary analysis, it's really the richness in
14 the conversation that we will be taking -- staff
15 will be taking notes and sort of adding to that
16 rationale as we go forward.

17 MS. PANACHAL: Are there any questions
18 before we move on to briefly look over the
19 workgroup charge? If you're not able to access
20 the voting link we can help you with that in the
21 break, as well. Great.

22 So, we talked about the Rural

1 Workgroup charge during the orientation meeting.
2 So, we will just briefly highlight a few points
3 here.

4 Rural Health Workgroup provides rural
5 perspective and input on the quality of measures
6 put forward to MAP. And Rural Health Workgroup
7 met a week or so ago to review all of the MUCs
8 and provided their feedback in the four areas.

9 The first area is the relative
10 priority and utility of the measure in terms of
11 access, cost, or quality issues encountered by
12 the rural residents. The second is data
13 collection and reporting challenges for rural
14 providers. Third is the methodological problems
15 in calculating performance measures for small and
16 rural facilities. Fourth is some of the
17 unintended potential consequences of including
18 specific health measures into the specific
19 programs. And last is any gap areas of
20 measurement relative to rural residents and
21 providers for specific programs.

22 So, after the Rural Health Workgroup

1 meeting, we had drafted a qualitative summary of
2 the Rural Health Workgroup and the voting results
3 were included in the discussion guide that Amy
4 had mentioned before as well.

5 Any questions on that? Great, so I
6 think we have a short break. So, we have a break
7 until 10:45, but we can take a ten minute break.

8 CO-CHAIR LAMB: Okay. So, everybody,
9 15 minute break. Come on back and we will start
10 reviewing measures.

11 (Whereupon, the above-entitled matter
12 went off the record at 10:25 a.m. and resumed at
13 10:49 a.m.)

14 CO-CHAIR LAMB: Home health with the
15 interesting potentially preventable
16 hospitalization measure. Quick review of the
17 process just so we're all on the same page.

18 Okay, is that Amy is going to start I
19 think and invite Alan comments as well. Then
20 we'll move to our lead discussants who for this
21 measure are Heather and Sarah. Then we'll move
22 to our liaison for the Rural Committee, Brock.

1 We will invite your comments. And then we'll
2 invite the additional reviewers if they would
3 like to add anything to what's already been said.
4 And then we'll open it up for the full workgroup.
5 And Kurt and I will remind you as we go through
6 this.

7 The one thing I would ask you all is
8 that please allow Kurt and me to summarize
9 questions to the measure developers, so that we
10 do that in a more organized way and that we can
11 present so -- I'm sure you have pressing
12 questions. What we will do, and if Kurt and I
13 miss anything of course you'll have that
14 opportunity to bring that in. But we'll try and
15 organize the questions as they go to the measure
16 developers.

17 Any questions about process before we
18 start? Okay, MUC2019-34. Amy, you're on.

19 MS. MOYER: All right. So, one quick
20 housekeeping item. We did not pull the slides
21 forward from the orientation webinar. If you
22 remember we went over the programs and the

1 measures of the programs and all of that
2 information. We do have those slides handy for
3 your reference. They are posted into the meeting
4 materials on the public.qualityforum, just in
5 case you do want to reference those and are
6 wondering where they are.

7 So, the Home Health Quality Reporting
8 Program to remind everyone is a penalty for
9 failure to report program. The data are reported
10 on the Home Health Compare website. I have
11 personally used this for family members and it's
12 a terrific resource.

13 The incentive structure of the program
14 is that home health agencies that do not submit
15 data receive a two percentage point reduction in
16 their annual home health market basket percentage
17 increase.

18 Information for the program data
19 sources are the outcome and assessment
20 information set and Medicare fee-for-service
21 claims. So, this measure kind of fits into a
22 suite of measure looking at readmissions in the

1 program.

2 There is a measure that looks at
3 admissions within the first 60 days, currently in
4 the program. There is also a measure that looks
5 at readmissions after discharge from a home
6 health program.

7 This measure kind of fills the gap in
8 between. And with that I will hand it over to
9 Alan to discuss. Those of you who are on the
10 phone you have Alan's slides also on the
11 public.qualityforum.org website, in case you want
12 to follow along with those.

13 MR. LEVITT: Thanks, Amy. Are they
14 going to do the slide up here too?

15 MS. MOYER: Yes.

16 MR. LEVITT: Okay, thank you. Thank
17 you again for having me represent CMS on the
18 workgroup. Once again, it's my seventh year
19 here.

20 With me today for the measure I have
21 Reneke Evans (phonetic), who has really done a
22 lot of the groundwork on the CMS end in terms of

1 the measure itself. I have Heidi Magladry and
2 Joan Proctor who are the leads in the Home Health
3 Quality Reporting Program who are sitting at the
4 table as well.

5 Right next to me is Alrick Edwards who
6 has helped lead this and an associate Saad
7 Comindari (phonetic) -- oh, you're there too --
8 is right there from ACME as well. We have other
9 contractors as well on the phone as well for any
10 questions that the Committee has.

11 If we go to the next slide, by now
12 you're familiar once again with meaningful
13 measures. And the two measures that we have
14 today that we will be discussing is really what I
15 would call meaningful measures in action.

16 When we are looking at all of our
17 measures -- we continue to look at all of the
18 measures in our program, we take many things into
19 account. We look at monitoring and evaluation of
20 our measures based on the data that comes to us
21 in terms of what that's showing to us.

22 There are changes that go on in terms

1 of regulations, law, standards of care, practice
2 that is going on within this setting, feedback
3 that we get from providers, from consumers, from
4 our federal partners.

5 So, we take all this into account in
6 terms of really helping to make a more meaningful
7 measure set with the Home Health Quality
8 Reporting Programs.

9 And what you're going to see here with
10 this measure is, once again, how we've taken in
11 particular the feedback that we've received from
12 you in terms of trying to develop a more
13 meaningful measure to hopefully advance forward
14 in the Home Health Quality Reporting Program.

15 Hospitalization and ER use measures
16 are present actually and they are reported on
17 Home Health Compare since the website began in
18 2003. It initially it started with OASIS based
19 versions of the measures. And two of the
20 original ten measures that actually were adopted
21 into the Home Health Quality Reporting Program
22 back in the calendar year 2007 rule were these

1 two OASIS based measures.

2 They were later replaced by claims-
3 based measures, measuring both hospitalization
4 and ER use. And those are the two measures that
5 continue to exist until today.

6 In 2015 in July, we first reported
7 quality of patient care Star Ratings and the
8 hospitalization measure was one of the original
9 measures that still remains a measure within the
10 calculation of that Star Rating.

11 A couple years later in 2017, we
12 actually recommended to add the ER use without
13 hospitalization measure to Star Rating. And the
14 feedback we received from the home health
15 community was negative.

16 The community felt that we should not
17 add this measure due to concerns about
18 attribution and that there were questions about
19 how much influence the Agency really had in what
20 may have been a voluntary decision by patients'
21 families, even the physician telling the patient
22 to go to the emergency room. That was really

1 outside of what the home health provider really
2 would have recommended.

3 And so, at that time we decided not to
4 add the ER use measured Star Ratings. But it got
5 us to thinking, well, how could we take these
6 measures and make them better? What piece or
7 component of the emergency room measure may be
8 something that we would want to add to the
9 hospitalization measure? And therefore, add that
10 component in and make the hospitalization measure
11 more meaningful and therefore be able to report
12 that on and continue to use that as part of our
13 Star Ratings.

14 And so, that's when the idea came
15 well, what about observation stays -- observation
16 status which is really, was included as part of
17 the emergency room measure?

18 MedPAC had noted increase in
19 observation status over the decade in which also
20 noted to be an overlap in the diagnostic coding,
21 particularly between the short stays in patient
22 hospitalizations and observation status.

1 There also were some high and low
2 volume users of observation status. And so, we
3 decided to look and see whether or not we should
4 or could account for that population within this
5 measure.

6 At the same time there's been a
7 general interest at moving, rather than using
8 all-cause types of readmission or hospitalization
9 measures to try and to look more at potentially
10 preventable outcomes instead.

11 We have already gone ahead and adopted
12 potentially preventable readmission measures
13 post-discharged in our post-acute care settings.
14 We have removed the all-cause versions of those
15 measures from those settings as well. And so,
16 that was again part of this whole measure
17 development as we were looking for this next
18 step.

19 And so, if you turn to the next slide.
20 So, the claims space measures that are part of
21 the Home Health Program include to impact
22 measures of Medicare spending per beneficiary and

1 discharged community. But then also these top
2 three measures, three rows on this slide. The
3 post-discharge potential readmission was an
4 impact measure. And that was for post-discharge
5 and that was potentially preventable.

6 But then we have these other two
7 measures. And when you look at these measures
8 and you started looking at them by the -- per
9 column, for example, there were certain other
10 questions that we really needed to answer besides
11 the fact of whether or not they were going to be
12 potentially preventable versus all-cause.

13 One of them would include well, what's
14 the observation window that we wanted to look at?
15 These were measures that were just based on the
16 first 60 days of home health and we had received
17 feedback that, well, what about after that in the
18 home health episode? Is that all we really care
19 about? And then it came up in terms of well,
20 I've discussed before the setting and whether
21 observation stays should be added, and then also
22 in terms of the all-cause versus potentially

1 preventable.

2 And so, the goal was to develop
3 hopefully a Row 4, which is there. And that Row
4 4 would then hopefully within time be adopted in
5 the program and would then replace Rows 1 and 2
6 in the program.

7 And so, we went ahead and we held our
8 technical expert panel, which is the next slide,
9 to try to start really answering some of the
10 questions. Next slide is not -- oh, there it is,
11 okay.

12 So, the next slide. And, we've missed
13 a slide, actually. The blank slide -- well,
14 there we go, okay. It's behind you if you're on
15 that side. The point being is that. obviously,
16 first and foremost we wanted to help to better
17 define what is potentially preventable condition
18 in home health.

19 We had already had certain guides for
20 us, that first column being what AHRC had
21 considered when they had originally defined
22 potentially preventable conditions. And then we

1 went to the third column there, which was really
2 the conditions that were used as part of our 30
3 day post-discharge readmission measure in home
4 health.

5 And they were in the categories of
6 inadequate management of chronic conditions,
7 inadequate management of infections, inadequate
8 management of unplanned events, and inadequate
9 injury prevention.

10 And so, the first thing we really
11 reviewed with the TEP was, well, do these
12 conditions apply to this measure which would be
13 more of a within-stay type of measure? And would
14 they also apply to both a population of
15 hospitalization and then also observations?

16 And the answer we got from the TEP
17 was, yes. And so, then that was really question
18 one that we were really looking at. And so, we
19 essentially are using those same types of
20 potentially preventable conditions that had
21 already been adopted within the IMPACT, that
22 mandated 30-day post-discharge measure.

1 And if you go to the next slide, we
2 then also asked the TEP the other questions.
3 Well, how should we define what we would consider
4 the -- within stay? We looked at different sorts
5 of ways. Should we have it for the entire stay?
6 Should we have it within a defined length of
7 stay, like we already had? We even looked at,
8 should we have a measure that looks at total
9 number of events within a home health episode,
10 because something should speak of in and out and
11 admitted within one episode?

12 So, we went over each one of these
13 scenarios. And what the TEP really recommended
14 was that we look at it as a whole episode within-
15 stay measure, that again if you had one episode
16 within that stay that would be it. So, in other
17 words, you wouldn't be double counted, triple
18 counted, quadruple counted. But again, we would
19 be looking really at that first episode.

20 And the TEP also recommended that we
21 do include observation stay, or observation
22 status, within the measure. The percentages

1 we're talking about are not high. So, again if
2 we're talking about -- if I know the exact
3 amounts -- we'll say 11, 11.5 percent rates of
4 potentially preventable hospitalizations within
5 that is probably a one percent or so observation
6 -- .9. About one percent of observation status
7 would be part of that preventable observation
8 stay.

9 So, again it wasn't all observation
10 stays. It was the ones that were potentially
11 preventable.

12 And so, we put that all together. And
13 as described further on that slide, it's all risk
14 adjusted. We use very much the risk adjustment
15 strategy that we used already within our other
16 claims-based measures in terms of those risk
17 adjustors.

18 We were sensitive to the question
19 about well, what about home health lengths of
20 stay? Because obviously as I talked to you about
21 before, we are concerned about those chronic home
22 health patients and particularly those agencies

1 that particularly care for that population.

2 And we wanted to make sure that we
3 weren't disadvantaging those agencies or that
4 population. And it turned out that actually when
5 we looked at episodes in home health by different
6 length of stay events that the longer length of
7 stay patients, their rate was actually similar to
8 those that were within the shorter stay. So, we
9 really weren't disadvantaging that population.
10 But that was a concern for us. And then the
11 calculation in the measure was very much similar
12 to the way we've previously calculated our
13 claims-based measure.

14 We also excluded planned
15 hospitalizations, as listed. And it's very much
16 similar to the way we had previously looked at
17 our other claims-based measures.

18 And again, if we go then to the next
19 slide. We have gone ahead and done testing on
20 the measure and we'll continue to look at testing
21 on the measure.

22 With our risk adjustment our C-

1 statistic is over .7, there. We did test for
2 different SDS factors, including urban and rural,
3 as well. There were some differences. Most
4 differences actually with risk adjustment
5 actually were very much minimized. The one that
6 wasn't minimized as much as I would have hoped
7 was dual enrollment, dual eligible.

8 However, when you actually look at the
9 model fit and the risk-adjusted rates, it was
10 very minimal in terms of any effect that it had
11 on as well as really with any of those other
12 factors that were there.

13 The split sample, the reliability
14 testing was .60, moderate. That's what we
15 typically have seen within our hospitalization or
16 readmission measures within the post-acute care
17 setting.

18 From a validity standpoint, we looked
19 at the different measures within our program to
20 see whether or not we would get the corresponding
21 validity, in other words, whether it would be
22 positive when it should be positive, negative

1 when it should be negative, and it was.

2 And so, it's tested well. I think it,
3 you know, does certainly add a new wrinkle to the
4 program in terms of including observation status
5 within hospitalizations.

6 It does respond to the feedback we
7 certainly have received about the ER-use measure
8 and whether or not that really is a measure that
9 truly represents home health performance or not.
10 And again, it also brings potentially preventable
11 rather than all-cause types of hospitalizations
12 into the program. And so, that's why we bring it
13 here to the Committee today -- to the workgroup
14 today, sorry.

15 Thank you. And we're here to answer
16 any questions after the review.

17 CO-CHAIR LAMB: Okay, so we're going
18 to go through our reviews. And you should all
19 have in your packets the preliminary staff
20 review. And just to draw to your attention, the
21 preliminary recommendation was conditional
22 support, pending NQF review. So, Heather, if you

1 would start us off and give us your discussion.

2 MEMBER SMITH: Absolutely. So, thank
3 you for all that information, Alan, because I
4 think that clarified some things that were going
5 on in my mind as I was reviewing the measure.

6 So, I appreciate the history leading
7 up to the development of this.

8 MS. MOYER: I am going to -- this is
9 a slight process change from the past. We are
10 actually going to have public comment before we
11 discuss the measure so that we can take public
12 comment into account during our committee
13 discussion. My apologies.

14 MEMBER SMITH: That's okay.

15 MS. PANACHAL: So, we have one hand
16 raised from Craig Jeffries.

17 MS. MOYER: Craig, are you able to
18 comment via the phone?

19 MR. JEFFRIES: Can you hear Craig
20 Jeffries?

21 MS. MOYER: We can.

22 MR. JEFFRIES: Yeah, I didn't want to

1 comment on the substance of the presentation.
2 But I'm remote and I couldn't see the slides that
3 he was referencing. So, my hand up was to sort
4 of get this -- in process to get the slides that
5 he was referring to available remotely. My
6 apology for interrupting the flow of the
7 conversation.

8 MS. MOYER: No, worries. So, for
9 those of you who are remote the slides are
10 available. You need to go to
11 public.qualityforum.org. And these -- this slide
12 deck and then there's also one on our second
13 measure are listed as MAP 2019 and then kind of
14 the name of the measure. They're out there as
15 PDF's on the public site, on the SharePoint site.

16 MR. JEFFRIES: Thank you.

17 MS. MOYER: Thank you for checking on
18 that.

19 PARTICIPANT: Are there any other
20 public comments on the phone or in the room?

21 MS. MOYER: Okay, Heather.

22 MEMBER SMITH: All right, now I'm on,

1 okay. All right, so again I think it was helpful
2 for the background and I really do appreciate
3 that.

4 As I was reviewing the measure, you
5 know, one of the things that came to mind is some
6 of the overlap. So, again I think that the
7 explanation was really helpful for me.

8 I think there's always a concern when
9 we see overlap in measures from my standpoint,
10 because obviously when you're in a -- more of a,
11 you know, quality reporting program versus kind
12 of, you know, more of a value-based purchasing
13 there is a fear that you could move in that
14 direction, and then there could be some
15 unintended consequences of being double,
16 basically penalized by measures that you overlap.

17 So, I was pleased to hear that the
18 thought process was, I think if I understood you
19 correctly, to move forward with implementing this
20 measure and in the future potentially retiring
21 the two other measures from the program.

22 Okay. Again, when I reviewed this

1 measure I thought there were some real benefits
2 to looking at the full stay. And I'm glad that
3 you guys talked about the difference between 60-
4 day and longer lengths of stay. I think that's a
5 real positive to really look at the full episode
6 of care, and also to focus on the potentially
7 preventable events.

8 In addition, I thought in reviewing
9 this measure that looking at both the inpatient
10 admissions and the observation stays was a
11 benefit compared to the predecessor or the, you
12 know, current existing measures.

13 One question that I had and I know
14 we're going to I think hold those questions in
15 the queue is I did notice that -- and I was just
16 wondering, I'm sure you guys can speak to this,
17 but one of the conditions for, you know, holding
18 out or removing patients from the measure is when
19 there's missing risk adjustment information. And
20 I would just be curious to know how often or
21 frequently that might happen, because there could
22 be a concern that we're missing patients in the

1 measure. And how we might, you know, potentially
2 address those issues to get a more robust
3 sampling.

4 So, I just wanted to bring that up as
5 an issue. I think we've already talked about the
6 preliminary analysis for this measure is
7 conditional support. And I believe there was not
8 public comments -- any public comments received
9 on this measure.

10 I think those were my initial
11 thoughts. And I'm not going to talk about the
12 Rural Health Workgroup input because I know Brock
13 is going to do that. But, Brock, I'm just
14 wondering as I was reviewing your -- the group's
15 comments on this measure risk adjustment came up
16 and I think that is something that is a concern
17 for rural. And I'm wondering when you speak if
18 you could just talk a little bit about if there
19 are any specifics around risk adjustment that
20 were discussed and what those might have been
21 specifically from the workgroup and if there were
22 specific comments around that. I think that's

1 all I have.

2 CO-CHAIR LAMB: Thank you, Heather.
3 That's great. Sarah, was also a lead discussant.
4 Is Sarah on the phone with us? Sarah, if you
5 would share your comments.

6 MS. MOYER: And, Sarah, you may be on
7 mute.

8 CO-CHAIR LAMB: Maybe let's just come
9 back around. Okay, Brock.

10 MR. SLABACH: Well, thank you and it
11 is a pleasure to be here able to present on
12 behalf of the Rural Measures Application
13 Partnership. Just a quick bit of history.

14 We were formed as a workgroup in 2015
15 per CMS contract. And we certainly appreciate
16 the support of CMS in its longstanding efforts to
17 try and resolve some of the issues of measurement
18 in quality reporting within the rural context.

19 And so, throughout the next two days
20 I'll be here for the hospital MAP tomorrow,
21 you'll probably hear some consistent themes. And
22 one of them, of course, is that as we look at

1 rural populations as a physician that I worked
2 with as a hospital administrator in Mississippi
3 always used to always say we have a lot of old
4 folks, poor folks and old folks and poor folks.
5 So, it's one of those -- and sick folks. I can't
6 believe I forgot the third one.

7 But the point there is that we do have
8 basically disproportional numbers of patients
9 with high comorbidities. And these comorbidities
10 can make care very complex in a rural context.
11 And particularly, as you have a dearth of
12 transitions to places post-acute, I mean to --
13 from acute to post-acute.

14 So, the options aren't a lot. So,
15 you've got limited choices and those choices can
16 somewhat be problematic in terms of getting care
17 access for rural population.

18 Having said all of that, I think that
19 the other key issue that we dealt with in NQF
20 with, through CMS has worked on the issue of
21 small volume. So, that will come through a lot
22 in the next couple of days as we look at small

1 volumes and how do we appropriately measure small
2 volumes in making sure that we're not
3 disincentivizing or creating more problems down
4 the road in terms of the small volume issue in
5 that measurement.

6 So, you'll see on the report, the NQF
7 staff nicely did a summary of the detail that we
8 reviewed on the call. And I won't go over every
9 one of those things directly. But I will say as
10 a hospital administrator, historically, one of
11 the things that I liked about this measure myself
12 is alignment of incentives. I've been told that
13 you can't herd cats -- I grew up on a farm -- you
14 just simply move the food.

15 So, what I like about this is that
16 hospitals are being incentivized in the value-
17 based payment program on the hospital
18 readmissions. And so, now if you get more
19 providers on the same team working towards the
20 same goals, at least in this case with
21 measurement, you're adding to the number of
22 people working together to make an outcome

1 hopefully happen that we're all seeking. And
2 that is potentially avoidable utilization.

3 Secondly, a lot of our rural
4 communities are transitioning to innovations
5 around either payment programs such as the
6 Medicare Shared Savings Program, or in
7 Pennsylvania we have the Pennsylvania Global
8 Budget, which is incentivizing our providers to
9 look at potentially avoidable utilization. How
10 do we work upstream to prevent the admissions to
11 our facilities that don't need to be there? And
12 so, I like the measure. The group liked the
13 measure because of that element to this look.

14 So, the relative priority is that
15 there is less numbers of home health agencies.
16 They do have high windshield times to get to
17 patients. And so, that certainly complicates the
18 care that's being provided and it certainly adds
19 to the cost. But this is a good metric to kind
20 of assess some of the outcomes of care that
21 they're giving.

22 The unintended consequence is that, I

1 talked about comorbidities and more complex
2 patients, and to get to the issue that Heather
3 raised we did not talk a lot about risk
4 adjustment. I was really pleased to see Alan's
5 presentation just now to give a lot more
6 background on how the risk adjustment would work.

7
8 I think the group would be comfortable
9 with that so far as we know that we can begin to
10 measure and monitor this going forward to see
11 what in fact is happening with regard to if it's
12 appropriately adjusting for the risk that rural
13 populations see in this area.

