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

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

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

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

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

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

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

And I am now going to turn it over to

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

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

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

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

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

many of you all in the room.

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

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

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

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

conversation. Janaki, are folks online?

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

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

MR. SLABACH: Slabach.

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

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

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

president for quality measurement at the National Quality Forum.

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

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

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

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

So, in case you cannot remember if you

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

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

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

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

disclose.

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

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

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

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

MEMBER COX: Hi, my name is Jill Cox.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER NUCCIO: No.

MS. MUNTHALI: Oh, okay.

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

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

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

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

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

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

MS. MUNTHALI: Okay, Rikki.

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

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

and Long-Term Care Medicine.

MS. MUNTHALI: Thank you very much. I think we have all of our subject matter experts in the group. So, we'll go to the phone to see if Sarah is with us.

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

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

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

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

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

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

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

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

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

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

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

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

MS. MUNTHALI: And Elizabeth from

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

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

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

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

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

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

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

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

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

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

I will turn it over to Michelle for

opening remarks from CMS.

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

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

PARTICIPANT: We can just put one there for you.

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

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

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

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

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

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

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

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

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

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

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

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

And in the end CMS does have the final

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

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

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

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

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

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

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

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

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

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

But in particular, we're interested in

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

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

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

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

So, if we can bring up our slides.

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

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

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

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

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

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

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

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

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

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

that have been the major thrust of CMS.

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

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

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

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

And its goal really was to try and

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

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

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

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

Much of our program development is

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

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

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

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

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

And finally, aligning across programs. I want to pause there for a moment because we've been doing a tremendous amount of work around alignment, because one of the criticisms of too many measures and it's confusing and I have to report a million of them and I will say that's true.

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

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

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

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

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

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

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

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

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

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

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

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

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

looking at to reassess.

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

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

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

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

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

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

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

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

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

But a 40 percent reduction is

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

put in and then they have to find them.

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

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

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

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

exchanging information in a very transparent and open way.

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

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

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

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

measures is what are some measures of the interoperability?

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

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

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

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

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

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

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

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

There is no other way of getting

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

standardized.

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

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

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

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

sources or measures?

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

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

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

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

MS. HALL: Go ahead.

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

about it.

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

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

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

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

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

this work.

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

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

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

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

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

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

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

MEMBER MAHAJAN: Yes.

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

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

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

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

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

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

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

So what are you seeing that will drive this?

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

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

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

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

MEMBER NUCCIO: Could you speak up, please?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But I'm also aware that there are

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

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

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

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

relative.

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

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

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

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

priorities for Meaningful Measures.

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

CO-CHAIR LAMB: Deb.

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

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

don't really help.

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

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

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

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

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

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

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

CO-CHAIR LAMB: Gene?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR LAMB: Liz?

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

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

CO-CHAIR LAMB: Other comments? Please keep these comments in mind, especially as we go to some of our discussions about priorities. You've all raised some, I think, critically important questions, comments, suggestions that we don't want to lose as we move forward.

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

(Laughter.)

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

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

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

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

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

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

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

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

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

here.

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

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

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

So, the Committee could also add other

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So, we talked about the Rural

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

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

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

So, after the Rural Health Workgroup

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

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

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

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

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

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

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

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

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

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

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

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

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

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

program.

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

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

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

MS. MOYER: Yes.

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

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

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

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

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

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

There are changes that go on in terms

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

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

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

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

two OASIS based measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

preventable.

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

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

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

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

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

And they were in the categories of inadequate management of chronic conditions, inadequate management of infections, inadequate management of unplanned events, and inadequate injury prevention.

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

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

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

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

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

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

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

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

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

that particularly care for that population.

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

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

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

With our risk adjustment our C-

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

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

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

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

when it should be negative, and it was.

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

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

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

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

would start us off and give us your discussion.

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

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

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

MEMBER SMITH: That's okay.

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

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

MR. JEFFRIES: Can you hear Craig Jeffries?

MS. MOYER: We can.

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

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

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

MR. JEFFRIES: Thank you.

MS. MOYER: Thank you for checking on that.

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

MS. MOYER: Okay, Heather.

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

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

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

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

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

Okay. Again, when I reviewed this

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

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

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

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

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

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

all I have.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The unintended consequence is that, I

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

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

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

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

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

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

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

CO-CHAIR LAMB: Yes.

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

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

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

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

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

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

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

MS. LIVESAY: Yes, perfect. Thank you.

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

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

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

So, a lot of these conditions by themself seem fairly straightforward as preventable conditions. But when you get them

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

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

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

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

CO-CHAIR LAMB: Thank you. I think we

got all of that.

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

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

MEMBER COX: Yes. So, I'm on the National Pressure and Injury Advisory Panel. So, of course, I'm looking at it through that lens.

So, I guess this is a methodological question for CMS. So, what actually would be a potentially preventable hospitalization in relation to something like a pressure injury? Is it that the person was brought to the ER because they were septic or there was just inadequate care? How did you determine that was a potentially preventable condition in terms of including in the data set?

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

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

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

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

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

The other thing that jumped out at me

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

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

CO-CHAIR LAMB: Rikki?

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR LAMB: Is that it, Rikki?

MEMBER MANGRUM: Yes.

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

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

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

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

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

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

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

point for that.

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

MEMBER NUCCIO: Certainly.

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

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

MR. LEVITT: I'll start.

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

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

Is that better?

MR. LEVITT: That would be great.

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

MR. LEVITT: For missing information?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ease there.

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

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

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

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

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

MEMBER SALIBA: No, he answered my question.

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

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

them differently.

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

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

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

The way these have been designed is,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To actually be hospitalized or to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER NUCCIO: And the other question?

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

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

And given you're reporting on about

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

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

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

MR. LEVITT: Yes.

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

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

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

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

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

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

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

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

MR. EDWARDS: Yes.

MEMBER NUCCIO: Okay. And prior care utilization.

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

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

MEMBER NUCCIO: So, yes, because as

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

MR. EDWARDS: Yes, absolutely.

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

(Simultaneous speaking.)

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

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

They're not what we consider post-

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

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

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

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

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

MEMBER NUCCIO: Okay, great.

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

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

MS. PANACHAL: That is correct.

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

MS. PANACHAL: Sixty percent.

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

bringing up the voting please say so.

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

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

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

The Workgroup recommends MUC2019-34 for conditional support.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I'll be spending actually a little bit

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

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

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

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

of life.

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

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

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

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

reported.

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

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

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

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

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

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

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

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

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

Particularly, you know, analyzing

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

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

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

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

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

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

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

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

was exactly the opposite.

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

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

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

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

So, in other words when RN services

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

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

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

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

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

all different types of care that are being provided.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

are conducting the visit.

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

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

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

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

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

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

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

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

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

And so, it turns out that from a

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

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

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

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

Go to the next slide. The next slide

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. PANACHAL: Nothing on the chat.

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

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

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

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

But my comment/concern about two

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

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

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

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

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

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

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

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

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

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

statistically significant.

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

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

(Pause.)

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

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

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

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

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

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

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

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

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

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

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

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

So, I really, I agree with most of

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

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

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

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

Thank you.

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

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

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

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

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

looking at Medicare Advantage.

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

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

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

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

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

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

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

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

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

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

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

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

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

experiences with relatives who are under hospice care.

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

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

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

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

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

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

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

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

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

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

So, I just think like it's a whole holistic approach there. So, I think you need to capture the entire team.

I definitely think that, you know, in terms of being process measure, you know, the quality versus quantity piece I think there could be correlation to outcomes or even, you know, patient or family experiences.

And I think it was already covered about, the other point I had was about how do we identify patients that, you know, defining imminent death and the criteria. I think that was already covered. But beyond that I think all the other ones were captured by everybody else here.

CO-CHAIR MERKELZ: Very good, thank you. We do have a Rural response.

MR. SLABACH: Thank you, Kurt. Yes,

I think that one of the concerns of the Rural MAP is obviously access to care. And this has been an area of a lot of concentration.

And so, when you look at access it's driven a lot of times by the availability of personnel that would be professionals that are able in rural communities to work in these various programs and hospice would be definitely one of those.

So, we see less numbers of hospice agencies in rural communities. And so, often patients are admitted late to hospice as a result because it's difficult to find a provider who will travel that far.

And so, often then the distance becomes a problem in meeting perhaps some of the metrics that would be measured under this particular proposal. So, that was part of the discussion.

The other, but I appreciated Alan's presentation which we didn't get to see on the call which not surprisingly to me had over 70

percent was meeting the metric in this particular area which it leads me to believe that these hospice agencies in rural communities because there is less volume they may have more time and availability to be able to follow through with the care that's being provided in these instances.

So, that's a good number that really makes me feel better about this. The vote yielded kind of a middle of the road. The vast majority of the votes were, voted Number 3 which is in the middle, not liking.

I guess it's like Goldilocks. You know, it's like not too hot, not too cold. So, I don't think there was passion on either side of the equation on this one. So, and I hope that was helpful to the discussion.