14 So, finally I'll just say that for the
15 voting everything is comparative. So, on this
16 measure you'll see that with the exception of two
17 people everybody voted a four or five, meaning
18 they support, which for our group was an amazing
19 amount of homogeneity based on the comparison to
20 the other measures that we took votes on.

21 So, I will say this was one of the
22 more consensus oriented outcomes of the Rural MAP

1 in terms of a favorable recommendation for its
2 adoption. So, with that I'll stop and if there's
3 any questions I will be glad to answer them.

4 CO-CHAIR LAMB: Thanks, Brock. We'll
5 hold questions and then we can have those in
6 discussion. I think Sarah is back with us.
7 Sarah, if you would share your comments in your
8 review?

9 MS. LIVESAY: Hi, can you hear me
10 okay?

11 CO-CHAIR LAMB: Yes.

12 MS. LIVESAY: Great, sorry about that.
13 So, I think my comments actually were more well
14 addressed by the presentation and so it was
15 helpful.

16 I echo the previous comments. It was
17 very helpful to hear the measure presented. I
18 really like the measure in concept.

19 The two kind of thoughts that occurred
20 to me when I was initially reviewing this was
21 again the unintended consequences and always the
22 concern if there is resistance to sending

1 patients and I think as Brock mentioned some with
2 significant comorbidities to get appropriate care
3 when it's needed in an effort to, basically avoid
4 a negative checkmark and what's the consequence
5 of that.

6 And then the other, I think, question
7 I had, or concern, was just around the burden of
8 collecting this information. I think
9 particularly when organizations aren't fully
10 aligned with home health services, you know, and
11 aren't in some sort of an integrated health
12 network what is the burden of collecting the
13 information across all of the patients served?

14 So, those are the two comments that
15 had occurred to me on initial review.

16 CO-CHAIR LAMB: Sarah, just to repeat
17 back because we're collecting the questions to go
18 back to the measure developers is you wanted to
19 hear about the burden particularly if home care
20 and hospitals are not in the same network and to
21 speak to any analysis of unintended consequences.
22 Is that right?

1 MS. LIVESAY: Yes, perfect. Thank
2 you.

3 CO-CHAIR LAMB: Okay, great. All
4 right, so we're going to go then to additional
5 reviewers who were asked to do the reviews. I'm
6 going to start with Deb.

7 MEMBER SALIBA: Yes. I also agree
8 that this is a very important measure and that
9 the inclusion of all patients as opposed to just
10 the immediate short stay patients might help a
11 little bit with the sample size issue and is
12 relevant.

13 I would like to echo earlier comments
14 about trying to figure out how to include
15 Medicare Advantage. And, you know, that is one
16 of the ones that patients typically complain
17 about. And as an AGS representative I do also
18 want to echo Brock's comments about multi-
19 morbidity.

20 So, a lot of these conditions by
21 themselves seem fairly straightforward as
22 preventable conditions. But when you get them

1 stacked on top of each other basically the
2 management becomes increasingly complex. It
3 looked like a very impressive C-statistic, in
4 terms of your model.

5 So, that does make me say, well maybe
6 I'm wrong about the multi-morbidity being
7 important. But I do think that from a clinical
8 perspective as opposed to a statistical
9 perspective, the multi-morbidity is a very
10 significant issue.

11 And I was wondering, you excluded
12 people that weren't continuously enrolled in Part
13 A Medicare for 12 months. That seemed like a
14 fairly long window. And I understand that's
15 because you were looking at the claims data and
16 you wanted to make sure you had, probably wanted
17 to make sure you had comprehensive claims data.

18 I'm wondering if you could -- how much
19 you would lose by using that 12-month window and
20 if you did some sensitivity analysis around where
21 to cut that 12-month cut point on that.

22 CO-CHAIR LAMB: Thank you. I think we

1 got all of that.

2 MEMBER SALIBA: I'm sorry. Did I talk
3 too fast?

4 CO-CHAIR LAMB: No, I followed all of
5 it. It was great. Jill?

6 MEMBER COX: Yes. So, I'm on the
7 National Pressure and Injury Advisory Panel. So,
8 of course, I'm looking at it through that lens.
9 So, I guess this is a methodological
10 question for CMS. So, what actually would be a
11 potentially preventable hospitalization in
12 relation to something like a pressure injury? Is
13 it that the person was brought to the ER because
14 they were septic or there was just inadequate
15 care? How did you determine that was a
16 potentially preventable condition in terms of
17 including in the data set?

18 I think it's a great measure. You
19 know, as a clinician myself, I'm in an acute care
20 setting, I've been there for many years, I do see
21 many patients coming into the ER, especially with
22 pressure injuries that probably if they had

1 adequate home care they wouldn't have been there.
2 But I'm just curious in this particular data set
3 how did you determine that was an preventable
4 hospitalization? So, I sort of was going between
5 preventable condition versus preventable
6 hospitalization.

7 And back to what I think, I'm not
8 sure, Debra said about multi-morbidity, I think
9 many of these conditions really are, they are
10 multi-morbidity. Pressure injuries don't happen
11 in patients that are not ill in other ways. So,
12 anyway that's just my question for clarification.

13 CO-CHAIR LAMB: Great, thank you. Ed?

14 MEMBER DAVIDSON: Yes. So, looking at
15 the perspective of the influence of transition to
16 care obviously, you know, we feel like that's a
17 big contributor. Even though this is within-stay
18 if there are multiple transitions and the initial
19 transition can contribute a lot to what happens
20 downstream. So, that's something that is I think
21 a factor that needs to be considered.

22 The other thing that jumped out at me

1 is there is a specific mention of reviewing
2 patient medication lists for potentially
3 inappropriate medications. And it's within the
4 framework of an intervention that might be
5 fruitful in reducing preventable
6 hospitalizations.

7 And I don't really think that's the
8 case. It's much more than that. It's overall
9 medication management. It's the initial
10 medication reconciliation. It's guideline based
11 care. It's taking patient preference into
12 consideration about what their goals of care are
13 and use of medication. So, I think narrowing it
14 down to the point where it might be interpreted
15 as a fruitful intervention looking at potentially
16 inappropriate medications with what people
17 considered to be the Beers list in long-term
18 care. I think that needs to be modified just a
19 little bit to overall medication management.

20 CO-CHAIR LAMB: Rikki?

21 MEMBER MANGRUM: So, one thing I
22 wanted to say just to follow on Alan's excellent

1 presentation is that this measure has a really
2 solid evidence base and that's really nice to
3 see.

4 Actually, I went and read all the
5 papers, and the systematic review by O'Connor,
6 and was impressed by how much the measure, you
7 know, within the constraints of working with
8 claims data was able to be responsive to the
9 specific findings about how preventable
10 hospitalizations happened in home health care.
11 So, that was really nice to see.

12 I think a lot of what I thought when
13 I looked at this has already been covered by
14 others. But there were a couple of things that
15 came to mind that I want to share.

16 One is the role that a patient or
17 caregiver may play in, for example, declining
18 care that would help manage comorbidities and
19 prevent an exacerbation. How does that fit in?
20 Do we account for that or not? And then also
21 what we see quite often is patients or caregivers
22 who demand to be taken to the hospital. And what

1 do we do about that? Do we instruct people to
2 say, no, or is there a way to take that into
3 account in the measure?

4 Following on something that I think
5 Brock said, there is always concern with measures
6 like this of how it affects human behavior around
7 the measurement that's happening. And so, in
8 areas where home health agencies can be choosy
9 about the patients that they take, there is a
10 risk that the higher quality are just managing
11 their patient population differently from people
12 who have less choice over the patients they
13 accept.

14 And another thing that -- question
15 that I had in my mind was whether the measure
16 performed similarly or differently between
17 exacerbations of chronic conditions versus
18 nosocomial causes of -- so an HHI or I'm trying
19 to think of what else I thought of.

20 There were some things on the list
21 here that could be the result of an immediately
22 preceding hospitalization and does it perform

1 differently or the same for that, would be
2 something of interest, I think.

3 Also whether it's possible to
4 disaggregate the measure, so that home health
5 agencies can actually see which are the
6 conditions that are driving my score.

7 CO-CHAIR LAMB: Is that it, Rikki?

8 MEMBER MANGRUM: Yes.

9 CO-CHAIR LAMB: Okay, all right. I
10 think that was all of our additional reviewers.
11 Did I miss anybody? Okay, let's open it up for
12 conversation then.

13 Additional comments, questions? Kurt
14 and I are taking a list here that we'll
15 summarize, make sure we've covered everything but
16 then we'll have the discussion with the measure
17 developers.

18 So, comments, things you would like to
19 add to what was already said? Gene.

20 MEMBER NUCCIO: I had five questions
21 that I had created previously but Alan's
22 presentation was very helpful, especially with

1 regard to potentially avoidable conditions list.
2 The quality of the prediction model, I believe he
3 reported 0.72, which is pretty strong.

4 There were -- I did have a couple of
5 questions regarding -- and then also the issue of
6 frequent flyers who are going back and forth
7 during their clinical period. One of the
8 questions I had was is the plan to use this
9 measure in the Star Rating computation? And if
10 so, is the interquartile range of .93 to 13.2 and
11 the overall range of 0 to 26.1 sufficient for the
12 methodology used in reporting that Star Rating?
13 As I recall, it seemed to use a decile approach
14 to splitting performance up and then aggregating
15 it up.

16 And the second part and I think this
17 was, Brock was raising this just a little bit,
18 was the reportability of the measure. Given that
19 there were just under 9,000 agencies used in the
20 data, in the analysis of about, I guess, 11.5
21 thousand agencies was the cut off 20 patients in
22 a 12 month period? Just so we have a reference

1 point for that.

2 CO-CHAIR LAMB: Great. And when we
3 get to the Q&A with the measure developers I'm
4 going to let you repeat your analytical question.

5 MEMBER NUCCIO: Certainly.

6 CO-CHAIR LAMB: Other comments,
7 questions, things you'd like to add? Okay,
8 anybody online, Janaki? Okay, all right. So,
9 I'm going to try and list off the questions that
10 came across. If I miss any, Kurt's going to
11 connect -- correct and please clarify if I get
12 any of the intent of your questions wrong.

13 Alan, Michelle, Reena, who is going to
14 be responding so that we just kind of --

15 MR. LEVITT: I'll start.

16 CO-CHAIR LAMB: You're going to do it,
17 all right. Brave man, brave man. All right, let
18 me just list off the questions that we have.
19 Let's check our lists, okay?

20 The first one is related to an
21 exclusion criteria. Do you want to just go
22 through them one by one rather than listing them?

1 Is that better?

2 MR. LEVITT: That would be great.

3 CO-CHAIR LAMB: All right, let's do it
4 that way. So, exclusion criteria --

5 MR. LEVITT: For missing information?

6 CO-CHAIR LAMB: -- missing risk
7 adjustment information. How often does it
8 happen?

9 MR. LEVITT: That's actually low. I
10 mean we're looking at, it's zero percent. It's
11 3,892 out of the, I guess, four million stays.
12 So, that piece is actually low.

13 CO-CHAIR LAMB: Okay. And actually I
14 think that's a nice process, which is if Alan
15 will answer the question if it doesn't completely
16 answer your question just feel free. Okay?
17 Anybody else can jump in as well.

18 All right. Second one I have, Alan,
19 is the question of unintended consequences. And
20 do you have any evidence that by measuring this
21 there is a potential in change in behavior and
22 avoidance of sending people to the hospital?

1 MR. LEVITT: The unintended
2 consequences of this measure or any behaviors
3 that providers may have in this measure are
4 really not going to be changed by this measure.
5 I mean, the outcomes that we're talking about
6 here are already accounted for in the existing
7 measures.

8 So, that if there indeed are
9 unintended consequences going on or provider
10 behaviors that may be occurring unfortunately
11 regarding not giving patients the appropriate
12 disposition if they're having need for
13 hospitalization.

14 That's not changing here. What we're
15 doing here is we're essentially trying to take
16 all of the different diagnoses that may result in
17 either an emergency room visit or a
18 hospitalization and trying to get them more into
19 a cohesive group of those that are most
20 potentially preventable. We're not adding any
21 more that wouldn't have been there otherwise with
22 these measures.

1 CO-CHAIR LAMB: Sarah, I think that
2 was your question. Is there anything that you
3 would like in follow up?

4 MS. LIVESAY: No, that's great,
5 thanks.

6 CO-CHAIR LAMB: Okay. Next question
7 is related to burden. My understanding that the
8 question was around, what if the home health
9 agency is not connected to a hospital? How do
10 they get that data and is there additional burden
11 for them?

12 MR. LEVITT: Well, this is a claims-
13 based measure, it's based on claims that Medicare
14 gets. There's no data submission requirements
15 for home health agencies in addition to what
16 already is going on with the claims that are
17 being submitted. So, from that standpoint there
18 is no additional burden.

19 And again, issues that providers may
20 have should not really change with this measure,
21 because like I said before, essentially, we're
22 taking the same outcomes that we've already been

1 measuring that have already been publicly
2 reported. And we're just hopefully reporting
3 them in a more appropriate, what we would think
4 of, way, rather than the way we're currently
5 doing it.

6 CO-CHAIR LAMB: Sarah, anything to add
7 to that? I believe that was also your question.

8 MS. LIVESAY: No, that's very helpful.
9 Thank you.

10 CO-CHAIR LAMB: Okay. Several people,
11 Alan, asked about plans for bringing Medicare
12 Advantage into this. Comments on that.

13 MR. LEVITT: It's an excellent
14 question. It's a question that we ask ourselves
15 within not just these measures, but in all of our
16 claims-based measures.

17 It is something we are, you know,
18 looking at not just for this measure but really
19 measures throughout the Agency. Some may
20 actually be easier than others because we may
21 have, for example, in hospice Medicare Advantage
22 patients convert over to, so there may be more

1 ease there.

2 The problem is getting the
3 appropriate, the data that is necessary for risk
4 adjustment. There was another question about,
5 well what about 12 months? Yet 12 months had
6 been the standard, has been, really been used
7 along for these claims-based measures.

8 Whether or not that should be re-
9 looked at because the volume of claims has
10 changed over time versus initially these types of
11 measures were developed, maybe that is something
12 that we really should do and really should look
13 in how much are we really getting not just for
14 this measure but really for all of our claims-
15 based measures in terms of the value of risk
16 adjustment based on this window that we've
17 chosen.

18 We are trying to be consistent, again,
19 with what has been used and been used
20 successfully in our other claims-based measures.
21 Just because it's been used successfully before
22 doesn't mean that we shouldn't, you know, look to

1 change it to hopefully then add more patients to
2 the measure.

3 CO-CHAIR LAMB: I think I'll jump
4 then, because, Alan, you were beginning to
5 address the 12 month window that, Deb, you were
6 asking about. Did you want to follow that Deb
7 with anything?

8 MEMBER SALIBA: No, he answered my
9 question.

10 CO-CHAIR LAMB: Okay, good, very good.
11 That may be something we also want to put on our,
12 kind of, priority list is to relook at the
13 windows as we get into that discussion. The
14 other question that Deb raised was multi-
15 crmorbidities and how those are handled in the
16 analysis.

17 MR. LEVITT: And again, we have been
18 using the risk adjustment that's been used
19 successfully in our other measures. We continue
20 to always look at risk adjustment models every
21 few years to see whether or not they are still
22 appropriate or whether we should be looking at

1 them differently.

2 It is a claims-based measure and so
3 therefore we are limited in terms of the
4 information that we get on the claims and how we
5 can look at the claims and potentially manipulate
6 -- I don't mean that in a negative way.

7 But, you know, manipulate them in
8 terms of whether we should be multiplying -- you
9 know, so it's other sorts of ways of looking at
10 it. As of now, we're continuing with the same
11 approach that we've used before successfully. It
12 is something that we continue to look at.

13 CO-CHAIR LAMB: Follow up? You're
14 good, okay. Thank you. This one then is related
15 to Jill's question about pressure ulcers being
16 potentially preventable and how is that
17 determined. Jill, did I get that right?

18 MEMBER COX: Yeah. So, how it is that
19 measure is set?

20 MR. LEVITT: I know -- I apologize for
21 the slides being so small that were there. But
22 pressure ulcers actually is one of the

1 potentially preventable conditions that was on
2 that, I guess, the fourth slide. And so, it is
3 included.

4 If you need to I could show all of you
5 the diagnostic codes that are ---

6 (Simultaneous speaking.)

7 MR. LEVITT: But again also, I mean,
8 complications to pressure ulcers if there are
9 infections associated, once again that would be a
10 claims that would come through. It wouldn't come
11 through as a pressure ulcer, it would come
12 through as whatever the infection is that may
13 have led to the hospitalization.

14 MEMBER COX: So, my question to that
15 was, how did would that determine that was
16 potentially a preventable hospitalization?

17 MR. LEVITT: And again, just because
18 these diagnoses are here doesn't mean that all of
19 these individual patients within the pixels or
20 the diagnoses that particular patient may have
21 been potentially preventable or not.

22 The way these have been designed is,

1 essentially, that these diagnoses are much more
2 likely to have, within a group of patients who
3 have those diagnoses being hospitalized, a
4 component of those would have been potentially
5 preventable.

6 It doesn't mean that every congestive
7 heart failure that gets admitted is, you know,
8 one that, you know, should have not been
9 admitted. It's the same thing with pressure
10 ulcers.

11 And again, the point is and that
12 really gets into all the attribution questions as
13 well that were also discussed. And again, when
14 it comes to and I'll move into that if that's
15 okay.

16 When we were talking things about
17 transitions. Again, obviously patients may be
18 getting discharged from the hospital, for example
19 and the diagnoses that may have brought the
20 patient back to be admitted to the hospital may
21 have been primarily due to the care that may have
22 been given or not given at the hospital.

1 Once again, it's really the diagnosis
2 itself that's really generating the idea of it
3 being a potentially preventable diagnosis. The
4 fact that home health agencies may only have a
5 component within that is true.

6 We only want to include it. And
7 that's what we brought to our technical expert
8 panel, the idea of we don't want to include
9 diagnoses where there is no possibility that a
10 home health agency would have influence on such a
11 patient being admitted to the hospital.

12 Those diagnoses we want to exclude.
13 But if there was a possibility that the Agency
14 would potentially, that sort of care within the
15 Agency would result in a patient being admitted
16 with that diagnosis we would include it.

17 CO-CHAIR LAMB: Ed, I think your
18 question, and if I got the intent wrong please
19 correct, is more about a narrow definition of
20 medication management, that there needed to be
21 thought given to managing medication to really
22 support transitions and reduce readmissions is a

1 much broader concept than what you saw reflected.
2 Is that right?

3 MEMBER DAVIDSON: Correct. So, I'm
4 specifically looking at, you know, the question
5 is the measure evidence based. It's strongly
6 linked to outcomes and an outcome measure.

7 And the answer is, yes, there's there
8 is an explanation. It's really the way that the
9 evidence base was nuanced focusing in on one
10 specific issue of reviewing the medication list
11 for potentially inappropriate medications, i.e.
12 the Beers list as a suggestion that that reduces
13 potentially preventable hospitalizations in this
14 population.

15 And I think the evidence base supports
16 that. The CDC has very good evidence from their
17 surveillance network about older adults and the
18 reasons for hospitalization and the Beers list
19 is, contributes very, very little to that.

20 There is a preponderance of evidence
21 that most of it's related to diabetes
22 medications, anticoagulants, opioids and

1 antibiotics. And that's consistent with the OIG
2 report looking at skilled nursing facility to
3 hospital transition.

4 So, there's a lot of evidence that
5 suggests that it's more than just a nuanced list
6 of medications. It is overall medication
7 management.

8 It's guideline based care such as
9 organizations like AMDA that focus on post-acute
10 long-term care space and medication
11 reconciliation and then patient preferences in
12 care.

13 MR. GELLER: This is Andy Geller from
14 the CDC and I wholeheartedly agree with what was
15 just said about the medication management and the
16 three high priority target areas rather than the
17 Beers criteria list. The data do not support
18 using the Beers Criteria for this list for this
19 purpose, thank you.

20 MS. MOYER: And if I can interject
21 briefly, it can be hard to tell sometimes where
22 the materials come from. That specific wording

1 is from the staff preliminary analysis and was
2 our attempt to kind of capture what was in that
3 systematic review.

4 And there may be nuances and
5 additional information there that we didn't quite
6 get in all these words. I don't want to put
7 those words in CMS's mouth.

8 MR. LEVITT: And again, this is a
9 measure that looks at the diagnoses or the
10 complications that may be associated. So, for
11 example, anticoagulant complications is a
12 diagnostic category that would be considered
13 potentially preventable.

14 So, we're not looking at what is
15 perhaps used by agencies or not used by agencies
16 to help in terms of managing the care of the
17 patients. We're really looking at the outcomes
18 themselves.

19 And so, if there are complications
20 related like a diabetic short term complications
21 is part of the list. So, somebody who became
22 hypoglycemic, that may be a potentially

1 preventable complication that could result in a
2 hospitalization, not necessarily how it's done.

3 CO-CHAIR LAMB: Thank you. Alan,
4 you're doing great. Let's just keep on rolling.
5 We just have a few more. The next one is how the
6 role of the patient's choice is handled in this
7 measure.

8 If a person chooses not to go to the
9 hospital or in fact the alternative demands to go
10 to the hospital is that handled in any way?

11 MR. LEVITT: So again, that gets back
12 to the original comments that we got back when we
13 first were recommending adding the emergency
14 department measure to the Star Ratings was that
15 the comments that we got back from the agencies
16 were that, well, yes, maybe we have part in
17 there.

18 But really primarily a lot that could
19 be really out of our control. Going to the
20 emergency room is or can be a voluntary decision,
21 either yea or nay to go there.

22 To actually be hospitalized or to

1 actually be put into observation status on the
2 other hand, there has to be certain criteria that
3 would put somebody in there. And so, that's why
4 we felt that in terms of if you have the
5 demanding patient or family bringing a patient
6 there that may happen.

7 But for them to actually be admitted
8 or for them to go on observation status there
9 needs to be other criteria other than, hopefully,
10 you know, demand.

11 CO-CHAIR LAMB: Rikki, I believe that
12 was yours. Are you good, okay. The next
13 question was whether the measure behaves
14 differently across the different categories of
15 preventable causes.

16 MR. LEVITT: I'm not sure, can we
17 repeat the question in terms of what?

18 CO-CHAIR LAMB: Rikki, do you want to
19 do that one?

20 MEMBER MANGRUM: Yes. So, what I was
21 curious was whether or not the measure performed
22 differently at all for exacerbations of chronic

1 conditions versus a nosocomial thing like an HHI
2 or a pressure, preexisting pressure ulcer.