CO-CHAIR MERKELZ: Thank you. Do we have any other comments from the chat?

MS. PANACHAL: No comments on the chat.

CO-CHAIR MERKELZ: And do we have any

comments from the room?

MEMBER MANGRUM: I'd like to ask a clarifying question. It seemed to me from the write up that we had that you actually used one item from the CAHPS survey which was the percentage of caregivers who said they would recommend the service.

Is that correct? Am I understanding that correctly?

MR. LEVITT: Actually, we looked at it across the board --

MEMBER MANGRUM: Okay.

MR. LEVITT: -- in terms of actually every question, you know, a whole group of questions. In other words, you look at the hospice CAHPS that include like --

MEMBER MANGRUM: Right, there's the various composites, okay.

MR. LEVITT: Exactly. And in every single one it showed, you know, positive correlation.

MEMBER MANGRUM: So, I think, you

know, one comment that I would make I think it echoes something that Raj said earlier is, you know, from a technical perspective you have a measure that you've developed by retrospectively looking at prior data, doing some statistical analysis.

You're doing a correlation between number of visits and reported caregiver experience. Eighty percent can report this measure already. Sixty-five, 70 percent are already meeting the standard.

So, the question I have is, is this really driving quality or are you sort of setting a practice guideline here that as sort of the minimum level of care that hospice should be providing is this many visits by certain clinicians during the last couple of days?

So, to me this measure cries out for careful attention at the pragmatic implementation period to see whether or not it affects other aspects of quality that you're measuring. Do those things also improve?

So, is this really measuring quality or is it just because there's a lot of room for confounding factors when you do this type of development. So, would love to see CMS and other support of either an actual trial or a pragmatic trial with results that can be examined.

CO-CHAIR MERKELZ: Thank you, Rikki. Gerri, want to --

CO-CHAIR LAMB: You know, Rikki's comment helped me clarify some of the questions in my mind. I appreciated that I came thinking, I was very ambivalent about this measure for many of the same reasons that have been mentioned.

Moving away from check list measures and certainly the very deep belief in hospice being interprofessional, you know. For goodness sake, I direct an interprofessional centered university.

I have to say that I found the testing compelling, particularly in the cuts of who were the providers who are associated with more positive outcomes. And it concerned me that at

the end of life there may be processes going on that we really need to look at closely as in say substituting for RNs or substituting for social workers.

I don't have answers for those questions related to interprofessional. But I am concerned that there are adverse outcomes with certain groupings of providers that I think we need to look closely at.

So, more speaking to ambivalence now about the measure where I came here not as ambivalent about my vote, now I'm more ambivalent.

MR. LEVITT: I would be glad to respond to everything when you give me a chance.

CO-CHAIR LAMB: Okay.

CO-CHAIR MERKELZ: We're almost there. Debra.

MEMBER SALIBA: I was a little bit curious about the 20 percent that weren't reportable if there was sort of a systematic difference between those and the 80 percent that

were reportable.

So, the particular types, groupings or agencies where you saw that the measures were not reportable. So, you get that 80/20 when you --

(Simultaneous speaking.)

MEMBER SALIBA: Were there any patterns in terms of who was not reportable because that might potentially bias that measure a little bit? The other is and I should probably know what's in hospice CAHPS.

But why not just ask families, did they get the support they needed in the last three days of life as opposed to checking off the boxes for these people? And let's see, and just one note.

I mean, it seemed to me like, you know, the visits every day versus some of the days that it was actually lower satisfaction probably was more of a marker for the patients who were having more stress or difficulty in their last three days and therefore were needing more visits as opposed, if I'm making any sense.

So, but I'm fine with the way you've dealt with that. Two out of three is fine. But just to plant that bee in your bonnet about that.

CO-CHAIR MERKELZ: Thank you, Debra. All right. We'll give Alan an opportunity here now to comment and I do want to, I can start off with the questions. Do we have one more, I'm sorry, did I forget a follow up?

MEMBER KENNEDY: Yes, actually I had a question. But I don't know if you know this. But what I hear talking to providers many times is that their return rates are low in terms of the CAHPS.

So, when you looked at the data from the measure as it is compared to the return rate did that make a difference? I mean --

MR. LEVITT: It's something we could look at. I'm not sure whether that would affect the result. I mean, the CAHPS measures are valid, reliable measures that are reported on.

MEMBER KENNEDY: Thank you.