3 I don't know if you did analysis for
4 that or if you did I would be curious to hear.

5 MR. LEVITT: I mean again, we looked
6 at it by percentages within each diagnostic
7 category. But I'm not sure what you're, you
8 know, what you're looking at in terms of, I mean,
9 essentially what we're looking at is the outcome
10 that, the cause of the hospitalization.

11 And so, we look at that within each
12 diagnostic group. From there I'm not sure what
13 you would be, you don't look at anything further
14 like how long their hospitalization was or
15 whether they died from it or anything further
16 from that event onward.

17 MEMBER MANGRUM: Yes. So, what I'm
18 curious, because this has sort of been the
19 aggregate score, you are aggregating a bunch of
20 causes of hospitalization.

21 So, my curiosity is, is that aggregate
22 score actually being driven by certain conditions

1 versus certain others or is it sort of equally
2 spread around because that would speak to whether
3 or not it would be helpful to the agencies to
4 disaggregate the measure so that they understand
5 which specific diagnoses are leading to their
6 hospitalizations.

7 I mean, they should know that on their
8 own. But for a lot of people it's actually
9 really hard to spend the time and effort to get
10 that information.

11 MR. LEVITT: One of our ongoing
12 challenges and the reason I've got less hair
13 every year after this committee is attempting to
14 get, for a non-payment related measure, patient
15 level information back to the post-acute care
16 provider for the claims-based measures because
17 again, providers have asked for that information
18 because like you said, oftentimes they should
19 know because the patient has been under their
20 care.

21 Sometimes they may not know for
22 whatever reason. And from a standpoint of them

1 being able to get that information it's easier if
2 you're actually in a payment program getting
3 access to that information is covered.

4 When you are not or you are in just a
5 public reporting type of program like there are,
6 there are other work arounds that need to be
7 done. We continue to try to do that because that
8 is one of our goals for not just this measure but
9 really for all of our claims-based measures we
10 have.

11 We want to be able to give that sort
12 of information back so that way providers may be
13 able to use it in their own quality activities
14 because, like you said, you know, knowing maybe
15 our potentially preventable hospitalization rate
16 is high, maybe it's all due to infections. Maybe
17 it's all due to inadequate injury prevention.

18 So, you're right and I think that that
19 sort of information would be very useful as a
20 previous post-acute provider myself.

21 And it is something we're continuing
22 to try to work through not just the legal but

1 also operationally how we would be able to set
2 that up within our, the systems that you're
3 submitting data in so that you could ask for that
4 information and then be able to receive it.

5 CO-CHAIR LAMB: Okay. We're moving
6 then into Gene's question was related to whether
7 there's a plan to use; this as part of the Star
8 Rating. And then, Gene, you had some questions
9 about analysis.

10 MEMBER NUCCIO: Yes. The methodology
11 for Star Rating for mental health requires
12 setting up, splitting the distribution up into
13 deciles.

14 And again, one of the questions I
15 think everyone struggles with is meaningful
16 differences. And given the interquartile range
17 of 9.3 to 15.2, is that a meaningful difference?

18 You know, how small can that be where
19 there are meaningful differences? So, I guess if
20 you answer the first question do you plan to use
21 it for Star Rating or --

22 MR. LEVITT: I mean, and again, if we

1 would propose the measure for the program we
2 would also at the same time plan for the removal
3 of the other measures. I mean, that would, you
4 know, be something we would want to do.

5 We, you know, categorization is easier
6 in terms of being able to categorize better,
7 worse, the same. I don't think that we've
8 actually looked at the decile breakdown and how
9 that would work out, Gene.

10 But we would obviously need to look at
11 that if we were going to want to substitute this
12 measure in Star Rating.

13 MEMBER NUCCIO: And the other
14 question?

15 CO-CHAIR LAMB: And, Gene, you had a
16 second question about portability. Do you want
17 to frame that one again?

18 MEMBER NUCCIO: Right. Many of the
19 measures that are reported require a certain
20 number of healthcare episodes over a period of
21 time, typically it's around 20.

22 And given you're reporting on about

1 9,000 agencies out of probably 11,500, so do you
2 use that 20 cut off?

3 MR. LEVITT: Yes. So, Alrick has the
4 spreadsheet.

5 MEMBER NUCCIO: I just wanted to
6 verify that. And so, what you have is not, is
7 typical of other health reported measures. So,
8 you're not doing anything strange here.

9 MR. LEVITT: Yes.

10 MEMBER NUCCIO: If I can follow up
11 with one more quick question. In the risk
12 factors that you identified in the text you have
13 original Medicare enrollment.

14 So, is that the number of years that
15 they've been on the Medicare Program? And is it
16 prior care utilization. So, is that, so the
17 length of stay at the hospital or is that whether
18 or not the patient has been on home care before?

19 Just curiosity. Perhaps it's too far
20 out in the weeds to even be worthy of asking.

21 MR. LEVITT: While Alrick is looking
22 I would like to comment that Gene's questions

1 have always actually been very good whether they
2 have been in the weeds or not. So, we actually
3 always do appreciate.

4 Alrick, I'm not sure if viewing the
5 slide could give more in terms of actually what
6 the risk adjustors are in terms of how they're
7 divided in that way.

8 MR. EDWARDS: What was the first one
9 you mentioned?

10 MEMBER NUCCIO: The original Medicare
11 enrollment. I presume it's number of years that
12 they've been under Medicare.

13 MR. EDWARDS: Yes.

14 MEMBER NUCCIO: Okay. And prior care
15 utilization.

16 MR. EDWARDS: Prior care utilization.
17 Yes, look at prior approximate hospitalization
18 whether or not they have, I see. We break it
19 down even more.

20 So, by proximal hospitalization,
21 whether they have ICU or CCU.

22 MEMBER NUCCIO: So, yes, because as

1 you all know there's a real difference between
2 typically patients who come in from the community
3 and whether or not --

4 MR. EDWARDS: Yes, absolutely.

5 MEMBER NUCCIO: -- you know, they get
6 better versus whether they're a recertification
7 or a resumption of care kind of thing whether
8 they go back to. I just want to make sure --

9 (Simultaneous speaking.)

10 MEMBER NUCCIO: To Debra's question
11 about multiple comorbidities as sort of an
12 overall global proxy for that.

13 MR. LEVITT: If I could just make a
14 point. This did remind me when the questions
15 were being asked, you know, one of the things we
16 really are very sensitive to in home health and
17 the reason this is a hospitalization measure and
18 not a readmission, within-stay readmission
19 measure is, like Gene is alluding to, is both the
20 home health community know is that over 60
21 percent of the admissions are from the community.

22 They're not what we consider post-

1 acute care in terms of coming from the hospital.
2 So, obviously we want to include those patients
3 within our measure because we obviously want to
4 include a much wider set.

5 But at the same time we want to be
6 able to appropriately risk adjust for that
7 population so that, you know, those sorts of
8 patients who are more of the, admitted from the
9 doctor's office or more chronic type of patients
10 are taken care of appropriately.

11 So, it is kind of one of the things
12 that we are sensitive to and that's why it's a
13 hospitalization measure itself.

14 The other thing again that brought on
15 is really in terms of rural one of the things we
16 really are also very sensitive to is particularly
17 and I've mentioned to the Workgroup before with
18 home health and with hospice is rural because
19 again the effects of these type of measures
20 particularly in the rural population taking those
21 things into account as well to ensure that we are
22 not disadvantaging that population.

1 MR. EDWARDS: I did want to add a
2 clarification for the original Medicare
3 enrollment it's reason for Medicare enrollment
4 either disability or age into Medicare, yes.

5 MEMBER NUCCIO: Okay, great.

6 CO-CHAIR LAMB: Thank you, for some
7 thoughtful questions and for your responses. I
8 think the next step is for us to take an initial
9 vote on the staff recommendation of conditional
10 support pending NQF review.

11 And just to clarify what that means is
12 the recommendation to bring it through NQF
13 traditional committee processes. Is that
14 correct?

15 MS. PANACHAL: That is correct.

16 CO-CHAIR LAMB: Okay. So, that means
17 our first step is to vote on what the staff has
18 proposed. And if we achieve a, Janaki, 66
19 percent?

20 MS. PANACHAL: Sixty percent.

21 CO-CHAIR LAMB: Sixty percent, then we
22 stop there. So, if anybody has any trouble

1 bringing up the voting please say so.

2 MR. HIRSCH: Voting for MUC2019-34
3 Within-Stay Potentially Preventable
4 Hospitalization Measure. Do you vote to support
5 the preliminary analysis as a Workgroup
6 recommendation?

7 Again, the preliminary analysis was
8 conditional support. Voting for this is now
9 open. Your options are yes or no.

10 Voting for MUC2019-34 Home Health
11 Within-Stay Potentially Preventable
12 Hospitalization Measure is now closed. The
13 Workgroup has voted yes 14, zero no.

14 The Workgroup recommends MUC2019-34
15 for conditional support.

16 CO-CHAIR LAMB: Okay. So, given that
17 we supported the staff recommendation it was
18 forwarded with conditional support and we are
19 done. Very good.

20 Thank you, everybody. I think lunch
21 is next on the agenda. And what time do we go
22 until, Amy?

1 MS. MOYER: We need to reconvene at
2 12:30, a 27 minute, 26 minute lunch.

3 (Whereupon, the above-entitled matter
4 went off the record at 12:04 p.m. and resumed at
5 12:39 p.m.)

6 CO-CHAIR MERKELZ: All right. We can
7 move into our next half and I'm going to turn it
8 over to Amy to introduce the measure under
9 consideration for the Hospice Quality Reporting
10 Program.

11 MS. MOYER: So, a reminder to everyone
12 that the Hospice Quality Reporting Program, this
13 is one of the non-IMPACT Act programs that we
14 handle on this workgroup. This is also a penalty
15 for the failure to report information.

16 The Hospice QRP was established under
17 the Affordable Care Act and hospices that fail to
18 submit quality data are subject to a two
19 percentage point reduction in their annual
20 payment update.

21 The information for measures in the
22 program comes from the hospice information set

1 and the Consumer Assessment of Healthcare
2 Providers and Systems Hospice Survey. And I'm
3 sure Alan will talk about this as well.

4 But as a reminder, all patients who
5 are in this program from Medicare are fee-for-
6 service and therefore we have the full claims
7 data which is relevant since this is a claims
8 measure. I will hand it over to Alan to talk
9 about the measure.

10 MR. LEVITT: Okay, thank you. Always
11 good to get pulled up and there we are. Okay,
12 well thank you. Thanks, folks, again. On the
13 phone I know that Cindy Masuda who is the program
14 lead for hospice is on, for CMS is on the phone.

15 Sitting next to me is T.J. Christian
16 and in the audience Kyle Cobb from Abt Associates
17 who have been invaluable in helping to develop
18 this measure or redevelop this measure. As well
19 as on the phone --

20 MS. MOYER: And for those of you on
21 the phone just so you know what we're looking at
22 here in the room, the slide set, this is another

1 one of the slide sets that's available on
2 public.qualityforum.org.

3 And this is the hospice visits slide
4 set. So, you can pull that up and follow along.

5 MR. LEVITT: Okay. Hospice Visits in
6 the Last Days of Life, MUC2019-33. And so, there
7 is also on the phone others from Abt Associates.

8 I also wanted to thank RTI who were
9 the original measure developers of the hospice
10 visits pair who also did a lot of the initial
11 analytics that I'll be discussing as well leading
12 up to this measure that we're going to propose to
13 you and the committee today.

14 I know there were a number of
15 questions about this particular measure proposal
16 and hopefully my presentation, similar to what
17 was with the previous measure, can help to
18 clarify some of the questions that you may have
19 had about the measure and we'll be glad to answer
20 other questions as well that are brought up after
21 this.

22 I'll be spending actually a little bit

1 of time on the first few slides on the background
2 and the rest will go more quickly. But as I
3 mentioned before and we can actually go to the
4 next slide, we continue to monitor and evaluate
5 the existing measures in our program.

6 And this is really yet another example
7 of that type of monitoring where we're looking at
8 and we're bringing to you a claims-based version
9 of a measure that is currently within the program
10 as an HIS based measure.

11 Just to give you some background on
12 it, in the Fiscal 2017 rule we adopted the HIS
13 based hospice visits when death was imminent
14 pair. When we had first presented this measure
15 to the TEP back in May of 2015, it was not a
16 pair. It was actually a single measure.

17 It was a seven day measure and it was
18 actually the TEP that, at the TEP discussion they
19 supported actually development of a measure set
20 rather than a single measure and they supported
21 using different time frames as well for different
22 types of care that were being provided at the end

1 of life.

2 They also recommended at that time
3 actually limiting this to patients who were just
4 receiving routine home care rather than all
5 hospice patients at that time. And so, the
6 measure pair, for those old timers on the
7 Workgroup, was brought to the Workgroup in
8 December of 2015.

9 And then we did propose it in 2016 in
10 the Fiscal 2017 rule. And it was proposed as a
11 measure pair. And as listed on the slide Measure
12 1 was addressing the clinical visits by the nurse
13 and physician in the final three days of life.

14 And Measure 2 was addressing the other
15 visits from the other hospice staff which include
16 the LPN, aide, social worker, chaplain and that
17 was in the final seven days of life. Data was
18 first collected on the HIS in April of 2017.

19 And then earlier this year we
20 announced that we were going to begin public
21 reporting of Measure 1 and we were beginning that
22 this summer which already is actually now being

1 reported.

2 But that Measure 2 did not meet or
3 currently meet what we called readiness standards
4 for public reporting. I'll explain that a little
5 bit more in the next slide.

6 In addition, in the rule this year we
7 then also finalized a proposal to continue to
8 collect data on Measure 2 while we were
9 completing this additional testing on the
10 measure.

11 Also, I would note separately and
12 that's on the final bullet on this slide, that in
13 the Fiscal 2016 rule we finalized a new payment
14 policy. It's called the Service Intensity Add-
15 On.

16 And that was to incentivize nursing
17 and social workers in the last days of life. So,
18 go to the next slide.

19 So, we became interested in re-
20 specifying this measure based on the results of
21 our monitoring and evaluation of the measure pair
22 regarding its readiness for public reporting.

1 To give you an idea as to what we do
2 with this measure really all of our measures in
3 our program we look at things such as frequency
4 analysis on exclusions like we talked about
5 actually at the last measure.

6 We also, the frequency of the visits
7 that are received by each discipline, when
8 they're received in the last seven days of life.
9 We look at the quality measure, distribution
10 itself for the variability like Gene was asking
11 about.

12 We look at the stability of the
13 measures. We look at the seasonal variation of
14 the measures. We look at reliability testing
15 with the, for example, split half reliability.

16 We perform regression analysis.
17 Sometimes we do that for our risk adjustment.
18 Sometimes we look at it like in a measure like
19 this to see whether there are certain patient or
20 hospice characteristics associated with higher or
21 local likelihoods for such an event happening.

22 Particularly, you know, analyzing

1 those things for disparities, for example. And
2 most importantly actually in this measure we do
3 validity testing.

4 We do validity testing as a way of
5 kind of trying to confirm our original
6 hypothesis. The original hypothesis being that
7 more visits by different hospice services or
8 disciplines near the time of death should be
9 associated with better outcomes of care for dying
10 patients.

11 And so, what we ended up doing is we
12 actually did Spearman Pearson correlation
13 analysis analyzing between these two measures,
14 the measure pair and our HIS measures and then
15 also our hospice CAHPS measures.

16 So, the experience of care that
17 hospice families will report on after a hospice
18 patient died in terms of the type of care that
19 the hospice patient received. Our assumption
20 being that more visits would equal more
21 satisfaction or better experience with hospice
22 care.

1 And contrary to the opinions of our
2 experts, the TEP that we first had for ourselves
3 by others in the hospice community who actually
4 have commented back on this measure saying well
5 why aren't you, you know, including x, y, or z?

6 What we found is that visits by
7 different disciplines or services that were
8 received near the end of life were not all
9 created equal and that we found that the results
10 of Measure 1 which was the clinical visits by RN
11 and physician correlated very well.

12 So, in other words there was a good
13 correlation between providers that scored well in
14 that measure and, well first of all the HIS
15 measures which was a little bit of a surprise
16 because one is at the beginning of care, one is
17 at the end of care. But there was some
18 correlation there.

19 But particularly, there was
20 correlation between the ones that had more visits
21 and also had greater satisfaction or better
22 experience of care results. However, Measure 2

1 was exactly the opposite.

2 That those that received those
3 services in the last seven days of life actually
4 had a negative correlation in both, particularly
5 with the experience of care. And so, that's got
6 our heads scratching.

7 And it got us to start thinking well,
8 let's take a better look at that. And first
9 announced that, you know, we're going to report
10 on 1 and we're going to continue to look at 2
11 because it didn't meet those readiness standards
12 and that we would do further sub-analysis as to
13 the why's.

14 And also at the same time look for
15 other approaches for the measure in terms of well
16 if, you know, Measure 1 is there maybe how else
17 should we collect it?

18 So, the first thing we looked at was
19 we started dividing things up by service. And
20 what we found were that there were positive
21 correlations across the board with RN services.

22 So, in other words when RN services

1 were given they were associated with a positive
2 experience of care. And that was a key component
3 for Measure 1.

4 But what we also found was that when
5 we subdivided Measure 2 as well was that social
6 workers also had a positive experience.

7 So, then RN's and social workers
8 consistently for all the different patient
9 experience of care no matter how you divided it
10 up, communications, spiritual, willingness to
11 recommend, rating of hospice, again, RN, social
12 workers at the end of life positively correlated.

13 Doctors, well, we didn't have enough
14 doctors to actually look at because there's only
15 about one percent claims. But doctors again,
16 were kind of generally maybe a little positive in
17 the middle.

18 Chaplains, well chaplains for
19 spiritual positive. Otherwise were kind of
20 neutral on that. But as far as for LPNs and
21 aides, we're talking now at the end of life not
22 during the whole hospice episode which is really

1 all different types of care that are being
2 provided.

3 And it was actually a negative
4 correlation, more strongly negative. And we even
5 looked at that further and said okay, let's do
6 correlations within the services.

7 And what we found there was that it
8 appeared that there was, when LPNs, for example,
9 were being substituted for RNs that was a very
10 negative correlation near the end of life.

11 And so, that got us particularly
12 thinking well let's really look at this measure
13 again and reexamine our hypothesis, reexamine
14 again how perhaps we can collect this measure
15 better to account for what we found.

16 And so, what we did is we started
17 exploring the visits measures that would include
18 RNs from Measure 1, social workers from Measure 2
19 since those were the two that correlated the
20 best.

21 Put those together in the
22 calculations. And noting that those are both

1 also reported by hospices on claims that could we
2 make into a claims-based measure.

3 And then we also noted, coincidentally,
4 that those are the two services that also are
5 part of the Service Intensity Add-On so we
6 actually are aligning with already what's being
7 incentivized within our payment.

8 So, a lot of information on one small
9 slide. But if we go to the next slide. So, are
10 we there? Next slide. So, the next question we
11 wanted to look at again was time frame.

12 And really the concept and idea as to
13 can hospices know, in general, you know, when
14 some, when their patients are nearing the end of
15 their life. And we reexamined that more closely.

16 And luckily we have Dr. Joan Teno
17 (phonetic). She's on our team and she's done a
18 lot of work on hospice visits. And so, her
19 support was invaluable in looking at all this and
20 looking at the literature as well.

21 And what we found, and again this is
22 one study from MD Anderson in Texas, that showed

1 that symptoms of dying did increase particularly
2 in the last two, three days of life.

3 What you may be able to see if you
4 actually had 20/10 vision and could see the
5 slides are that these bottom seven symptoms that
6 are there from peripheral cyanosis on down, when
7 they started looking at them in Graph B, is that
8 really when you looked at the last really three
9 days of life you saw that these symptoms
10 significantly increased.

11 And so, there really was this
12 recognition that hospices, in general, could
13 recognize symptoms of end of life. And that
14 correlated actually with what clinical experts
15 had been telling us as well.

16 And it also corresponded when we
17 started looking again at the frequencies in our
18 data analysis, the frequency of service visits
19 for example, with what hospices were doing
20 already because what we saw in the frequencies
21 were that really for all services, not just for
22 social worker, RN, that what you saw is that

1 there was this increase that you saw in the last
2 few days of life.

3 So, hospices were recognizing this and
4 actually many of them were already increasing
5 these type of services. So, we felt very
6 comfortable that if we looked at something
7 particularly over the last three days of life it
8 should be something that in general hospices can
9 recognize and are already recognizing and then
10 that we should be able to measure that and really
11 measure that using those services that really do
12 correlate best with a positive experience of
13 hospice care.

14 So, I know I've told you a lot. So,
15 if we go the next slide what we, you know,
16 decided to do is relook at the measure. And what
17 you'll see on all the subsequent slides for now
18 are different scenarios that we put together.

19 We put them together based on number
20 of days prior. And so, we used three days as our
21 guide. And so, we looked two, three, four. We
22 looked at RN and social workers as the ones who

1 are conducting the visit.

2 And then we tried to look within each
3 one of those groupings of two day, three day or
4 four day whether or not visits, whether it's
5 better to have just one visit to look at within
6 that scenario, consistent daily visits or maybe
7 something in between like an intermittent as
8 well.

9 And so, what you'll end up seeing on
10 the next slides are first what you'll see is M1,
11 M2 are the claims-based versions of the old HIS
12 based measures so that you can see kind of what
13 it looked like. Then you'll see groupings of
14 single visits, visits every day and visits minus
15 one.

16 And we'll be looking at all these
17 sorts of things that we're talking about in terms
18 of readiness for public reporting which includes
19 things from reportability to variability, to
20 validity and reliability.

21 You guys all still here with me?
22 Okay, so let's go to the next slide so I can

1 confuse you. This next slide you don't have to
2 read.

3 But again, it really divides all these
4 things up. And the point of this next slide is
5 really, in terms of reportability, about 80
6 percent of hospices would be able to report using
7 claims-based measure.

8 As a reference and you'll see numbers
9 up there, it's hard for me to see. But, you
10 know, let's say 3,590, 3,570. As a reference for
11 the HIS based measure that's currently out 3,560
12 actually hospices report.

13 So, you actually get a slightly
14 increased number versus HIS even though there are
15 patients, for example, who are let's say a
16 private insurance or have Medicaid alone. There
17 may be patients actually that would not be on
18 hospice claims.

19 It turns out they're balanced off on
20 the fact that hospices may not be submitting
21 their HIS. They're always submitting claims.

22 And so, it turns out that from a

1 really reportability standpoint you're not losing
2 anything with a claims-based version of this
3 measure versus an HIS based version. Go to the
4 next slide.

5 And this is looking at genes
6 variability. And the point being here is that if
7 you looked at the third, fourth and fifth boxes
8 there those are the ones, just one visit, whether
9 it's two day, three day, four day they're getting
10 pretty near the topped out range.

11 And so, from a variability standpoint
12 they may not be the best measures. The next
13 grouping of three which are visits everyday has
14 good variability, low mean there.

15 And when you get to the third grouping
16 of the visits kind of missing one day. So, if
17 it's two days, it's one and two days, two and
18 three days, three and four days, those again fall
19 in where there's good variability and at least
20 for the last two they're not in risk of being
21 topped out as of yet.

22 Go to the next slide. The next slide

1 those first two groupings are what we saw with
2 the HIS based version. What we saw essentially
3 when you looked at, if you look at the, I guess,
4 the brown is the would recommend and gray is
5 rating.

6 That you would see positive
7 correlations with Measure 1, the old Measure 1,
8 claims-based now, negative correlations with
9 Measure 2. Now, this is claims-based but again
10 they corresponded very much to what we saw with
11 HIS.

12 What we start seeing then as we kind
13 of subdivided things up again was we saw that the
14 any visits, three through five were not as good
15 as the rest, right, they were slightly lower.
16 And that it appeared that actually missing one
17 day, particularly for Measure 10 and 11 actually
18 had best correlation with family reporting of the
19 experience of care with hospice there.

20 So, it was actually slightly better
21 than even the any visit. I know there have been
22 some comments that, you know, well what happens

1 if families refuse hospice and end of life maybe
2 for a particular day.

3 Maybe that's true. Maybe actually,
4 you know, giving that option where they could
5 either, you know, have two out of three, for
6 example, rather than having to do all three,
7 maybe that does result in more satisfaction.

8 Go to the next slide. Looking at
9 reliability they're all good. They're all kind
10 of in the .8 or so range. So, reliability seems
11 to be good no matter where you look.

12 And then if you go to the next slide
13 so based on all of this what we ended up
14 proposing was a claims-based version of this
15 measure now where you get hospice visits by the
16 two services that we know correlate best with the
17 experience of care in at least two out of the
18 last three days of life.

19 And that's the measure that we're
20 bringing here for consideration by you. The
21 exclusions would be obviously those hospice
22 patients that don't expire.

1 It's still only those that receive the
2 routine home care. So, other types of hospice
3 care are excluded.

4 And again, if you're enrolled in
5 hospice for two days or less, in other words, not
6 the last three days you're also excluded. So,
7 those who have very short stays are excluded as
8 well.

9 And similarly to what I discussed in
10 the last measure is, if this measure was to be
11 proposed within our Hospice Quality Reporting
12 Program it would be proposed as a replacement for
13 the existing HIS based measure.

14 And so, we know have this claims-based
15 measure. Go to the next slide. Just to show you
16 that we've, you know, gone further and we've
17 actually done testing of this measure across
18 different characteristics particularly with
19 disparities because as we've talked about before,
20 you know, hospice benefit itself, there are, you
21 know, disparities, racial disparities that
22 obviously we're hoping improve over time.

1 We do note those here as well, that
2 those disparities do exist. Also, disparities
3 with dual eligibility. It turns out actually
4 rural hospice rates were higher than urban
5 hospice rates.

6 So, that was good news to us.
7 Obviously we wouldn't want to risk adjust away
8 these disparities. First of all, this is a
9 process measure. We wouldn't want to do risk
10 adjustment on process measure.

11 And we want these disparities to
12 improve. And so, we would not want to risk
13 adjust these away.

14 And I think that's it. T.J. is next
15 to me. T.J., do you have anything you want to
16 add before we go to, okay, so that's it.

17 CO-CHAIR MERKELZ: Thank you. Alan,
18 that was again a very thorough review for the
19 measure under consideration. Appreciate you
20 walking us through that.

21 I guess now we'll move into looking at
22 our lead discussants and any comments they have

1 regarding and then we'll start off with the
2 Society for Post-Acute Care, Raj.

3 MS. MOYER: Actually, I apologize, to
4 jump in. We are going to do the public comment
5 first so that we can react to those comments.

6 MS. PANACHAL: Nothing on the chat.

7 CO-CHAIR MERKELZ: And they're
8 listening in. A reminder they can continue to
9 type in and send a chat for us to comment on.

10 MS. MOYER: That is a good remark. At
11 any point we can take comments and we also have
12 an overarching public comment at the end of the
13 day. Anyone in the room? I apologize.

14 MEMBER MAHAJAN: There were two public
15 comments in the packet. So, I was going to just
16 try to do a quick synopsis for the second one
17 from NIHC is very long.

18 I don't know, it's kind of all over
19 the place. So, I think again, Alan, your
20 explanation really helps with a lot of questions
21 that, for the information we have in the packet.

22 But my comment/concern about two

1 visits in the last two days addresses the
2 quantity not the quality. And if checking boxes
3 of doing visits would do the trick we would all
4 be in a different place.

5 We all know that you could have one
6 true hand holding satisfying visit from whoever,
7 whatever trade could mean a whole lot then having
8 very qualified people doing a single visit every
9 three days, right, all three days.

10 So, I think it probably makes sense to
11 start with a process measure like this. But
12 somehow factor in that every year we do somehow
13 assess if it's really addressing what it's going
14 to do as in, are the patients happier?

15 And are those number increased as the
16 compliance of these visit requirements in
17 reporting is increasing? And so, I do see a fair
18 potential of people just checking boxes because
19 it becomes a reporting program.

20 That's one thing. The other thing
21 which came through the first comment was people
22 are still trying to better define imminent death

1 and how do you as a provider determine when it's
2 your last three days.

3 And I guess there is more data coming
4 through best practices and through trades to help
5 these agencies better spot those imminent death
6 times. But that still, I think, is a concern
7 where people not knowing that and having one
8 visit in the last few days but that visit itself
9 was much more impactful than having two or three.

10 So, those are the few things. You
11 cleared the thing about it's a replacement
12 because a lot of comments did mention whether
13 it's going to be added on or it's going to be a
14 replacement.

15 So, if it's a replacement then it
16 makes sense. I had one more comment on the
17 disparity numbers.

18 Those are pure percentages. I'm not
19 sure if there was statistical analysis done on
20 that to see if those were kind of statistically,
21 you know, if there was, statistically there were,
22 some of those numbers were close enough to not be

1 statistically significant.

2 So, it would be good to just, you
3 know, with all the research folks in this room to
4 see if that was there. And so, those are some of
5 the few comments I had on this.

6 CO-CHAIR MERKELZ: Very good. Thank
7 you, Raj. I'm going to switch over to the NHPCO
8 after the music interlude.

9 (Pause.)

10 CO-CHAIR MERKELZ: It's a nice little
11 happy moment. Okay, what a nice introduction for
12 the NHPCO. Lori Bishop was not able to be
13 present. Please, Raj.

14 MEMBER MAHAJAN: No, the social work
15 of the music therapist should be included.

16 CO-CHAIR MERKELZ: Perfect. Stepping
17 up and standing in for Lori Bishop we have
18 Jennifer Kennedy, Jennifer.

19 MEMBER KENNEDY: Thanks, Kurt. First
20 of all, I want to mirror everything that you just
21 said, Raj. I do have concerns about this
22 becoming a check box sort of thing.

1 And also, you know, as a nurse
2 providing hospice care for 20 out of my 37 years,
3 sometimes it can be very difficult to know even
4 with recognizing clinical and behavioral
5 indicators of imminent death it's not the same
6 for every person.

7 I think that's a consideration. I
8 think my biggest concern is that hospice is
9 interdisciplinary. We work as a team. We are
10 all working towards common goals and to just not
11 consider the contribution of all of the team I
12 don't think is prudent.

13 Many times symptoms at the end of
14 life, they vary but they are interrelated. We
15 could have clinical issues that are also tied to
16 emotional and spiritual pain issues. And they
17 all present as one.

18 So, I think it would be prudent for
19 CMS to figure out how, if we're looking at
20 quality interdisciplinary care for hospice, how
21 you can measure all of it not just two aspects of
22 the care.

1 I'm afraid if we do that we're
2 medicalizing what hospice care is and not really
3 looking at it as it was it designed to be a
4 holistic approach to end of life care.

5 CO-CHAIR MERKELZ: Thank you,
6 Jennifer. I'll now shift over to the additional
7 reviewers from the American Academy of PM&R,
8 Kurtis Hoppe.

9 MEMBER HOPPE: Thank you, first of
10 all, for allowing me to participate. In a lot of
11 ways this measure reflects a service that is so
12 profoundly importantly for patients.

13 Having been a hospice medical director
14 in a prior life as well as currently having a
15 family member in hospice, you can fully
16 understand what other commenters have brought
17 forward including the fact that this process
18 measure in some ways is kind of thin and doesn't
19 really get to the richness of the experience or
20 the necessity of these patients and caregivers
21 and the families at the end of life.

22 So, I really, I agree with most of

1 what my commenters have said. I'm wondering
2 though when we want to look at what this measure
3 really gets to, do we have other measures such as
4 the other hospice measures that look at dyspnea?

5 Is there some way that, is there some
6 correlation between that particular measure and
7 this particular measure so that there is a little
8 bit, it relieves some of the thinness of the
9 measure, of course, which is important in all
10 process measures to try to overcome and really
11 get to what we want to do in the last number of
12 days of life.

13 I also want to really reiterate the
14 hospice and I'm sorry, there was noise on the
15 line so I didn't hear the entire conversations.
16 But this really is an interdisciplinary approach.

17 And relieving some of the
18 medicalization of this through this process
19 measure is helpful. Now maybe that could also be
20 addressed by looking at the CAHPS hospice survey
21 and adding particular questions of more import --
22 to make this measure a little bit more robust.

1 Thank you.

2 CO-CHAIR MERKELZ: Thank you, Kurtis.
3 Moving to VNA, Danielle. Is she on? I have a
4 question mark here. Okay, moving on to the
5 American Occupational Therapy Panel.

6 MEMBER ROBERTS: Thank you very much
7 for the understanding of where some of the
8 implementation -- with providers in the last
9 three days of life.

10 Although I do agree with my colleagues
11 about the interdisciplinary nature of hospice.
12 And having experienced hospice with my mother
13 this year it's really important.

14 And then also trying to figure out the
15 last three days of life, I think it's much more
16 than what symptoms but is comfort achieved. And
17 that to me -- my mother went on for three weeks
18 and they thought she was dying every day.

19 So, I think it's more about keeping
20 the person comfortable. And if somehow we could
21 add that into it. And then we talked about this
22 is a Medicare fee-for-service, so also we are

1 looking at Medicare Advantage.

2 CO-CHAIR MERKELZ: I'll move now to
3 the National Partnership for Hospice Innovation,
4 John Richardson.

5 MEMBER RICHARDSON: Thank you. I just
6 want to thank Alan for the great presentation and
7 your colleagues from MAP, too. Obviously a lot
8 of analysis went into this, quantitative
9 analysis.

10 I also appreciate the history of the
11 measure and I think it's very interesting that
12 we're kind of back where you started in 2015 with
13 one measure that tries to capture the whole
14 thing. And then I wonder if that isn't where
15 this should end up in some manner of speaking.

16 I want to echo my colleague's comments
17 about the interdisciplinary care team. I do think
18 that only having an RN and social worker as a
19 component of the measure misses some of the
20 experience, at least that I've heard from our
21 members with their patients as they go through
22 hospice.

1 You never know who the patient and
2 their families are going to bond with, whether
3 it's the hospice aide or chaplain or spiritual
4 counselor or the nurse or the social worker. It
5 could be any member of the interdisciplinary care
6 team.

7 I think the timeframe should be, I
8 appreciate the research that you presented that
9 shows that the symptoms of imminent dying or
10 active dying sort of appear around three days.
11 But again, there is variability around that and
12 that the measure should take that into account
13 when you're looking at as broad a population.

14 Especially I wonder if the conditions,
15 what conditions were evaluated in that particular
16 study based on whether it be cancer patients, for
17 example, or if there was a broader array of
18 terminal conditions as there is in the Medicare
19 population. So, those are my feedback. Thanks.

20 CO-CHAIR MERKELZ: Thank you, John.
21 Any additional reviewer that I didn't have
22 listed? All right, Eugene.

1 MEMBER NUCCIO: Yes. I had several
2 questions some of which were addressed in the
3 presentation or through side conversations.

4 My first question has to do with
5 defining what a day is in that if you die at
6 12:01 a.m. that's a day. We reported that you
7 died on this particular date.

8 I am happy to hear that the measure is
9 reportable for about 80 percent of the agencies
10 using claims data. So, it doesn't appear that
11 the length of the day apparently is not a
12 problem.

13 With regard to the process measure and
14 the quality of interaction and who is involved, I
15 guess I saw this as the first step on the way to
16 a more robust measure. That right now at least
17 if the data could be believed only about 60 or 70
18 percent of agencies meet this criteria.

19 So, there is clearly even in terms of
20 process an opportunity to rank that up regardless
21 of what is being done. I am very sensitive, I
22 think many of us in the room have had recent

1 experiences with relatives who are under hospice
2 care.

3 And bonding with different members of
4 the hospice staff really does make a difference.
5 One of the things that I did question about is
6 again a more technical issue regarding the
7 exclusion says that HHAs need to discharge their
8 patients prior to the hospice care agency picking
9 up that patient.

10 And because of the responsibility of
11 the agency. And I was concerned that, it would
12 seem to me that most of hospice care occurs in
13 institutional settings such as assisted living or
14 nursing homes.

15 And I don't think the same rule
16 applies. You don't want a patient who is in a
17 nursing home being discharged to their home if
18 they do have one or to a relative.

19 And I was told that, no, that rule of
20 discharge does not apply. But that raises the
21 question if you could stratify the results
22 between patients who were residing in the

1 community with this hospice rate versus patients
2 who are in an institutional setting that might
3 also be informative in terms of knowing where we
4 need to turn the lever to improve performance.

5 So, my concern is that patients who
6 are in the community might be getting this
7 service at a lower rate than patients who are in
8 some sort of institutional setting.

9 CO-CHAIR MERKELZ: Thank you, Gene.
10 Ashish.

11 MEMBER TRIVEDI: I think Raj and
12 Jennifer pretty much captured the majority of my
13 thoughts. But one thing is that looking at the
14 path forward for this measure you think of the
15 existing measure, the new measure one thing is
16 rather than just replacing maybe combining the
17 paired measures and amending them with some of
18 the similar language because when you, it is a
19 holistic approach in terms of treating the
20 patient.

21 I don't think it's binary just nurses
22 and social workers. Seeing as, you know, from my

1 own family experience having a grandmother who
2 has gone through hospice she sought comfort with
3 her respiratory tech, wasn't a social worker or a
4 nurse.

5 So, I just think like it's a whole
6 holistic approach there. So, I think you need to
7 capture the entire team.

8 I definitely think that, you know, in
9 terms of being process measure, you know, the
10 quality versus quantity piece I think there could
11 be correlation to outcomes or even, you know,
12 patient or family experiences.

13 And I think it was already covered
14 about, the other point I had was about how do we
15 identify patients that, you know, defining
16 imminent death and the criteria. I think that
17 was already covered. But beyond that I think all
18 the other ones were captured by everybody else
19 here.

20 CO-CHAIR MERKELZ: Very good, thank
21 you. We do have a Rural response.

22 MR. SLABACH: Thank you, Kurt. Yes,

1 I think that one of the concerns of the Rural MAP
2 is obviously access to care. And this has been
3 an area of a lot of concentration.

4 And so, when you look at access it's
5 driven a lot of times by the availability of
6 personnel that would be professionals that are
7 able in rural communities to work in these
8 various programs and hospice would be definitely
9 one of those.

10 So, we see less numbers of hospice
11 agencies in rural communities. And so, often
12 patients are admitted late to hospice as a result
13 because it's difficult to find a provider who
14 will travel that far.

15 And so, often then the distance
16 becomes a problem in meeting perhaps some of the
17 metrics that would be measured under this
18 particular proposal. So, that was part of the
19 discussion.

20 The other, but I appreciated Alan's
21 presentation which we didn't get to see on the
22 call which not surprisingly to me had over 70

1 percent was meeting the metric in this particular
2 area which it leads me to believe that these
3 hospice agencies in rural communities because
4 there is less volume they may have more time and
5 availability to be able to follow through with
6 the care that's being provided in these
7 instances.

8 So, that's a good number that really
9 makes me feel better about this. The vote
10 yielded kind of a middle of the road. The vast
11 majority of the votes were, voted Number 3 which
12 is in the middle, not liking.

13 I guess it's like Goldilocks. You
14 know, it's like not too hot, not too cold. So, I
15 don't think there was passion on either side of
16 the equation on this one. So, and I hope that
17 was helpful to the discussion.

18 CO-CHAIR MERKELZ: Thank you. Do we
19 have any other comments from the chat?

20 MS. PANACHAL: No comments on the
21 chat.

22 CO-CHAIR MERKELZ: And do we have any

1 comments from the room?

2 MEMBER MANGRUM: I'd like to ask a
3 clarifying question. It seemed to me from the
4 write up that we had that you actually used one
5 item from the CAHPS survey which was the
6 percentage of caregivers who said they would
7 recommend the service.

8 Is that correct? Am I understanding
9 that correctly?

10 MR. LEVITT: Actually, we looked at it
11 across the board --

12 MEMBER MANGRUM: Okay.

13 MR. LEVITT: -- in terms of actually
14 every question, you know, a whole group of
15 questions. In other words, you look at the
16 hospice CAHPS that include like --

17 MEMBER MANGRUM: Right, there's the
18 various composites, okay.

19 MR. LEVITT: Exactly. And in every
20 single one it showed, you know, positive
21 correlation.

22 MEMBER MANGRUM: So, I think, you

1 know, one comment that I would make I think it
2 echoes something that Raj said earlier is, you
3 know, from a technical perspective you have a
4 measure that you've developed by retrospectively
5 looking at prior data, doing some statistical
6 analysis.

7 You're doing a correlation between
8 number of visits and reported caregiver
9 experience. Eighty percent can report this
10 measure already. Sixty-five, 70 percent are
11 already meeting the standard.

12 So, the question I have is, is this
13 really driving quality or are you sort of setting
14 a practice guideline here that as sort of the
15 minimum level of care that hospice should be
16 providing is this many visits by certain
17 clinicians during the last couple of days?

18 So, to me this measure cries out for
19 careful attention at the pragmatic implementation
20 period to see whether or not it affects other
21 aspects of quality that you're measuring. Do
22 those things also improve?

1 So, is this really measuring quality
2 or is it just because there's a lot of room for
3 confounding factors when you do this type of
4 development. So, would love to see CMS and other
5 support of either an actual trial or a pragmatic
6 trial with results that can be examined.

7 CO-CHAIR MERKELZ: Thank you, Rikki.
8 Gerri, want to --

9 CO-CHAIR LAMB: You know, Rikki's
10 comment helped me clarify some of the questions
11 in my mind. I appreciated that I came thinking,
12 I was very ambivalent about this measure for many
13 of the same reasons that have been mentioned.

14 Moving away from check list measures
15 and certainly the very deep belief in hospice
16 being interprofessional, you know. For goodness
17 sake, I direct an interprofessional centered
18 university.

19 I have to say that I found the testing
20 compelling, particularly in the cuts of who were
21 the providers who are associated with more
22 positive outcomes. And it concerned me that at

1 the end of life there may be processes going on
2 that we really need to look at closely as in say
3 substituting for RNs or substituting for social
4 workers.

5 I don't have answers for those
6 questions related to interprofessional. But I am
7 concerned that there are adverse outcomes with
8 certain groupings of providers that I think we
9 need to look closely at.

10 So, more speaking to ambivalence now
11 about the measure where I came here not as
12 ambivalent about my vote, now I'm more
13 ambivalent.

14 MR. LEVITT: I would be glad to
15 respond to everything when you give me a chance.

16 CO-CHAIR LAMB: Okay.

17 CO-CHAIR MERKELZ: We're almost there.
18 Debra.

19 MEMBER SALIBA: I was a little bit
20 curious about the 20 percent that weren't
21 reportable if there was sort of a systematic
22 difference between those and the 80 percent that

1 were reportable.

2 So, the particular types, groupings or
3 agencies where you saw that the measures were not
4 reportable. So, you get that 80/20 when you --

5 (Simultaneous speaking.)

6 MEMBER SALIBA: Were there any
7 patterns in terms of who was not reportable
8 because that might potentially bias that measure
9 a little bit? The other is and I should probably
10 know what's in hospice CAHPS.

11 But why not just ask families, did
12 they get the support they needed in the last
13 three days of life as opposed to checking off the
14 boxes for these people? And let's see, and just
15 one note.

16 I mean, it seemed to me like, you
17 know, the visits every day versus some of the
18 days that it was actually lower satisfaction
19 probably was more of a marker for the patients
20 who were having more stress or difficulty in
21 their last three days and therefore were needing
22 more visits as opposed, if I'm making any sense.

1 So, but I'm fine with the way you've
2 dealt with that. Two out of three is fine. But
3 just to plant that bee in your bonnet about that.

4 CO-CHAIR MERKELZ: Thank you, Debra.
5 All right. We'll give Alan an opportunity here
6 now to comment and I do want to, I can start off
7 with the questions. Do we have one more, I'm
8 sorry, did I forget a follow up?

9 MEMBER KENNEDY: Yes, actually I had
10 a question. But I don't know if you know this.
11 But what I hear talking to providers many times
12 is that their return rates are low in terms of
13 the CAHPS.

14 So, when you looked at the data from
15 the measure as it is compared to the return rate
16 did that make a difference? I mean --

17 MR. LEVITT: It's something we could
18 look at. I'm not sure whether that would affect
19 the result. I mean, the CAHPS measures are
20 valid, reliable measures that are reported on.

21 MEMBER KENNEDY: Thank you.

22 CO-CHAIR MERKELZ: All right. Thank

1 you, Jennifer. Well, I'm going to steer the
2 questions and come back over towards Raj. I'll
3 do my best to paraphrase the questions and if we
4 need further clarification to what I'm stating
5 please just jump in.

6 Raj started off and really it's been
7 echoed throughout the room regarding quantity not
8 equaling quality. He gave a general comment
9 about this.

10 But it does seem that it potentially
11 would be more towards a check box process,
12 concerns regarding quantity versus quality.

13 MR. LEVITT: Again, we are looking at
14 the types of services and not the quality of the
15 service that was provided during that particular
16 time. This is not a check box measure.

17 This is a measure that's collected on
18 claims. It's data that's already being
19 submitted. They are claims that the service is
20 already being incentivized.

21 So, hospices are already incentivized
22 to report on these two services because they'll

1 get additional payment, an add-on for it. So,
2 there's no check box here.

3 This is a claim. And there's no
4 additional collection of data that will be
5 required unlike the existing check box HIS based
6 measure which is a burdensome, which adds burden
7 to hospices that would be removed if we went to a
8 claims-based version.

9 CO-CHAIR MERKELZ: I'm going to tie
10 this to Rikki's comment where she was saying
11 that, you know, this process was and I think it
12 ties into this quantity versus quality.

13 MEMBER MAHAJAN: I just wanted to give
14 an analogy of hanging up the phone. So, in case
15 you've never seen the rotary phones so even in
16 cell phones we hang up the phone.

17 Right, so you really don't, so that
18 was figure of speech. Check box you're not
19 really checking boxes. It's you tell them we
20 need two visits in three days and they just do it
21 to do it.

22 So, the check box here is more of a

1 metaphor or a figure of speech.

2 CO-CHAIR MERKELZ: And I'll come back
3 to your other two questions, Raj, absolutely.
4 But I think it did pair well with Rikki's comment
5 regarding retrospective review that is done in
6 this question development.

7 And is this actually developing some
8 type of minimum guidelines or will it drive, is
9 it really driving back to quality or more setting
10 guidelines because generally dying is not seen as
11 a significant change in condition from the
12 hospice world.

13 That's typically how we see it from
14 GIP utilization or continuous care utilization.
15 And it does seem this is in some way setting up
16 in a guideline that it is a significant change in
17 condition.

18 I'm wondering if there was any
19 confusion there to what's being communicated.

20 MR. LEVITT: So, again we used the
21 CAHPS survey because it's our best real proxy
22 outcome that we can look at in terms of the

1 experience of the dying hospice patients since
2 obviously we can't ask them.

3 And so, we rely on those family
4 members or caregivers that are hopefully involved
5 in the care of the patient. So, that is our
6 ultimate outcome.

7 And that's why we use it. Every
8 measure that we use is based, is kind of based on
9 retrospective data. I mean, this isn't new.
10 This is just that we're using the monitoring and
11 evaluation of our measures the way we're supposed
12 to.

13 You know, we brought a measure here
14 four years ago that the Workgroup reviewed. The
15 measure was adopted in the program. And through
16 our monitoring and evaluation this is what we
17 found.

18 And so, that's why we are bringing it
19 back to you in this way. We aren't in any way,
20 I'm like Gerri. I spent my life taking, involved
21 in interdisciplinary teams.

22 I've been doing this for, you know, 35

1 years. This isn't any sort of insult to the
2 interdisciplinary process.

3 This is trying to ensure that the
4 right services are provided to a dying hospice
5 patient and that, you know, services for their
6 symptom management or in terms of the support of
7 counseling that are provided either by an RN or
8 by a social worker are provided in those last
9 days.

10 If, as I told you, an LPN is sent
11 rather than an RN or an aide is sent rather than
12 a social worker in those last three days
13 according to the data that we've collected, the
14 outcome that's the wrong thing to do.

15 It's not saying anything against all
16 the other services. It's not saying anything
17 against the interdisciplinary process. It's like
18 what should we be doing in these last three days
19 of life?

20 And what we should be doing is we
21 should be incentivizing to ensure no matter what
22 that RNs and social workers go in and see these

1 patients. We're incentivizing it by payment.

2 We're also going to measure it. What
3 happens otherwise throughout the entire hospice
4 stay and even at the end in terms of other
5 disciplines that may come in, that's not what
6 we're dealing with here.

7 But if we approach the end of life as
8 an interdisciplinary process we run the risk of
9 having the wrong people coming to see the patient
10 at the time that they need the right people
11 there. And this is what we learned.

12 Now, I go back to the first lecture I
13 ever gave as an academic attending was on the
14 effects of bed rest and deconditioning in the
15 elderly. And part of my lecture was I showed all
16 the slides of evidence from old medical
17 literature of the positive effects of bed rest
18 including after an MI, for example, the
19 cardiology techs in the 1940s said there are lots
20 of controversies but there are two absolutes, bed
21 rest and barbiturates.

22 That was the community standard at the

1 time. That's what if I went there and I said
2 don't do that because all your patients were
3 going to die of pulmonary emboli you would all be
4 looking at me saying what are you talking about,
5 we all do it this way.

6 You know, this is the way we've done
7 it. We haven't studied it. We haven't really
8 looked to see who is right at the end of life.
9 But this is the way we feel and it's an insult to
10 actually say, to ensure and make sure that these
11 services are there.

12 What I'm telling you is that's the
13 wrong way to think here. The way to think here
14 and what we need to do as a first step it's not,
15 you're absolutely right, Raj, it's not quality.

16 Right now it's quantity because that's
17 the best we can do. The best we can do right now
18 with the data sources and the tools we have is to
19 measure the visit.

20 Hopefully one day smarter people than
21 me at least will be able to figure out how to
22 bring quality into this. But right now it's

1 quantity.

2 And we have to ensure, it's beholden
3 to us to ensure that we make sure that RNs and
4 social workers are there at the end of life.
5 What happens all the other days maybe they should
6 be there too, I don't know. I don't know.

7 The reason hospice visits came up is
8 not a CMS thing. This is, you know, this was a
9 domain of interest for hospice care that predates
10 me, you know, being here sitting at the table.

11 That result that it was important to
12 have visits at the end of life. All we're
13 telling you now based on the data that luckily
14 we've collected, I mean, hospice care has been
15 going on since I graduated medical school.

16 Has anybody actually looked to see
17 what services really are important at the end of
18 life? I've been in post-acute care. Services
19 are our drug, you know, so to speak in terms of
20 what we provide post-acute care.

21 You know, this is as far as I know,
22 the first way of really looking and saying, okay,

1 what services do we really need in this one
2 particular situation. And what we're telling you
3 is that we need to have RNs and social workers
4 there.

5 Now if you find that an insult to the
6 interdisciplinary process that otherwise should
7 be there for the entire hospice stay, I
8 apologize. I can just tell you what needs to be
9 there for these patients at the end of life.

10 I can also tell you that for the
11 majority of hospice patients and for the majority
12 of hospices themselves they are somehow able to
13 identify close to the end of life, when they
14 should be ramping up services.

15 They're even incentivized now for
16 these services because if they do it CMS will pay
17 them more for it as well. Will they sometimes be
18 wrong? Of course they will.

19 Will they often be right? I hope they
20 are. Sorry, I didn't answer all the other
21 questions. But I think that was the main, you
22 know, theme.

1 CO-CHAIR MERKELZ: I'll touch on some
2 of those there. But I think this still ties in
3 and I want to bring back in Jennifer Kennedy's
4 comment regarding the interdisciplinary nature
5 which you did a very good job in expanding on.

6 But truly to the context of holistic
7 care spirituality and looking at this data
8 chaplains aren't currently listed in the claims-
9 based data.

10 So, when we're talking about the needs
11 based on the data how do we merge that concept
12 between the holistic nature and not having the
13 data for chaplains?

14 MR. LEVITT: And again, we are just
15 looking in the last three days of life. And
16 chaplains may be important throughout the entire
17 hospice stay.

18 But when it comes to these last three
19 days of life they, what the social workers
20 provide certainly appeared to be more. That's
21 nothing to say against chaplains.

22 What we're trying to do here is we're

1 trying to incentivize and make sure that no
2 matter what chaplains can still come, LPNs can
3 still come, aides can still come. We've got to
4 incentivize and measure what we know matters.

5 CO-CHAIR MERKELZ: I'm going to come
6 back to Raj's last two points for clarification
7 and again echoed by many in the room was
8 regarding the prognostication and the difficulty
9 for prognosticating the final three days.

10 MR. LEVITT: And again, I mean
11 obviously we can agree to disagree. But again,
12 evidence both from research that's been done and
13 evidence from our experts and evidence as to what
14 hospices are already doing in practice suggests
15 that for the most part it can be done. Can it
16 always be done? Obviously not.

17 CO-CHAIR MERKELZ: And finally, Raj,
18 statistical analysis reviews completed where
19 there were disparity numbers.

20 MR. LEVITT: Okay. And regarding
21 disparities again, they were just rates. And
22 what we do here is, what we really care about is

1 trends.

2 So, what we will follow in this, if
3 there's one thing you've learned from us at least
4 now it is we're going to continue to monitor and
5 evaluate these measures. That's what we do.

6 We literally, you know, we do this on
7 a regular basis. We will follow the trends of
8 those rates. We don't, you know, we haven't done
9 any statistical manipulation, anything like that.

10 But what we're hoping to see is that
11 if there are differences in the rates that are
12 there that hopefully they would decrease.

13 CO-CHAIR MERKELZ: Raj, was there
14 anything other, that pretty much encapsulates?

15 MEMBER MAHAJAN: So, I could just have
16 an operational question about claims-based
17 reporting. So, although claims are there but you
18 still have to manually report them into the
19 system or --

20 MR. LEVITT: We're not really changing
21 anything that's going on already.

22 MEMBER MAHAJAN: No, no, no. This is

1 a general question not about this particular
2 measure.

3 MR. LEVITT: In terms of us or --

4 MEMBER MAHAJAN: For example, if you
5 are a QRP program and your penalty is not to
6 report. And if the only measures there are
7 claims-based which are already there, so is there
8 on top of them being available for everybody, do
9 they still have to manually report them into the
10 system and if they don't report then they get
11 penalty versus --

12 MR. LEVITT: Okay. You know, claims-
13 based is interesting because obviously the part
14 about all health programs.

15 And again, in reality when we actually
16 look and determine compliance or non-compliance
17 we're really looking at the assessments that are
18 completed or in the case of somewhere around the
19 post-acute care programs the submission of NHS
20 data to the CDC.

21 MEMBER MAHAJAN: Right.

22 MR. LEVITT: So, although they are

1 required to report they are already reporting
2 because otherwise they won't get paid. I mean,
3 we're just using the claims that otherwise we're
4 submitting for payment.

5 CO-CHAIR MERKELZ: Kurtis, question
6 from the American Academy of PM&R. What's really
7 tying the measure towards outcomes? Is there a
8 correlation between patient outcomes in the
9 measure?

10 For instance, he said dyspnea. Pam
11 also commented regarding is comfort achieved.
12 So, is there a comment from you regarding the
13 correlation between outcomes and the measure?

14 MR. LEVITT: Well, the only outcomes
15 that we're looking at right now are the
16 experience that the hospice patient had. They
17 are broken down.

18 You know, part of that CAHPS measure
19 is regarding some of the symptom management that
20 was done or the symptoms that the individual
21 patient had. We are, as some of you know and
22 actually are helping us, we are in the process of

1 developing an assessment instrument for hospice
2 patients.

3 One of our goals of that is to include
4 assessment of symptoms within that instrument so
5 that we could develop and build assessment based
6 measures in that way so we could look better at
7 symptomatic. So, that's a goal of ours.

8 But right now this is the best we can
9 do in terms of looking at that sort of, these
10 sorts of outcomes.

11 CO-CHAIR MERKELZ: And Pamela
12 regarding Medicare Advantage data.

13 MR. LEVITT: And again, because this
14 is a process based measure last year we had a
15 very good discussion which has had us really
16 rethinking some of the claims-based outcome
17 measure development within hospice because
18 Medicare Advantage patients even if they are fee-
19 for-service during the hospice time you needed to
20 be, for risk adjustment you needed it to be 12
21 months before which we didn't have.

22 Medicare Advantage patients are

1 included in this measure. This is a process
2 measure based on the fee-for-service claim that
3 comes in. So, they are actually in this measure.

4 CO-CHAIR MERKELZ: Gene raised a
5 question regarding the day, what is a day as it's
6 being defined in the measure?

7 MR. LEVITT: Again, we use again the
8 definitions that are used for the filing of the
9 claim.

10 One of the things that we did notice
11 because like I was telling you one of the nice
12 things, one of the things I felt very good about
13 was the fact that I saw the hospices in terms of
14 level of service of all the different disciplines
15 went up, up, up, you know, the last really two,
16 three days of life.

17 What we did see for certain
18 disciplines was that last day it actually went
19 down because they probably didn't have time to
20 come in. And so, there probably is some affect
21 being the fact that it isn't a full day.

22 You know, we're talking about the

1 number of hours that they have there that the
2 hospice may have alive. But again, that's
3 counted as a death.

4 CO-CHAIR MERKELZ: And for
5 clarification, the day starts at 12:01, 12:00
6 a.m. So, if the patient dies at 1 o'clock in the
7 morning it's the second day of service?

8 MR. LEVITT: Correct.

9 CO-CHAIR MERKELZ: So, they wouldn't
10 get the visit intensity. Third day of death a
11 death visit doesn't count towards the measure.
12 It doesn't count as an RN visit.

13 MR. LEVITT: And again, that's
14 included because it is again the two out of
15 three. And you're, where are we going with this?
16 Well, maybe what we'll see is the percentages
17 will hopefully go up even better than they are
18 already.

19 And so, that way hospice patients near
20 the end of life are actually getting more of the
21 services they deserve to get. Maybe one day I'll
22 be back here talking about doing a three out of

1 three measure to come and then we can have the
2 same exact conversation again for the three out
3 of three measure because that's what we do.

4 We do this monitoring and evaluation.
5 We're going to continue to look at the data.
6 We're going to continue to help to decide what's
7 the best course to take here with your help.

8 CO-CHAIR MERKELZ: And, Gene, I want
9 to make sure I get your comment right regarding
10 the potential for service, community based
11 patients getting services at a lower rate as home
12 health is required to discharge the patient prior
13 to the patient coming onto hospice.

14 And it's not, application isn't still
15 seen in the nursing homes. So, might there be a
16 lower rate?

17 MEMBER NUCCIO: My question is, did
18 you do just a stratification based on patients
19 who were in an institutional setting versus
20 community setting? And if so, does it really
21 show a difference in rates?

22 MR. LEVITT: And to that, I go to T.J.

1 MR. CHRISTIAN: Yes, we did actually.
2 So, I'm just looking at the numbers quickly. It
3 looks like people in the home are doing a little
4 bit better than in the nursing facilities.

5 So, in the, among people in the home,
6 in their own home about 68 percent of people
7 achieved the measure. In the nursing facilities
8 it's down around like 60 percent.

9 MEMBER NUCCIO: Sixty?

10 MR. CHRISTIAN: 6-0 percent.

11 MEMBER NUCCIO: 6-0.

12 MR. CHRISTIAN: Yes. So, they have a
13 little lower in the facilities. Assisted living
14 is kind of more up kind of comparable to
15 patient's own home, a little higher.

16 MEMBER NUCCIO: Okay, thank you.

17 CO-CHAIR MERKELZ: Ashish, I think
18 already addressed some of the comments regarding
19 the CAHPS. But just, you were asking regarding
20 correlation with patient and family experience.

21 MEMBER SALIBA: I think what I was
22 trying to ask was more why not just ask the

1 patients and families about the last three days
2 of experience especially given these concerns
3 about what's the right mix and how do we get the
4 right mix and having a lot of RN -- I agree the
5 substitution is probably the right answer for the
6 LPN versus the RN thing. But, you know --

7 MR. LEVITT: And again, we're using,
8 you know, I always say you can only bake the
9 cookies with the ingredients you have in the
10 pantry.

11 MEMBER SALIBA: Right.

12 MR. LEVITT: And we luckily have the
13 hospice CAHPS survey which has been validated,
14 which is reliable which we luckily have adopted
15 in our program. Could there be other ways we
16 could look at it in terms of other types of
17 outcomes, perhaps.

18 But we have already this available
19 data source that, you know, it's a good data.

20 CO-CHAIR MERKELZ: I'm going to
21 continue then on with you, Debra, regarding any
22 patterns among the groups that were not

1 reportable if that was looked at and is there any
2 understanding among the 20 percent that was not
3 reportable.

4 MR. LEVITT: And again, ones that
5 would be not reportable would either have too low
6 an amount or almost no amount. I'm not sure if
7 we settle them together, if we look at say
8 whether or not, what the rates were of the non-
9 reporters together as a group versus that.

10 MR. CHRISTIAN: Yes. No, I mean
11 basically as Alan said, it would be the smallest
12 hospices that would be the ones we didn't have
13 data for. They might be shown in the CAHPS
14 hospices as well would be more likely to have
15 data to validate.

16 So, just kind of go along with just
17 smaller providers would be the, what we were
18 going to have. We may want to have a formal look
19 at that, yes.

20 MEMBER SALIBA: I just wanted to know
21 if it's systematic and if it is systematic what's
22 driving the systematic?

1 MR. LEVITT: Did we look at by hospice
2 size, the results?

3 MR. CHRISTIAN: Yes, we would have
4 left out the really small ones.

5 MR. LEVITT: Right. But it would give
6 a trend in terms of where the ones that were 20
7 to 50, for example at a lower rate than 200 to
8 500.

9 MR. CHRISTIAN: Yes, it's not, this is
10 kind of the medium ones is a little bit of a
11 lower rate. So, one of the highest hospices, the
12 more populous hospices there's a higher rate of
13 these. But, yes.

14 MR. LEVITT: It's something, it can be
15 part of our monitoring and evaluation.

16 MEMBER SALIBA: It was a friendly
17 suggestion.

18 MR. LEVITT: No, no.

19 CO-CHAIR MERKELZ: And finally from
20 Brock representing Rural questions regarding
21 access to care and availability of personnel,
22 some concerns regarding potentially also the

1 distance can become a problem in meeting the
2 measure.

3 Certainly you showed us about over 70
4 percent meeting in the data shown. But certainly
5 a concern over the availability of personnel in
6 rural areas and I think the same availability
7 carries over into even urban markets as well with
8 many places only having seen social workers
9 ability to provide seven day coverage would be a
10 concern.

11 MR. LEVITT: And again, we'll continue
12 to monitor that. We, regarding social workers,
13 for example, seven day coverage we don't say it
14 has to be one and one or two and two or whatever.

15 However it's done, it's done. But
16 certainly as I've said before we are sensitive
17 to, you know, continuing to follow rural versus
18 urban statistics including that as part of our
19 monitoring and evaluation.

20 If we did, you know, decide to adopt
21 this measure and ended up coming back with a
22 three out of three, it would be something again

1 that we would need to discuss with you especially
2 if like you are considering is true.

3 CO-CHAIR MERKELZ: Did we have any
4 other questions that came in over chat?
5 Jennifer.

6 MEMBER KENNEDY: I just, just for
7 future thinking, you know, if I were a patient
8 and I was told this is the time for hospice care
9 from a transparency standpoint if I'm referred to
10 go hospice shopping on Hospice Compare and I was
11 told that hospice is holistic, it's going to be a
12 nurse and physician, a social worker, spiritual
13 care counselor and I log on and all I see is
14 nursing and social work and I don't see anything
15 else that tells me about this hospice and their
16 ability to provide a full cadre of services and
17 what hospice is, I just want you to consider that
18 moving forward because I don't think it
19 represents -- and I hear what you're saying about
20 interdisciplinary.

21 I do. But I don't think from a
22 transparency standpoint it doesn't represent the

1 experience in the whole complement of services
2 that are provided to a patient no matter when
3 they come on to hospice service.

4 MR. LEVITT: We are, as we always do
5 we're going to need help with messaging for any
6 measures that we publicly report. But again, it
7 should be publicly reported.

8 This is kind of like the ICU of
9 hospice, those last three days. And that, you
10 know, those last three days you get the right
11 services in.

12 And so, that's the point is that the
13 hospice may, you know, is, hopefully is the model
14 for interdisciplinary care. But when we know
15 that we need to pull in the right people we pull
16 them in. We'll need help with that message.

17 MEMBER KENNEDY: Thanks.

18 MEMBER MANGRUM: I just want to make
19 sort of a follow up comment. And the reason that
20 I asked the question that I did about whether you
21 had used a single item or had looked at all of
22 the composites is that those composites in the

1 CAHPS measure really get at some of these issues
2 that you're raising because one of the big
3 composites I believe is around, you know,
4 effective communication in the care team.

5 So, already there you have caregivers
6 assessing whether or not there was communication
7 and they were receiving the services that they
8 want.

9 So, I am greatly reassured by hearing
10 that, you know, when you look at this proposed
11 measure that you're seeing a correlation between
12 that number of visits and all of these different
13 things that caregivers are being asked to assess
14 about hospice.

15 You know, I'm also glad to hear, you
16 know, continued monitoring goes on because there
17 can always be these sort of unintended effects.
18 And, you know, this is sort of a de facto
19 standard that you're setting.

20 These are the services that people
21 should receive in the couple of days of life.
22 But in the theory of standardization there is

1 this odd thing that happens where sometimes the
2 maximum becomes the minimum and the minimum
3 becomes the maximum.

4 So, if you think about speed limit we
5 set a speed limit of 65. Well suddenly that's
6 not the minimum speed everybody travels. So,
7 that could be one impact.

8 You know, minimum wage it's the
9 opposite. You set the minimum wage and suddenly
10 it becomes kind of the maximum that anybody
11 offers.

12 So, when you set a de facto standard
13 like this you kind of need to watch to see how
14 does it behave when it gets into the hands of
15 humans. Does it become that, you know, hospices
16 are suddenly only providing these services in the
17 last couple days of life and sort of saying we
18 don't need to bring in chaplains and we don't
19 need to do that?

20 If that happens that's something that
21 has to be addressed. But you can't say based on
22 the measure and the testing that you've done that

1 will or will not happen. You have to just
2 observe and respond.

3 MR. LEVITT: Rikki, you're absolutely
4 right. Unfortunately, there are unintended
5 consequences to everything that we do here
6 whether it's on a quality standpoint or from a
7 payment standpoint.

8 As a reminder, those unintended
9 consequences are already here because payment is
10 already incentivized a social work and RN coming
11 in. So, they are already incentivizing it which
12 as an unintended consequence could deincentivize
13 other services that may actually be necessary for
14 that individual hospice patient.

15 That is true. And it is something we
16 have to continue to monitor. One of the things
17 we'll continue to monitor is like we've done is
18 the frequency of the types of services that
19 hospices are providing.

20 I mean certainly if we see a dramatic
21 shift, for example, and suddenly no aides are
22 coming in even a week or two weeks prior to that,

1 that would be a concern.

2 So, again in other words there has
3 been such a shift that maybe we have over-
4 incentivized one piece for one particular part of
5 the stay and the unintended consequence has been
6 that the patient is no longer getting services
7 when they could have really used those services
8 at the other part.

9 The key is monitoring. I mean, you
10 know, it's not, you know, putting your head in
11 the sand. And also coming here and admitting
12 when something real, came here thinking we were
13 doing the right thing with Measure 2.

14 And guess what, we weren't. And
15 that's part of quality, part of all of our
16 universe here, you know, whether we're inside CMS
17 or outside world is we should be monitoring
18 everything we do and when we find that something
19 is wrong we don't ignore it, we fix it.

20 We continue to look from there.
21 That's what we continue to do.

22 CO-CHAIR MERKELZ: At this time I

1 guess I'll turn it back to Amy looking at voting
2 considerations for MUC2019-33.

3 MS. MOYER: So, we had a robust
4 discussion around this measure. Just briefly
5 from the preliminary analysis because I'm not
6 sure we add anything to this discussion by
7 reviewing it, I do want to talk about the staff
8 recommendation which was conditional support for
9 rulemaking.

10 And there are actually two conditions.
11 Only one is listed in the discussion guide. One
12 was removal of the existing measure so there is
13 not the duplication in the program which CMS has
14 already indicated they are doing.

15 The other is NQF review and
16 endorsement, our standard. So, with that any
17 questions on that as the starting point? I think
18 we are ready to open for voting.

19 If anyone has issues with voting
20 please raise your hand or let us know because we
21 do want to make sure that we get everyone's vote
22 accounted for.

1 MR. HIRSCH: Voting for MUC2019-33
2 Hospice Visits in the Last Days of Life. I do
3 support the preliminary analysis of the Workgroup
4 recommendation.

5 Again, the preliminary analysis was
6 conditional support. Your options are yes or no.
7 Voting is now open.

8 Voting for MUC2019-33 Hospice Visits
9 in the Last Days of Life for supporting the
10 preliminary analysis Workgroup recommendation is
11 now closed. Nine votes for yes, six votes for
12 no.

13 (Simultaneous speaking.)

14 MR. HIRSCH: So, the Workgroup has
15 elected to take the preliminary analysis
16 recommendation of conditional support.

17 MS. MOYER: I think it is time for a
18 break. We'll reconvene in 15 minutes.

19 (Whereupon, the above-entitled matter
20 went off the record at 2:05 p.m. and resumed at
21 2:23 p.m.)

22 CO-CHAIR LAMB: We're going to move

1 into the strategic considerations discussion.
2 And two things Kurt and I would like to do to
3 introduce this. One is to tell you about how
4 excited we are to have this time to do this
5 together. The other is just some suggestions
6 about launching the discussion.

7 So first off, we have been, Kurt and
8 I, have been talking with Amy and Janaki and
9 Jordan about having a robust discussion about
10 what are the gaps in post-acute long term care,
11 where are areas that are priorities for
12 alignment?

13 And for those of you who have been
14 around this table for a number of years, you
15 know, usually we have a lot of measures. And by
16 the time we get to make recommendations, people
17 are tired and they're just kind of, do this, do
18 this, do this, do this.

19 So we were wanting, and here's our
20 hope, is that if we can talk with focus for an
21 hour about where should we be going, what's
22 important in post-acute long term care to

1 measure. I mean, just look at the wealth of
2 expertise around this room. An hour of focus? We
3 will be thrilled to pieces. So we're just -- just
4 so pleased to have this hour together to do this.
5 What we're going to suggest is a couple of
6 things. With Amy and Janaki and Jordan's
7 assistance, is where we thought we might start
8 this discussion -- and we're certainly open to
9 your recommendations -- is to start with two
10 things.

11 One is CMS's Meaningful Measurement
12 2.0 just to kind of do a reminder of what are
13 CMS' priorities; what are the new priority areas?
14 And then what we'd like to do is show you what
15 are the leverage opportunities that we, as a
16 group, in post-acute long term care identified
17 last year and start from there.

18 This is an open dialog. Anything that
19 you want to recommended is on the table. So how
20 does that sound, if we just do a quick reminder
21 of CMS 2.0 and then look at our own leverage
22 opportunities?

1 For those of you who looked at the
2 different post-acute long term care programs, if
3 you had a chance to look at where do we have
4 measures in some key areas, where there are gaps,
5 that might be something to bring up. Okay?

6 Like, for instance, in, with my other
7 hat in patient experience, care coordination and
8 function, what I mentioned before is in that
9 committee, we have several function measures
10 coming forward.

11 We have very few patient experience
12 and care coordination measures coming forward. So
13 with your expertise, to identify where do we have
14 gaps, where might we make recommendations,
15 particularly as we have our CMS colleagues here,
16 measure developers here.

17 So how does that sound as a starting
18 place? Is that good? Anybody want to add anything
19 to it that they would like to kind of bring into
20 this? Okay. Could we bring those slides up?

21 MS. SCHREIBER: Can I just make one
22 comment, if I may?

1 CO-CHAIR LAMB: Sure.

2 MS. SCHREIBER: I'm sure there will
3 be, really, lots and lots good ideas. I have no
4 doubt about that. But I'd also ask us to think
5 about the prioritization of those ideas so that
6 we have some directionality of what really most
7 important because we're never going to accomplish
8 them all.

9 CO-CHAIR LAMB: Well, that certainly
10 sets limits on our conversation. Obviously, we
11 can't brainstorm everything.

12 All right, so you all heard Michelle's
13 request that we also say what's most important.
14 Okay, so here are the questions that we are
15 posing to each other. What are important quality
16 concepts? Does everybody have this in front of
17 them on the table? So you have this.

18 MS. MOYER: There is a separate
19 printout of this because we may bring some
20 different things on the screen throughout the
21 discussion. But we wanted you to have the
22 questions handy. So it's in your stack of handout

1 materials.

2 CO-CHAIR LAMB: Okay, it's labeled as
3 discussion questions. It's under your pile of
4 materials.

5 MS. MOYER: And for people on the
6 phone, this is in the slide deck for the new
7 team, Slide Number 48 of the personal slides.

8 CO-CHAIR LAMB: Okay. So what we're
9 going to be looking at is quality concepts, gaps,
10 alignment across our post-acute long term care
11 settings and priorities. Okay?

12 All right, you want to put up the
13 meaningful measures? I think it's Slide 19 that
14 we were looking at earlier today. And then if we
15 could go back to Slide 15. So let me -- yeah.
16 No, that our leverage -- this is CMS' meaningful
17 measure areas. 19.

18 All right. And you should be able to
19 see it at some around the room. We're not
20 memorizing this, but just to go -- these are six
21 core concept areas that you just want to get in
22 your head: communication, coordination,

1 prevention, treatment, chronic illness, chronic
2 disease, communities and healthy living, make
3 care affordable, safer and patient and family or
4 person and family engagement.

5 And communication, coordination,
6 chronic disease, community and healthy living,
7 affordability, safety and patient engagement.

8 And by all means, you jump in anywhere
9 you see fit because this is a collaborative
10 activity. If you would go back now to Slide 16?

11 Okay, and these are the priorities
12 that Michelle and Reena and Alan spoke about,
13 which is patient reported outcomes, the
14 electronic clinical quality measures.

15 This is just again, to remind us what
16 does CMS put priority on. Doesn't mean we have to
17 align with that. This is our discussion. Opioids
18 and avoidance of harm, nursing home infections,
19 maternal mortality and I can't read that -- oh,
20 sepsis.

21 MS. MOYER: Sepsis.

22 CO-CHAIR LAMB: Okay. Does anybody

1 need to review either of those? This is just sort
2 of a reminder about what CMS says is their
3 priority areas.

4 MR. MAHAJAN: Gerri, I would just add
5 cost.

6 MEMBER HOPPE: I mean, I'm on the
7 phone. I just had a question about why sepsis
8 was removed from my category of nursing home
9 infections. Is this meant to be the entire PAC
10 continuum? And what do CMS or others think about
11 sepsis? Obviously, they think it's appropriately
12 recognized and treated.

13 CO-CHAIR LAMB: I think the question
14 is why is sepsis a separate category of priority
15 categories from nursing home infections?

16 MEMBER DUSEJA: Because of cost of
17 care to continuing to -- yeah, so --

18 MEMBER HOPPE: Not just the cost of
19 care.

20 MEMBER DUSEJA: -- every hospital --
21 well, we had some measures in the hospital
22 setting and they were off, so it wouldn't be to

1 post-acute care.

2 CO-CHAIR LAMB: So this is across the
3 continuum and this is across settings?

4 MS. SCHREIBER: Plus, for us, we
5 actually view sepsis in a somewhat different
6 category with different measure than infections.
7 Infections is usually, you know, it's reported
8 through NHSN CLABSI CAUTI, and sepsis is actually
9 a distinctly different measure and almost
10 process.

11 CO-CHAIR LAMB: Does that answer your
12 question? Who was that, Dheeraj?

13 MR. MAHAJAN: That was Kurt.

14 MEMBER HOPPE: It does. To the
15 clinician, the infection, certainly in multiple
16 areas of post-acute care can be problematic. And
17 I agree that in a skilled nursing facility, that
18 it tends to go outside of the hospital setting,
19 sepsis can be a profoundly important issue to
20 recognize.

21 CO-CHAIR LAMB: Good question.

22 MEMBER HOPPE: But I was just

1 wondering if there was an answer, if there have
2 been a separate issue with sepsis.

3 CO-CHAIR LAMB: Thank you. Thanks for
4 the question. Okay, if you would put up now our
5 leverage opportunities. These are the ones that
6 our group identified last year as priorities for
7 post-acute long term care.

8 MS. SCHREIBER: And for those of you
9 who are on the phone and can see a computer -- I
10 know some of you may be driving now -- this is
11 Slide 14 from the orientation webinar. Public
12 Deck Quality Forum deck for it, I want to say.

13 MS. PANACHAL: And if you're on the
14 Web platform, I can share the link as well for --
15 with us.

16 CO-CHAIR LAMB: And for those of you
17 who have limited vision like me, I'm going to
18 have to stand right up close to that.

19 The key areas, if you remember those
20 six areas for CMS Meaningful Measures 2.0, we
21 also identified six areas. In my view, some of
22 them overlap with CMS priorities. Some do not.

1 So what you have in front of you is --
2 oh, thank you, Amy -- is function. If you want a
3 jot these down, because this is where we said we
4 wanted to encourage the CMS to put energy --
5 function, and the core concept is functional and
6 cognitive status and mental health.

7 Next one was goal attainment, and it's
8 the achievement of patient family caregiver goals
9 and advanced care planning and treatment.

10 Next one is patient and family
11 engagement, experience of care, shared decision
12 making, patient and family education.

13 Next one is care coordination:
14 transitions of care transits, transmission of
15 information.

16 Safety -- so there's seven of them --
17 safety: falls, pressure ulcers, adverse drug
18 events, cost and access, inappropriate medicine
19 used, infection rates, avoidable admissions.

20 And then finally, quality of life:
21 symptom management, social determinants of
22 health, autonomy and control and access to lower

1 levels of care.

2 So we had recommended one, two, three,
3 four, five, six -- seven core concepts with some
4 similar measures to what CMS has set as a
5 priority and some different. So here is an
6 opportunity to look at what do you believe is
7 important.

8 You're representing organizations also
9 as content experts. Where should we be heading?
10 Is there any other information you would like
11 before we just launch into a discussion?

12 MS. SCHREIBER: Can I ask a question?

13 CO-CHAIR LAMB: Of course.

14 MS. SCHREIBER: Can you just explain
15 to me a little bit how goal attainment is maybe
16 different than quality of life? Goal attainment
17 wouldn't be something in quality of life? Or I
18 just don't understand the difference.

19 CO-CHAIR LAMB: Does anybody remember
20 the discussion? My thought on that was that it
21 was such a dominant part of the conversation, we
22 wanted it separated out specifically in terms of

1 goal setting with patients and patient
2 involvement.

3 And it could also be part of patient
4 and family engagement. So I don't know that it
5 was as clean cut as you're thinking, Michelle.

6 MS. SCHREIBER: Okay.

7 CO-CHAIR LAMB: Does anybody remember
8 any different?

9 MEMBER SALIBA: I think Michelle
10 raises an important question. I think the
11 difference is typically, then, that most of the
12 quality of life surveys are just getting at our
13 assumption of what constitutes your quality of
14 life, right, so being for your pain, not being
15 short of breath, you know, being able to spend
16 time with family and friends.

17 But whereas the other would be you set
18 the priority. You set the goal. And then it's
19 measured. It's sort of a traditional difference,
20 but, clearly, you can't have quality of life
21 without your own priorities being met, so.

22 MR. STOLPE: I guess that this was --

1 is dated 2012. I'd be surprised if anyone --

2 CO-CHAIR LAMB: Oh, actually it is
3 though.

4 MR. STOLPE: -- in the room can
5 remember exactly what the intent was. But in our
6 person-centered planning committee, we spent
7 quite a bit of time talking about patient family
8 caregiver goals, particularly to the relevance to
9 back LTC settings with the idea being that
10 person-centered planning is not just about the
11 health and safety of the patient, but to take
12 into account a variety of things related to the
13 care that they receive, which may include goals
14 that are entirely separate from what the
15 patient's medical goals may be and that this is a
16 necessary element of their care.

17 So just not --

18 CO-CHAIR LAMB: Thanks.

19 MR. STOLPE: -- not strictly focusing
20 on quality of life per se, but getting more
21 granular as to what the needs and desires,
22 preferences of the patient actually are.

1 MS. MOYER: Ms. Lamb, this slide is
2 not available to the work group, right? Or -- we
3 didn't see it in our materials.

4 CO-CHAIR LAMB: It was part of our
5 orientation seminar.

6 MS. MOYER: Okay.

7 MR. STOLPE: So it is available.

8 CO-CHAIR LAMB: It is available.

9 MR. STOLPE: It's just a separate
10 presentation.

11 MS. MOYER: Got it. Okay, just note
12 --

13 CO-CHAIR LAMB: But as Sam is pointing
14 out, it's old.

15 MR. STOLPE: Old, right.

16 CO-CHAIR LAMB: So if your pleasure is
17 such that, even where we are today, you see
18 adjustments, go for it. So who wants to start the
19 dialog? What do you see as important gaps that we
20 need to address in post-acute long term care?

21 PARTICIPANT: Hi. This is Marie
22 (phonetic), and I'm Acting Long Term Care

1 Coordinator at CMS.

2 And what you've already met, then, as
3 far as patient engagement, coordination care,
4 safety, we also are looking -- we'd like to see a
5 gap or address the gap of nutrition. That tends
6 to come up a lot in the industry to have that
7 within our purview of what we are looking for.

8 And then also fragility is come up
9 with frailty among the patient population. There
10 are two other areas that we see some gaps in as
11 well as the sepsis that's already been mentioned.

12 I think some of these fit into some
13 the other categories that you mentioned. And as
14 far as patient goals, we do have some of that
15 already captured in a function measure. But it's
16 not patient driven. It's more about clinician
17 driven of what the patient can do as opposed to
18 what the patient probably would like to do.

19 But those things could be married up
20 moving forward.

21 CO-CHAIR LAMB: Brock?

22 MR. SLABACH: Thank you. One of the

1 concerns of the Rural MAP -- and we've talked and
2 I mentioned it earlier -- is access to care. And
3 looking at metrics that -- let's start to get a
4 handle on the costs of not having care or the
5 costs of inaccessible care in an area or a
6 community.

7 I'm looking at the cost access line,
8 the second from the bottom, and I'm not --
9 neither of those core major concepts really
10 address the issue of access. It's mostly cost.

11 And when I look at states like South
12 Dakota, where there's been in one fell swoop,
13 nine nursing home closures, all in rural
14 communities, those create real voids that are
15 hard to measure. And the impact of that is really
16 significant.

17 So I don't have any suggestions in
18 terms of measures. This could be measure
19 development, but I think it's an important
20 conversation in terms of going forward.

21 CO-CHAIR LAMB: Raj?

22 MEMBER MAHAJAN: I just wanted to --

1 I mean, I definitely think the care coordination
2 piece is really important. And from experience,
3 really a lot hinges on information getting
4 transferred more electronically than papers.

5 And since interoperability has been
6 such a high on the CMS list when it comes to the
7 position QPP that the whole meaningful use has
8 been renamed as promoting interoperability, I
9 would definitely like for CMS to look into having
10 a proper interoperability-related measure in a
11 cross-setting.

12 CO-CHAIR LAMB: Rikki?

13 MEMBER MANGRUM: Following up on
14 something that Brock just referred to, and I come
15 from a state where there are also these sort of
16 deserts of care. It's not just for nursing homes
17 but even for hospitals.

18 And so I think it's-- it was nice to
19 be reminded that this is old because I feel like
20 we've started to do more synthetic thinking about
21 how these things are interrelated.

22 So when I think of access, I come now

1 to think more and more about how far are people
2 having to travel for care. So that has a lot of
3 knock-on effects. It can affect quality of life
4 by limiting visitation from families and friends.

5 It affects care coordination if you
6 have to no longer receive care from your
7 preferred provider who may have been your doctor
8 for decades. And it can also lead to sort of
9 dropped balls in terms of even knowing what the
10 patient and family's goals were, let alone being
11 able to attain them.

12 So, to me, that's sort of a very
13 simple way of measuring things. It's used for
14 other types of care. But I've not seen it used
15 much in post-acute and long term care, sort of
16 good looking at those population statistics of,
17 you know, how many counties are more than a
18 hundred miles or 50 miles or whatever we might
19 want to say is it is too far from a SNF or a
20 nursing home.

21 There's been other discussion of it in
22 terms of how far do providers have to travel for

1 care and how does that impact all of these
2 categories.

3 CO-CHAIR LAMB: Heather?

4 MEMBER SMITH: I would just like to go
5 on the record to say that I support Raj's
6 suggestions. I'd like to see us really think
7 about a measure around interoperability and care
8 transitions. There's a lot of transitions that
9 happen throughout this and, you know, between
10 acute care and post-acute care settings as well.

11 The other thing I would mention -- and
12 I know we've talked about it quite a bit --
13 talked about it a little bit earlier today and
14 then, you know, in previous discussions over the
15 past couple of years -- patient reported outcomes
16 for these settings, I think are really critically
17 important to bring the voice of the patient in.

18 And although this probably falls
19 beyond the realm of this group in particular, I
20 would really like to see us think about function
21 as it relates to what is going on as they're
22 transitioning out of acute care into post-acute

1 care, especially as we're starting to think about
2 getting patients to the right level of care as
3 they transition through these settings.

4 And all of the changes that are going
5 on across the post-acute care continuum right now
6 with payment policy changes and just structural
7 changes as we move to, potentially going towards
8 a unified payment structure, really thinking
9 about level of function for those patients that
10 are coming out of acute care and how that should
11 drive appropriate level of care at the next
12 setting.

13 So I realize that's probably a little
14 bit beyond this because we're focusing on post-
15 acute care, but I do think it's really important
16 to start to connect these dots a little bit more.

17 CO-CHAIR LAMB: I'd like to add
18 something to Heather's, which is I was looking at
19 kind of the lists that we get of our post-acute
20 long term care settings, trying to look at where
21 we're -- where do we have similar measures across
22 settings.

1 And one place that we do have some
2 similar measures is the function -- exactly what
3 you're saying, Heather -- but not all the same.

4 MEMBER SMITH: Right.

5 CO-CHAIR LAMB: So that may be a low
6 hanging fruit one. And in looking at -- in some
7 of them, we have things like mobility and
8 ambulation and so forth. But there are some
9 similarities there, that we might look at, moving
10 them across all the settings.

11 MEMBER SMITH: I mean, I know that
12 that was discussed in the IMPACT Act as well, and
13 so I just wanted to bring that up.

14 CO-CHAIR LAMB: Yeah, because that's
15 one for alignment.

16 MS. SCHREIBER: Can I just add a
17 little bit to the alignment? So you're talking
18 about aligning across post-acute care, but I'd
19 also like us to be thinking about aligning across
20 the continuum of care.

21 So are there post-acute measures that
22 should be in the hospital and vice versa -- or in

1 the ambulatory setting or what have you? You
2 catch the drift, is how do we know this across
3 the community.

4 CO-CHAIR LAMB: Absolutely.

5 MR. STOLPE: Maybe in the long-term --

6 MEMBER HOPPE: This is Kurt Hoppe. I
7 have a question about -- well, I'd like to see a
8 more robust discussion of where we're all going
9 with social determinants.

10 Because I think that that's a very
11 rich area for a lot of research and a lot of
12 discussion. I would like to see those social
13 determinants of health to be sketched out in a
14 broader perspective as well, probably get a lot
15 more granular than we have now, and what effects
16 that would have upon access and care provision
17 across the entire post-acute care continuum as
18 well as transition from acute care.

19 And I think that there's -- there are
20 some avenues that providers may be able to
21 address some of the issues that delay discharge
22 or do not lead to outcomes that we all desire for

1 these patients.

2 But I think it really needs to have a
3 lot more work before it's probably foisted on the
4 provider community.

5 CO-CHAIR LAMB: Does anybody want to
6 speak to social determinants?

7 MS. SCHREIBER: Actually, can I just
8 speak for a second?

9 CO-CHAIR LAMB: Sure.

10 MS. SCHREIBER: I think your last
11 point, that it needs more work before we foist it
12 on people is really important because frankly, we
13 are doing a lot of work within CMS.

14 ASPE is looking at social
15 determinants. Actually, probably every group I
16 know is looking at social determinants. And the
17 issues are several.

18 Number one, there isn't consensus
19 about what you look at and what you measure. Is
20 it just dual status? Is it, you know, census
21 data? Is it an area deprivation index? Is it
22 food, transportation, literacy? I mean, you know,

1 the list goes on and on. And so I think that's
2 one issue.

3 And then the second issue is there is
4 a real philosophic disagreement in the quality
5 community about what you do with that, because
6 there's a group who says you don't just because
7 you're really creating a two-tiered level of
8 care.

9 You're giving a buy, for
10 example, if you adjust for this and then there's,
11 of course, another group that says, no, you must.
12 So I think some of these, A, operational and, B,
13 philosophic issues almost need to be settled.

14 And then I don't -- I'm not proposing
15 that we even have an answer. But I think there's
16 a lot of work and it is ongoing. But I think it
17 needs to be settled a little bit more first.

18 MEMBER NUCCIO: If I could jump in --

19 CO-CHAIR LAMB: Sure, go ahead.

20 MEMBER NUCCIO: Thank you. I'll take
21 part of the blame for social determinants, so --

22 CO-CHAIR LAMB: All right.

MEMBER NUCCIO: So given those in NQF

1 that foisted that on the system, NQF does have a
2 wonderful report on -- that outlines social
3 determinants, socio-demographic characteristics
4 are. The issue is -- I think it's a nice laundry
5 list to start with.

6 The problem that we're having in terms
7 of using that information with our measures is
8 there's a lack of data at a granular level that
9 will provide us with the information to
10 adequately or to improve the models of prediction
11 that we use for that.

12 It's getting better, but that is a
13 limitation. Regarding the philosophical
14 difference between should you adjust for it or
15 shouldn't you adjust for it, that came up
16 actually in the last scientific methods panel.
17 And a measure was not approved, if you will, or
18 sent back to the developers, because they said in
19 their report, yes, it is very clear that there
20 are social determinants health related to opioid
21 use, but we're not going to adjust for it.

22 And we're like, really? And the point

1 is that you can do it. You can adjust for some of
2 these factors and then see what else is going on.
3 The difference is then, even after you've
4 adjusted, points to what policy differences there
5 are within the different states, for example,
6 because it's a population measure.

7 But there's a difference in policy
8 matters for different states and not by adjusting
9 for social determinants of health and equalizing
10 the footing, that you can see what else matters.

11 And in some of these what else matters
12 that can, you know, push us in a, or push,
13 perhaps advocacy groups tend to make changes in
14 those areas. So I think that's my medical byte, I
15 guess.

16 CO-CHAIR MERKELZ: Well, Gene, I
17 appreciate that we finally have somebody to
18 blame. Yes, I appreciate you owning that.

19 MEMBER NUCCIO: Yes.

20 CO-CHAIR MERKELZ: I think there is --
21 and there's a lot of -- there's far more
22 questions regarding how to further venture in the

1 socio-economic determinants. But I think there's
2 also some launching pads that we could look at.

3 And medication management comes back
4 commonly. We see it across the board. We commonly
5 see it in these measures. And as we look at the
6 ability for providers to measure the same thing,
7 whether it's from a hospital to a post-acute to
8 keep a home health, even to a hospice, how
9 patients get access to their medications, how
10 they utilize their medications, how they monitor
11 their medications, how they respond to their
12 medications.

13 This does get into many of the socio-
14 economic factors and actually it can become a
15 very good cross-alignment measure to look at
16 further.

17 CO-CHAIR LAMB: Rikki?

18 MEMBER MANGRUM: So for me, social
19 determinants of health comes back to something,
20 Michelle, that you talked about very early on,
21 which is the notion that there needs to be
22 greater partnership.

1 I think -- I feel -- agree that there
2 is a lot of sort of important and also
3 uncomfortable conversations that have to happen
4 about what social determinants are, what impacts
5 they have and how they should be addressed.

6 And I think that there is now a
7 growing recognition on all sides of the table or
8 the roundtable, all angles of it about that. I
9 mean, one of the things that I've noticed just in
10 the last couple of years is that a lot of people
11 in public health or organizations that actually
12 work to address social determinants in the
13 community don't even like the term anymore, and
14 they just want to talk about equity.

15 And so, you know, that, to me, is
16 bothersome because I've had a long career and
17 I've been to a lot of these rodeos where we just
18 argue about terminology for five years and then
19 we start over with another disease --

20 (Simultaneous speaking.)

21 CO-CHAIR MERKELZ: It's easier to do
22 that than face the issue.

1 MEMBER MANGRUM: Right, exactly.
2 Exactly. But another comment that I hear very
3 often is that it would be helpful to people who
4 are trying to address these things if the big
5 measures were just aggregatable so that you could
6 really look at these different social and
7 economic groups, racial groups, whatever you
8 wanted to look at and see how they are
9 performing.

10 And that gets back to the basic adage
11 of, you can't change what you can't measure. And
12 some of the measuring that I see going on by like
13 a like grassroots organization is kind of
14 sketchy. It would be good if they maybe were able
15 to use the same kinds of measures.

16 Another sticky wicket, I think, is
17 that there is a lot of distrust outside of the
18 health care sector of the health care sector,
19 because they have so much money and so much
20 control.

21 And very often, and I agree that this
22 is a realistic criticism of us, we focus a lot on

1 health care delivery and we talk about patients
2 who are already sick. And so I've seen in the
3 last ten years almost a more of a pulling away
4 and wanting to not work with health care
5 providers, which I don't think is healthy.

6 But I think it's something that can be
7 addressed and that CMS can help the community
8 world address by helping to facilitate
9 partnerships and a rebuilding of trust.

10 CO-CHAIR LAMB: Along -- Rikki, along
11 those lines, one of the questions I have, because
12 I just became more aware of all the efforts going
13 on to measure social determinants, and there's a
14 lot.

15 And going back to what Michelle was
16 saying, is there a lot of philosophical issues as
17 well as measurement. Is this train out of the
18 station and kind of like your five-year let's
19 watch this happen is, it seems to me that there
20 are organizations now that are proposing risk
21 stratification for social determinants. They're
22 doing use cases.

1 I'm just wondering if CBS needs to be
2 involved in kind of that national movement to
3 really help standardize it because it's moving.

4 MEMBER MANGRUM: No, I agree with you.
5 It is. Look, I'm a primary care physician from
6 the city of Detroit. These are very important to
7 me. I mean, this has been my life.

8 And I wish we had the answers. We are
9 working on them. Again, I know ASPE, because a
10 big white paper that will be coming out with some
11 recommendations. The Office of Minority Health
12 within CMS is working on these.

13 I think you're right. We need to --
14 maybe it's just take a stab at putting something
15 together and moving it forward. I think it's also
16 going to help as more organizations are starting
17 to collect this data.

18 So, for example, Abbott, the EMR
19 vendor this year, in their latest upgrade has a
20 whole host of social determinants that they're
21 now starting to collect in a very systematic way.
22 Once we/they have that data and can start looking

1 at it, I think it will help answer questions. But
2 I think you're right. We kind of need to get
3 ahead of it because the train has clearly left
4 the station.

5 CO-CHAIR LAMB: Now should -- and I
6 wonder if any of the rest of you see it or have a
7 concern about a similar thing that I saw with
8 care coordination, which is it moved from kind of
9 very primitive measurement into coding, into
10 payment.

11 And then we started trying to deal
12 with attribution, but never really got very far
13 with it. Meanwhile, only certain providers can be
14 paid for it. And there's a cast of millions
15 behind them who are not represented in the EHR.

16 And I see the same thing happening
17 with social determinants potentially. And that's
18 a concern as we've talked a lot about teamwork
19 today and inter-professionalism with hospice. And
20 our EHRs don't support that. Deb?

21 MEMBER SALIBA: Yeah. So. I guess my
22 comment that Alan made earlier today that I would

1 like to go back to the framework of talking
2 about, I call them social drivers -- sorry to get
3 into the terminology, but determinant that go
4 like this, this fixed thing that, no matter what
5 you do, the outcomes are just always going to be
6 worse for certain populations.

7 Whereas I do think driver is more of
8 a way of recognizing that it's driving the
9 outcomes for people. However, I think Alan made a
10 really important point earlier today, and that is
11 how are we going to use these?

12 Are we going to use them to let people
13 off the hook for quality and accept that they are
14 going to be quality differences with a different
15 populations. Or are we going to use this to say,
16 let's understand why these differences exist and
17 look at the differences, which, obviously, the
18 way I'm framing this, I'd prefer the latter.

19 And -- or we going to use these to
20 say, well, you know what, it takes more resources
21 to take care of certain populations. And so
22 therefore, instead of letting people off the hook

1 quality wise, we are going to provide more
2 resources if you're providing care for those
3 people.

4 So I think we need to think about how
5 we need to be very careful about how we plan to
6 use these. That said, we definitely need good
7 measures of what this is so that we can do those
8 root cause analyses.

9 We can look at organizational literacy
10 in the way that organizations approach folks. And
11 so -- and that's been always one of my concerns
12 when we get in here and we start talking about
13 reliability of the measures and within group
14 variation versus within provider variation as
15 opposed to across provider variation.

16 Because if there are biases within
17 organizations and how they treat different sub-
18 populations, we're going to see large or poor
19 reliability within organizational performance.
20 And we're going to dismiss that as a bad measure
21 when, fundamentally, the problem with the measure
22 may just be that certain populations are getting

1 better care with a certain provider than other
2 populations.

3 And so I think it's very important to
4 be able to measure this, to be able to look at
5 it. I would be not at all support risk adjusting
6 quality measures for it until we're much, much
7 further down the path.

8 MS. PROCTOR: This is Joan Proctor,
9 and I've been troubled for many years now
10 regarding this discussion about social
11 determinants --

12 CO-CHAIR MERKELZ: Joan, could you
13 raise your voice?

14 MS. PROCTOR: I said I've been
15 troubled for a while --

16 CO-CHAIR LAMB: I still don't -- I
17 still don't -- could you raise your voice.

18 MS. PROCTOR: I've been very troubled.
19 Just, to me it almost appears that it's taking on
20 a life of its own in this discussion in
21 recognizing that there are disparities of care
22 among the various segments of our society.

1 But I think it's -- to me it's almost
2 like it's stating the obvious and that the real
3 focus needs to be, if we originally go back to
4 what our real focus is health care, which is
5 improving the quality of care across the
6 spectrum.

7 This issue gets subsumed within that.
8 It wouldn't take much for me to tell you some
9 nightmare stories that I've seen over the years
10 with health care and that all of us seen in areas
11 in which there is an obvious difference in the
12 quality of care available to a patient based upon
13 their zip code.

14 And so that type of analysis, you
15 know, it's sort of like -- and I go back to the
16 old ways, as the way my grandmother used to
17 describe things. You know, you think that's sort
18 of what her response was when it was very obvious
19 what the answer was.

20 We know what the problem is, but I
21 think it's systematic of something that's bigger.
22 It's a symptom of something a lot larger than

1 healthcare. And if I, from my perspective believe
2 that those nuances that exist need to be
3 addressed into totality of quality of care, and
4 what that is.

5 Because to me, as an African-American,
6 my medical needs are no different from anyone
7 else, from any cultural group. So assuming that
8 they are the same, I believe the approach -- the
9 only way to make the approach fair and to be
10 comprehensive is to look at it from that
11 perspective of everyone's need for quality health
12 care.

13 And I'll get off my soapbox here.
14 Probably not very popular at this moment, but
15 that's just, you know, that's sort of the
16 thinking that has been coming at this is, is why
17 are we making this distinction with how many of
18 us haven't been to a poor hospital and said to
19 ourselves, we couldn't wait to get out of there
20 because we knew that the family member wasn't
21 going to get good care there?

22 Well, the truth of the matter is that

1 hospital doesn't have the same resources as some
2 of the nicer hospitals do. It's not a mystery as
3 to why the outcome would be different. So I don't
4 know if this conversation, if CMS, as a fellow
5 agency, is really ready for this type of
6 conversation that we've involved in health care.

7 Michelle, I'm just saying it, just
8 sharing my thoughts here that, you know, this is
9 where I'm coming from. This is my perspective.

10 MS. SCHREIBER: I don't think what
11 you're saying is that different from what other
12 folks are saying today. I think there is a
13 recognition that, you know, we've been describing
14 disparities for a very long time.

15 I do disagree that we might not know
16 the root of all the disparities. I think we need
17 to understand how to fix it and how to go in and
18 really make it better. And is it more resources?
19 I don't know. I might be.

20 I mean, clearly, these are under-
21 resourced communities and under-resourced
22 facilities. Is that enough? Is that going to

1 deal with, you know -- I mean, we, you know, in
2 the Veterans Administration, we see less
3 disparities, but there's still disparities, even
4 in the VA where everyone is getting paid -- you
5 know, the payment doesn't vary based on
6 somebody's social determinants, drivers at all.

7 So I think it's complicated, but
8 you're right. It's not just about describing the
9 differences. We need to go in and fix them. And
10 that's what everybody's saying. It's just a
11 matter of, you know, what's the best way to do
12 it, so I don't think you're going to get fired
13 yet.

14 MS. PROCTOR: Hopefully not.

15 CO-CHAIR LAMB: Al?

16 MEMBER LEVITT: I've been here for
17 seven years now. We were having the same
18 discussion, unfortunately, seven years ago. This
19 is a challenge, something we really do look at
20 every day.

21 I mean, you know, and it reminds me
22 evaluation because it is something that does keep

1 some of us up at night, you know, trying to make
2 sure that when we have the right thing in our
3 measures.

4 And, to me, sometimes our measures are
5 our measures, and it's not the measures
6 themselves. It's how they end up getting used.
7 And maybe we should be looking more at that and
8 saying, okay, well, you know, these are the
9 particular results that we're getting within
10 whatever subset. Do we ever want to subdivide
11 them?

12 And then looking at that and saying,
13 okay, well, these are the measure results and
14 whether we categorize them, whether we put
15 different sorts of schema on them to recognize
16 that there are certain challenges that providers
17 of health care within certain -- taking care of
18 particular groups of patients have different
19 challenges.

20 Whether it's the resources they have
21 or the patients' abilities to get medicines or,
22 you know, all the other multiple factors, whether

1 we should be really approaching it more that way.
2 I, too, don't believe we should kind of risk
3 adjust away the results of them because then we
4 don't -- we no longer can even identify them up
5 front.

6 So at least if we don't risk adjust
7 them we continue to look at them. And then we
8 just take the next step, take those results and
9 then we analyze the results themselves in terms
10 of how we use them, approach it more that way,
11 and I'm not on the risk adjustment side of
12 things.

13 MEMBER DUSEJA: I just want to add to
14 Alan his comments. We do have examples within
15 CMS, hospital-based programs, for example, HRT,
16 where we actually adjust at the program level
17 when it comes to payment.

18 So similarly, with MIPS, we also have
19 like a complex of adjustment for providers, to
20 add additional an bonus for those providers. And
21 I think that that's another consideration. I'm
22 curious to hear from the reaction from the work

1 group that that's the way we should be thinking
2 about it.

3 Instead of controlling or trying to
4 adjust away at the measure, but to do it from a
5 standpoint of the incentive structure. Certainly
6 we could affect payments. We could think through
7 ways to provide more resources when we identify
8 certain facilities are poor performing.

9 Just wanted to get your thoughts
10 because we have examples of that across the other
11 sites.

12 MS. MOYER: Hi. I said I'd interrupt
13 now, but four months ago was running pay for
14 performance programs and had a lot of discussions
15 with providers around things. Sometimes I worry
16 the more complicated an adjustment we make the
17 payments for things that we risk kind of
18 obfuscating the costs.

19 And you know, one of the things we'll
20 hear as well, this costs so much because of that.
21 Well, then let's allocate those costs and
22 allocate those payments and put things so we can

1 see what things really cost and what money needs
2 to go where to have the effects we want to.

3
4 And so sometimes I worry it just all
5 becomes so complicated. It's just all theoretical
6 and not tied to any of it. It's hard to kind of
7 make it real.

8 CO-CHAIR LAMB: Any other areas that
9 anybody would like to speak to? So I think what
10 we will do is kind of put up what we've listed so
11 far and just see if there's any agreement on some
12 priorities to share with CMS.

13 One thing that I would like just
14 before we move into that, Rikki, I've been
15 thinking about your comment from this morning,
16 which is that we need a new way to look at
17 patient preferences and getting the patient into
18 this story.

19 Can you speak a little bit to what
20 you're thinking there?

21 MEMBER MANGRUM: Yeah, so, I mean,
22 this even is applicable to this conversation

1 about social determinants because one argument
2 that gets made there with some groups is that a
3 lot of the measures that we use are already
4 biased against certain social groups because of
5 the way that we go about making measures.

6 And so that, along with some other
7 experiences I've had over the last ten years, has
8 really made me wonder if we haven't reached a
9 phase in which we need to do some real
10 intellectual navel gazing at how we go about
11 making measures, how we go about evaluating them.

12 And is it really a one size fits all
13 proposition? Because I'm not sure that it is. And
14 I know a couple of years ago NQF talked about it
15 or maybe has already implemented sort of a new
16 dimension of examining quality of measure by
17 looking at its implementation.

18 I think to your point, Reena, how
19 people behave around measures, I think, is
20 something we need to spend more time looking at,
21 because that's where all of the unintended -- not
22 all of them, but many of the unintended

1 consequences tend to occur.

2 So I just recently watched a weird
3 YouTube video by a physicist who talked about
4 some particle that sort of goes along in space
5 and it's rotating like this, and the second you
6 measure it, it stops.

7 (Simultaneous speaking.)

8 MEMBER MANGRUM: And I thought, what
9 a beautiful metaphor for the problems of
10 measuring things, right, like the second you
11 measure it, its behavior changes. And that's not
12 something that we see a lot in what we do.

13 And I think it's because we've been
14 through this phase in health that I think that
15 has the social determinants that equity folks are
16 in right now of producing lots of measures and
17 sort of throwing lots of darts and waiting to see
18 what sticks to the wall.

19 And then you go through a period of
20 tearing your hair out, saying, we need a personal
21 --

22 (Simultaneous speaking.)

1 MEMBER MANGRUM: And that has made me
2 wonder whether the piece of the puzzle we haven't
3 been missing is looking at how the process and
4 the existence of metrics actually changes the way
5 people behave and understanding what looks like.

6 So that's what's been in my mind a
7 lot. And I think another point that I was making
8 specific to patient reported outcome measures, is
9 that we have a lot of them for which we don't
10 really know what we should know about the
11 foundation of that measure in terms of the
12 patient voice.

13 So, you know, you see a paper where
14 they say, well, we had some focus groups and we
15 talked to some people who look like this and they
16 told us these things, and here are themes. I've
17 got to the point now where I want to see your
18 transcripts.

19 You know, we have very good systems
20 for how we clean up and share quantitative data
21 with each other. We need to do the work on
22 figuring out how to do that with qualitative

1 information and doing a better job. You know, I
2 have a side gig as an editor for the qualitative
3 report, which is a qualitative methods journal.

4 And you wouldn't believe the quality
5 disparity we see where the method section is this
6 long and you say, well, that's just not enough
7 information. No one can replicate this. We don't
8 know what you've done. You've given us some
9 quotes there out of context.

10 And I think that, from my perspective
11 as a qualitative researcher, this is a huge gap
12 in what we do. We don't have really rigorous and
13 robust and consistently adhered to standards for
14 how this type of information gets reported so
15 that it's also usable for the purposes of
16 building and testing out new measures, right,
17 because we keep having focus groups of people
18 about their pain and interviews about them, with
19 their fatigue and what is depression like for
20 you. And that's because we don't have good
21 methods for atomizing this data being able to
22 share it and use it.

1 CO-CHAIR LAMB: I'm really impressed
2 that you are that articulate at 3 o'clock in the
3 morning.

4 (Laughter.)

5 CO-CHAIR LAMB: It's just so --

6 (Simultaneous speaking)

7 CO-CHAIR LAMB: Anyway, all right. So
8 we've generated a list of things that you all
9 have mentioned. And in our last, before we kind
10 of sum up the meeting, Jordan, are you ready to
11 put it up?

12 MR. HIRSCH: Just one moment.

13 CO-CHAIR LAMB: One moment. And what
14 we're going to do is just look at the list, see
15 if there's anything else you want to add, because
16 look at this, it's 2012 and we're about to create
17 the 2019 version. Now if we'll only prove it
18 right, that's a good thing.

19 MR. HIRSCH: It'll be on in just a
20 moment, back.

21 (Off-microphone comments.)

22 MR. HIRSCH: Well, we can make it

1 bigger if anyone needs to.

2 CO-CHAIR LAMB: All right, so these
3 are the areas, the concepts and priority areas
4 that we've all mentioned. One is access to care,
5 for example, availability of resources, travel
6 distances.

7 Another is the care coordination, data
8 set, a measure set, interoperability, patient
9 reported outcomes, social determinants/drivers.
10 And there also was a call for looking at
11 alignment across the continuum, particularly in
12 the area of functionality.

13 Is there anything that you'd like to
14 add to this before we put any priorities?
15 Understanding this is not a complete list. It's
16 sort of a think list. This will not -- I would
17 assume go into posterity at this point, but it'll
18 be our thing work together.

19 MS. AMIN: Gerri?

20 CO-CHAIR LAMB: Yes.

21 MS. AMIN: Just add to, that I heard,
22 well, first about fragility and nutrition, I

1 think were also added on.

2 CO-CHAIR LAMB: Okay, now were those
3 from -- those are CMS priorities. So those did
4 not come up in this group.

5 MS. AMIN: Oh, okay. Yeah, thanks.

6 CO-CHAIR LAMB: Okay, important, but
7 not from this group.

8 MS. AMIN: Okay, that's correct. Thank
9 you.

10 CO-CHAIR LAMB: Raj?

11 MEMBER MAHAJAN: One of the things
12 that we have discussed last few years that some
13 of us believe is the reason why this whole
14 quality concept in post-acute long term care is
15 not progressing, is because of the practitioners
16 -- i.e., physicians, practitioners.

17 Their incentives are not aligned with
18 the incentives for the facilities. And I would --
19 there is somewhere on the table, somewhere the
20 concept of, through the MIPS program, enabling
21 facility-based reporting within post-acute long
22 term setting.

1 I'm not sure where that work is. It's
2 fairly complicated, not as simple as hospital
3 where you just use your VBP score. So I would
4 love to bring that back on a high priority list
5 where we can harmonize the measurements for the
6 facilities and the practitioners.

7 And some of the possible funding out
8 there could be channeled as to that work.

9 CO-CHAIR LAMB: Give us the language
10 that you'd like to have added to this.

11 MEMBER MAHAJAN: Let's say aligning
12 facility and practitioner measures.

13 MR. STOLPE: And post --

14 MEMBER MAHAJAN: And post-acute long
15 term care.

16 MS. MOYER: May I ask a question
17 related to that? With being new to this program,
18 is reporting within this program at the physical
19 facility level? Is there kind of an aggregate
20 level, like an MPN that lists the hospitals?

21 I'm just thinking about usability of
22 the data to like patients and families. They're

1 looking for an actual, I'm going here versus I'm
2 going to the system.

3 MEMBER MAHAJAN: Yes. Yes, but focus
4 --

5 MS. MOYER: Okay, thanks.

6 CO-CHAIR LAMB: Okay, so Raj, that
7 captures what you wanted in?

8 CO-CHAIR MERKELZ: As far as language.

9 MEMBER MAHAJAN: Yes. I mean,
10 incentives or measures is same --

11 (Simultaneous speaking.)

12 CO-CHAIR LAMB: Okay, Gene?

13 MEMBER NUCCIO: Under alignment of
14 function, across the function, I think we need to
15 recognize that the different providers work with
16 different kinds of patients.

17 And alignment of function should
18 represent the entire continuum of what we believe
19 our patients should be from the time that they're
20 most in need and most debilitated to the time
21 that they're fully functioning.

22 And if we only represent a small

1 portion of that, then we're going to be using --
2 my analogy is we're going to be using a one-foot
3 ruler, okay, to measure how tall each of us is,
4 and we only get to measure -- use the ruler once.

5 Okay, that doesn't work. So we have to
6 get -- it's a function across the continuum of
7 patient function. So that, I just to -- that was
8 the only --

9 MEMBER SALIBA: Yeah, this where the
10 EMR could be helpful. We're not talking about my
11 negative comments today, and that is to build in
12 Al and Debbie's approach using the IRT or, you
13 know, whatever you posit, but it's basically IRT,
14 to have robust set of items within the limit,
15 what any particular provider is, for one thing.

16 And, you know, Mark could really help
17 you do that by using the CAD and the IRT kind of
18 approach.

19 CO-CHAIR LAMB: Ed?

20 MEMBER DAVIDSON: So I'm trying to
21 think where this -- you know, you made a comment
22 about medication management. And this, it's in

1 the background of a number of these things.

2 And I thought originally care
3 coordination, but if I look at it, it really,
4 under concepts of priorities, it falls under
5 access to care. Can the patient afford the
6 medications?

7 Care coordination is the right, you
8 know, are the medications being managed between
9 all the different specialists as they transition
10 to different settings?

11 Interoperability, if we had good
12 interoperability, we wouldn't have the scope of
13 medication related problems that we have now when
14 someone moves from the hospital to home or
15 hospital to skilled because those formularies
16 would line up.

17 The lists would be aligned and the
18 patient wouldn't be confused when they got it
19 home and they open that bag up of prescriptions.

20 Patient-reported outcomes, a lot of
21 times patient adherence is related to patients
22 having bad symptoms due to medication. And we

1 don't realize that they've been non-compliant
2 until they go to the ED.

3 And social determinants of health,
4 again, do they understand the medications that
5 they're taking? Do they have access to them? Do
6 they have access to providers that can write the
7 prescriptions that they need for their diabetes
8 and their heart failure and other things?

9 So I just, I think medication
10 management fits in there somewhere. I'm not --
11 maybe it's in all of those categories. Or maybe
12 it's another item.

13 CO-CHAIR LAMB: How would you feel
14 about putting it under alignment across the
15 continuum and say that it's cross-cutting, that
16 you can see how it relates to all the priorities?

17 MEMBER DAVIDSON: I think that works.
18 I think that works.

19 CO-CHAIR LAMB: Because your holistic
20 thinking related to medication management might
21 make it an interesting prototype for looking
22 across the continuum, and is it capturing the

1 right thing?

2 Anything else before we do a quick. Oh

3 -- Alan, sorry, didn't see yours up. Go for it.

4 MEMBER LEVITT: Blaming it on the live
5 computers because telling us what we should be
6 doing.

7 (Laughter.)

8 MEMBER LEVITT: But I am also somebody
9 with a chronic disease and chronic ailments that
10 maybe I get to speak a little bit. But I thought
11 Gene was going to take me there so I wouldn't
12 have to do it.

13 But, you know, and there was a Wall
14 Street Journal essay that was out this week and,
15 about two health care systems in America, one the
16 system of disease and the other the system of
17 illness.

18 And in post-acute care, we actually
19 cross both places where we deal -- you know, some
20 are with diseases of getting things, getting
21 better. But we also deal a lot of illness, with
22 kind of the chronic care of somebody for a long

1 time where our outcomes are not the outcomes that
2 everybody else, tomorrow or the next day or all
3 the people, the sexy topics of the world are
4 looking at.

5 Our outcomes are different. They may
6 not be hospice outcomes, but they're in between.
7 And when we think of concepts and priorities,
8 although some of those things attach, you know,
9 trying to develop better measures or approaches
10 for measures for the care, just the chronic care
11 of the patients within a population, I think,
12 should be somewhere up there.

13 CO-CHAIR LAMB: So allowing Alan to
14 take off his CMS hat and just be one of the rest
15 of us, how do you feel about adding that to our
16 list?

17 MR. STOLPE: Under concepts and
18 priorities.

19 CO-CHAIR LAMB: Cool. All right. Would
20 you please add chronic illness?

21 MEMBER LEVITT: Dealing with a chronic
22 illness or just really, it's essentially the

1 care. You know, the outcomes of care are not, you
2 know, improvement; are not, you know, care
3 coordination should be part of it.

4 But, I mean, it's really, you know,
5 quality of life more within whatever realm that
6 would be.

7 CO-CHAIR LAMB: I might add that in
8 that list from 2012, that was under a little bit
9 of quality of life. And that speaks to me of
10 sometimes we need to pull out important stuff
11 because it's getting lost in our overarching
12 concepts.

13 Heather?

14 MS. SMITH: Yes, so I would echo
15 Alan's comments. I think this is a struggle so
16 I'm going to put my physical therapist hat on and
17 tell you this is a real struggle in our community
18 because many of the functional measures look at
19 improvement.

20 And again, in certain conditions it's
21 not improvement, it's preventing decline when
22 you've done a -- we haven't really done any job

1 at trying to address that.

2 And in fact, many providers are really
3 concerned about being able to deliver good care
4 to patients where the end goal is preventing
5 further decline or, you know, making sure they're
6 safe at home and staying on as much of a stable
7 trajectory as possible for as long as possible
8 with those conditions.

9 I do think that that has crossover to
10 patient goals. Again, because here those goals
11 may be, you know, being able to function
12 longitudinally as long as they can at that level
13 of function.

14 And so I do think that this crosses a
15 number of areas. And so I just wanted to bring
16 that up because it is definitely something we
17 have struggled with -- our practitioners have
18 really struggled with.

19 And worry that indicating that we're
20 doing care for those patients, you know, has a
21 different level of scrutiny because we're always
22 looking for this improvement where it just isn't

1 always the goal or the reality of a patient's
2 situation given a disease or a disease process or
3 condition. So I just wanted to bring that up.

4 (Simultaneous speaking.)

5 MEMBER LEVITT: Including the payment
6 structure has not been incentivized to do that.

7 MS. SMITH: Correct. Correct. And we
8 get questions all the time from our practitioners
9 about what do we do and what are -- I mean,
10 what's appropriate care. So I do think it's an
11 area that's important for us to think about
12 addressing.

13 MEMBER HOPPE: This is Kurt Hoppe on
14 the phone. And first of all, I agree with Heather
15 and Alan that maintenance of good health in the
16 face of chronic illness is of critical
17 importance, making sure that we have good patient
18 outcomes.

19 I think we forget about the fact that
20 some things aren't cured, but some quality of
21 life can be maintained. The second issue that I
22 have is I'm not sure exactly where this fits, and

1 this goes into fairly of care and of care for
2 chronic illnesses, is the issue of drug
3 interactions, because that becomes a major issue
4 as a chronic illness progresses.

5 It's not unusual for us to see
6 patients with 20 to 30 medications, all
7 prescribed by different practitioners for
8 different reasons in different care settings. And
9 I think that needs to find a home somewhere in
10 our particular list or else we're going to have
11 patients that don't function well.

12 We don't know why, but we probably
13 have two cooks stirring the pot here and have
14 major medications interactions. That's --
15 sometimes people don't feel comfortable dealing
16 of with because of either lack of primary care or
17 it's treatment by multiple specialties.

18 And the last issue is should the
19 use/misuse and provisions abuse for opiates be a
20 separate category? This is an area that is so
21 moving so fast and involves so many players, from
22 regional to state to federal players.

1 And those of us who are clinicians
2 sometimes feel caught in the middle here,
3 especially when we're discharging patients or
4 trying to help patients work through the pain of
5 surgery or simply the pain of having a chronic
6 illness.

7 CO-CHAIR LAMB: Okay. Kurt, would you
8 like to add that to the list, which is another
9 area, is substance use and opiates.

10 MEMBER HOPPE: Yeah, specifically
11 opiates because, certainly in the press, it's
12 been highlighted, all the problems around the
13 country. And in fact, in those I would suggest
14 that in those parts of the country that also
15 probably have a poorer or worse social
16 determinants of health that that becomes an issue
17 in and of itself.

18 But it's moving so fast, and for
19 providers to have someone who's getting the
20 alignment with quality measurements may be
21 particularly helpful.

22 CO-CHAIR LAMB: Great. Thank you. And

1 may I ask, is it opioids? Or is it mental health
2 or -- Debra, did you want to --

3 MEMBER SALIBA: Can I say something?
4 I mean, I agree with -- the direction your
5 question's going, I think, is an important one.

6 I would be very concerned to make it
7 just about opiates. At the very least, it should
8 be pain management that looks at other approaches
9 to managing the pain in addition to opiates or
10 mental health, which despite, supposedly, the
11 requirements for equity, there doesn't appear to
12 be equity with medical care, both in terms of
13 access and in terms of payment by insurers.

14 So I would say both. I would say that
15 pain management is such an incredibly important
16 topic and issue right now, albeit difficult and
17 challenging, that I will pull it out, but I think
18 mental health is also really important too.

19 CO-CHAIR LAMB: Kurt, are you willing
20 to take an amendment from Deb in changing that to
21 pain management? And, Deb, did you want a
22 separate category on mental health?

1 MEMBER SALIBA: I think so. I mean, I
2 think that, you know, I see some heads bobbing
3 about that as well. So I would suggest that.

4 (Simultaneous speaking.)

5 MS. AMIN: It's both physical and
6 mental health, and psycho-social.

7 CO-CHAIR LAMB: Right. Jennifer?

8 MEMBER KENNEDY: I just wanted to leap
9 frog off of Alan's statement. If we're talking
10 about chronic illness, chronic illness that turns
11 into serious illness, and we're not quite at
12 hospice yet, but we're in that gap. So I would
13 propose that we add serious illness in terms of
14 palliative care provision as well.

15 CO-CHAIR LAMB: How should we put
16 that, Jennifer?

17 MEMBER KENNEDY: Can we either
18 piggyback off of chronic illness or -- I don't
19 know, what do you think? Maybe get palliative or
20 serious illness, a separate category under
21 concepts?

22 MEMBER LEVITT: I guess serious and

1 certainly some chronic illness concept.

2 (Simultaneous speaking.)

3 MEMBER KENNEDY: Somebody could have
4 a serious illness but not, you know, I think they
5 would be separate.

6 CO-CHAIR LAMB: I think so. Can we add
7 that, serious illness?

8 MS. MOYER: Is that somewhat? I kind
9 of want to lump and I kind of want to not lose.
10 It feels a little like we're kind of talking
11 about appropriate care meeting the patient where
12 they're at across a broad continuum again, kind
13 of like we were talking about the broad continuum
14 of function.

15 You know, there's this broad continuum
16 of care where a patient may be and making sure
17 that we're matching them or providing or somehow
18 moving with them or meeting them where they're
19 at. Is that an appropriate lump or am I losing
20 all kinds of granularity there?

21 MEMBER KENNEDY: I think it's part of
22 the lump, but I think, you know, there's a point

1 in an individual's disease trajectory where, you
2 know, just going, bouncing back to home health
3 isn't going to cut it. You know what I mean?

4 They need a different care approach,
5 which is palliative care management. But they're
6 not in the six-month or less window. So, I mean,
7 I think your concept of the right care at the
8 right time in the continuum is extremely valid.

9 But if we're going to pay attention to
10 chronic illness, I think we equally have to paid
11 attention to serious illness as well.

12 CO-CHAIR LAMB: Michelle, did you have
13 -- no? Okay. All right. So we're trying to
14 figure out how to respond to Michelle's request
15 for priorities, because these -- it's an
16 important list. Isn't it?

17 So how about if -- let's make this up
18 as we go along. If you would look at the list
19 that Jordan has up there and, in your head pick,
20 if CMS us could only do a couple things -- is
21 that fair, Michelle?

22 In the next period of time, this is

1 what you think really is important and should be
2 part of the Meaningful Measures portfolio. Is
3 that fair? Yeah?

4 MS. SCHREIBER: Perfect.

5 CO-CHAIR LAMB: All right. So how
6 about you pick your top three? And let's see what
7 we get. Is that good?

8 MR. KIRSCH: I think that's fair.

9 CO-CHAIR LAMB: All right. And we're
10 just going to go through -- just put up your hand
11 and we'll count. And Jordan will put numbers next
12 to it. All right. And who do we have on the
13 phone?

14 MEMBER HOPPE: Kurt Hoppe.

15 CO-CHAIR LAMB: Kurt. Anybody else?

16 (Off-microphone comments.)

17 CO-CHAIR LAMB: What would you put --
18 it's going to probably take another ten minutes
19 to do that. Do you want us to do a summary while
20 Jordan's doing that? We'll vote at the end? It's
21 up to you all. We can either vote by hand or we
22 can do a poll. I put my computer away. How about

1 we vote by hand?

2 MS. MOYER: It seems like we just have
3 Kurt.

4 CO-CHAIR LAMB: Kurt's another one?
5 Okay, Kurt, how about if you go out? Okay? All
6 right.

7 MEMBER HOPPE: I'd be happy to scream.

8 CO-CHAIR LAMB: Good. That'll be
9 great, Kurt. Thank you. All right. So we're
10 just going to go through it. Put up your hand if
11 it's one of your top three.

12 MEMBER SALIBA: Can you tell us what's
13 the difference in Category 2, Item 1 and 3 are?

14 CO-CHAIR LAMB: Say that again, Deb.
15 I'm sorry.

16 MEMBER SALIBA: Category 2 and then
17 Item 1 and 3, they seem like they're the same.

18 CO-CHAIR LAMB: Yeah, they are. So
19 let's take out 1. Under Category 2, take out
20 Number 1, Function, because we have Function
21 under 3. There you go. Very cool. All right, of
22 course.

1 Let's see how complicated we can make
2 this. We should -- all should be good at this.
3 All right, so we have concepts and priorities and
4 we have alignment across the continuum.

5 So I'm just wondering if we should
6 group those together or keep them separate. Kurt?
7 Let's see where we get.

8 All right, so access to care, for whom
9 is that a -- one of your top three?

10 Okay, zero. Kurt, remember to yell
11 out. Care coordination? Got it? All right. And
12 remember, you only get three votes.

13 Interoperability?

14 MR. HIRSCH: Do you have two arms up
15 there?

16 (Laughter.)

17 CO-CHAIR LAMB: I almost cheated and
18 voted on that. But none voted. This is going to
19 be hard enough to put up votes on all of them.

20 Patient-reported outcomes?

21 Okay. Social determinants? Okay, it
22 looks like a zero.

1 Chronic illness care? Quality of life?
2 Okay, pain management? Mental health? We all
3 expended our votes early on. Can we vote --

4 MEMBER KENNEDY: Give it a 1.

5 CO-CHAIR LAMB: Give it a 1?

6 Serious illness? Okay, Kurt.

7 MEMBER KENNEDY: Kurt, are you able to
8 hear us?

9 MEMBER HOPPE: Am I able to what?

10 MEMBER KENNEDY: Are you able to hear
11 us? Are you, have you voted yet on any of them?

12 MEMBER HOPPE: Yeah, I am. No, I
13 haven't. I was going to wait till the end because
14 I don't --

15 CO-CHAIR LAMB: Oh, okay. Smart man,
16 smart man. All right.

17 MEMBER HOPPE: That's fine, Deb.

18 CO-CHAIR LAMB: All right, now we have
19 to vote to the second tier? Or have you shot all
20 your votes?

21 (Simultaneous speaking.)

22 CO-CHAIR LAMB: All right, aligning

1 facility and practitioner measures and
2 incentives?

3 (Simultaneous speaking.)

4 CO-CHAIR LAMB: Put a 1 there, yeah.

5 Function across the continuum -- the
6 individual patient's continuum of care. Yeah, I
7 need more votes.

8 (Laughter.)

9 CO-CHAIR LAMB: Medication management,
10 cross-cutting? Tier 2.

11 All right. We need a promise from CMS
12 you're going to take this with a grain of salt,
13 because we're killing ourselves here, wanting to
14 raise our hands for everything.

15 MS. SCHREIBER: Yes.

16 CO-CHAIR LAMB: Kurt, what are you
17 choosing?

18 MEMBER HOPPE: I'm going to go for
19 care coordination, pain management -- since I
20 brought up the subject -- and then I'm going to
21 also go for function across continuums.

22 CO-CHAIR LAMB: Very good. Very good.

1 All right. So this will be our working list and
2 we'll continue to have a dialogue together.

3 MS. PROCTOR: So just to make sure I
4 have it, the winners are care coordination,
5 interoperability and patient-reported outcomes as
6 the top three? Am I correct in reading it?

7 CO-CHAIR LAMB: That is correct. Thank
8 you. And then the cross-cutting one is Function.

9 (Off-microphone comments.)

10 MS. SMITH: Can I just --

11 CO-CHAIR LAMB: You can't stand it,
12 Heather. Go for it.

13 (Laughter.)

14 MS. SMITH: I just want to note that
15 I do think that there is quite a bit of overlap
16 in this list. Obviously, I think if we think
17 about this, I think we can find some real natural
18 alignment for some of the ones that got lower
19 votes.

20 For instance, I think function across
21 the care continuum requires interoperability. And
22 so, I mean, I think there's a number of natural

1 harmonizations here, so.

2 MEMBER KENNEDY: You can't manage
3 serious illness without managing medication.

4 MS. PROCTOR: Absolutely. That's
5 right.

6 CO-CHAIR LAMB: All right. Michelle,
7 you have the whole list? Okay.

8 MS. SCHREIBER: And I'm trusting NQF
9 to send to people.

10 CO-CHAIR LAMB: And you will. Okay,
11 perfect. Later, we are in our agenda here.

12 MR. HIRSCH: We'll have a whole report
13 for you.

14 MS. SCHREIBER: Can't wait.

15 CO-CHAIR LAMB: All right. We're
16 supposed to do public comment?

17 MS. PROCTOR: That's a good idea.

18 CO-CHAIR LAMB: Okay, Janaki, public
19 comment?

20 MS. PANACHAL: Yeah. So we're going to
21 open the lines for public comment. If anyone has
22 a comment, free to shout out or also just type in

1 the chat box and we'll read it out loud.

2 I mean, we can start with people in
3 the room. If anyone has a comment we'll take it
4 down.

5 CO-CHAIR MERKHELZ: Anyone on the
6 phones?

7 MS. PANACHAL: We have one in the chat
8 box.

9 CO-CHAIR MERKHELZ: Very good.

10 MS. PANACHAL: So we have one from
11 Jessica French. Sorry. Go ahead, Jessica.

12 MS. FRENCH: Hi. This is Jessica. Can
13 you hear me?

14 MS. PANACHAL: Yes.

15 MS. FRENCH: Great. I just wanted to
16 mention, because there was a nice discussion
17 about goal-based care and how it differs from
18 quality of life.

19 And I wanted to make sure people are
20 aware that -- and TQA is doing some research
21 right now on what we're calling patient driven
22 outcomes. But it's an approach to both delivering

1 care that reflects what's most important to the
2 patient, as well as measuring quality based on
3 implementation to that approach, but ideally also
4 attaining outcomes identified by the patient as
5 their priorities.

6 So I'm happy to talk with folks about
7 it offline. But I wanted you to be aware of the
8 work.

9 CO-CHAIR LAMB: Thank you. That's
10 great to know. Any others?

11 MS. PANACHAL: None in the chat box.

12 CO-CHAIR LAMB: Okay. All right, we're
13 up to summary of the day. Do you want to start?

14 CO-CHAIR MERKHELZ: Yeah, well, we
15 certainly want to thank everybody for their
16 participation. Certainly the, all the
17 communication from CMS, very, very helpful, very
18 enlightening.

19 I certainly, personally, came into the
20 process with some different understandings that
21 matured and I think evolved during the
22 discussions. I certainly think -- thank you for

1 your fruitful discussion that was provided.

2 And again, just the importance and the
3 value of this type of work and the work that
4 we're doing, thank everybody for being here.
5 Gerri?

6 CO-CHAIR LAMB: Ditto. That's great.
7 I really look forward not only to the review of
8 the MUC measures. And I really appreciated the
9 thoughtful conversation, the input from CMS, the
10 passion and the concern for measuring the right
11 things.

12 And I really look forward to the
13 strategic discussion, so thank you for doing that
14 as well. Good meeting. I look forward to kind of
15 continuing this dialogue together about what
16 we're reviewing and what's important to patient
17 care.

18 So thank you all. Amy, it's in your
19 court.

20 MS. MOYER: Sure. So just as like a
21 quick summary of today, we had a discussion, a
22 lot of discussion around meaningful measures on

1 measure alignment.

2 We reviewed the two measures from the
3 MUC, and we'll be sending those both to the
4 coordinating team with recommendations -- I've
5 forgotten; it's been a long day -- conditional --
6 thank you -- what was the words.

7 MR. HIRSCH: Yeah, conditional support
8 for rulemaking.

9 MS. MOYER: Conditional support for
10 rulemaking, thank you. And that meeting happens
11 in January. And I'm probably closing in on the
12 next steps, which, actually, Jordan is going to
13 go over.

14 MR. HIRSCH: Thank you, Amy. So
15 obviously we are in the December parts of the
16 middle portion of this arrow with the in-person
17 working group for NAPPAC, obviously again today,
18 and tomorrow will hospital. Thursday will be
19 clinician.

20 We move later into December with
21 public commenting period will be open. And then
22 the middle of January, the 15th, the coordinating

1 committee will have their meeting and then pre-
2 rulemaking deliverables will be provided in
3 either the end of January or middle of February.

4 Moving forward, extension of public
5 commenting on the work group recommendations for
6 all maps will be open from December 18th until
7 January 8th.

8 Coordinating Committee's in-person
9 meeting will be January 15th and final
10 recommendations will be due to CMS on January
11 24th with the PAC LTC and hospital reports being
12 sent out on February 15th and the clinician
13 report on March 15th.

14 If anyone would like further
15 information, go to the public page at
16 qualityforum.org and search for any post-acute
17 care, long term care work group. You can visit
18 the SharePoint site at share.qualityforum.org and
19 you can email the PAC LTC team with any questions
20 that you have. Thank you all.

21 MS. MOYER: So thank you all for all
22 of the work that went in today and the discussion

1 and for joining us and bearing with the strategic
2 discussion. And thank you, Gerri and Kurt, for
3 your leadership and getting us through this.
4 Appreciate it. Thank you.

5 (Applause.)

6 CO-CHAIR LAMB: We also acknowledge
7 this was Amy's first meeting. So she is now well
8 seasoned. Thank you all. Have a wonderful day.

9 (Whereupon, the above-entitled matter
10 went off the record at 3:38 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: MAP Post-Acute Care and
Long-Term Care Work Group

Before: NQF

Date: 12-03-19

Place: Washington, DC

was duly recorded and accurately transcribed under
my direction; further, that said transcript is a
true and accurate record of the proceedings.



Court Reporter

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