CO-CHAIR MERKELZ: All right. Thank

you, Jennifer. Well, I'm going to steer the questions and come back over towards Raj. I'll do my best to paraphrase the questions and if we need further clarification to what I'm stating please just jump in.

Raj started off and really it's been echoed throughout the room regarding quantity not equaling quality. He gave a general comment about this.

But it does seem that it potentially would be more towards a check box process, concerns regarding quantity versus quality.

MR. LEVITT: Again, we are looking at the types of services and not the quality of the service that was provided during that particular time. This is not a check box measure.

This is a measure that's collected on claims. It's data that's already being submitted. They are claims that the service is already being incentivized.

So, hospices are already incentivized to report on these two services because they'll

get additional payment, an add-on for it. So, there's no check box here.

This is a claim. And there's no additional collection of data that will be required unlike the existing check box HIS based measure which is a burdensome, which adds burden to hospices that would be removed if we went to a claims-based version.

CO-CHAIR MERKELZ: I'm going to tie this to Rikki's comment where she was saying that, you know, this process was and I think it ties into this quantity versus quality.

MEMBER MAHAJAN: I just wanted to give an analogy of hanging up the phone. So, in case you've never seen the rotary phones so even in cell phones we hang up the phone.

Right, so you really don't, so that was figure of speech. Check box you're not really checking boxes. It's you tell them we need two visits in three days and they just do it to do it.

So, the check box here is more of a

metaphor or a figure of speech.

CO-CHAIR MERKELZ: And I'll come back to your other two questions, Raj, absolutely. But I think it did pair well with Rikki's comment regarding retrospective review that is done in this question development.

And is this actually developing some type of minimum guidelines or will it drive, is it really driving back to quality or more setting guidelines because generally dying is not seen as a significant change in condition from the hospice world.

That's typically how we see it from GIP utilization or continuous care utilization. And it does seem this is in some way setting up in a guideline that it is a significant change in condition.

I'm wondering if there was any confusion there to what's being communicated.

MR. LEVITT: So, again we used the CAHPS survey because it's our best real proxy outcome that we can look at in terms of the

experience of the dying hospice patients since obviously we can't ask them.

And so, we rely on those family members or caregivers that are hopefully involved in the care of the patient. So, that is our ultimate outcome.

And that's why we use it. Every measure that we use is based, is kind of based on retrospective data. I mean, this isn't new. This is just that we're using the monitoring and evaluation of our measures the way we're supposed to.

You know, we brought a measure here four years ago that the Workgroup reviewed. The measure was adopted in the program. And through our monitoring and evaluation this is what we found.

And so, that's why we are bringing it back to you in this way. We aren't in any way, I'm like Gerri. I spent my life taking, involved in interdisciplinary teams.

I've been doing this for, you know, 35

years. This isn't any sort of insult to the interdisciplinary process.

This is trying to ensure that the right services are provided to a dying hospice patient and that, you know, services for their symptom management or in terms of the support of counseling that are provided either by an RN or by a social worker are provided in those last days.

If, as I told you, an LPN is sent rather than an RN or an aide is sent rather than a social worker in those last three days according to the data that we've collected, the outcome that's the wrong thing to do.

It's not saying anything against all the other services. It's not saying anything against the interdisciplinary process. It's like what should we be doing in these last three days of life?

And what we should be doing is we should be incentivizing to ensure no matter what that RNs and social workers go in and see these

patients. We're incentivizing it by payment.

We're also going to measure it. What happens otherwise throughout the entire hospice stay and even at the end in terms of other disciplines that may come in, that's not what we're dealing with here.

But if we approach the end of life as an interdisciplinary process we run the risk of having the wrong people coming to see the patient at the time that they need the right people there. And this is what we learned.

Now, I go back to the first lecture I ever gave as an academic attending was on the effects of bed rest and deconditioning in the elderly. And part of my lecture was I showed all the slides of evidence from old medical literature of the positive effects of bed rest including after an MI, for example, the cardiology techs in the 1940s said there are lots of controversies but there are two absolutes, bed rest and barbiturates.

That was the community standard at the

time. That's what if I went there and I said don't do that because all your patients were going to die of pulmonary emboli you would all be looking at me saying what are you talking about, we all do it this way.

You know, this is the way we've done it. We haven't studied it. We haven't really looked to see who is right at the end of life. But this is the way we feel and it's an insult to actually say, to ensure and make sure that these services are there.

What I'm telling you is that's the wrong way to think here. The way to think here and what we need to do as a first step it's not, you're absolutely right, Raj, it's not quality.

Right now it's quantity because that's the best we can do. The best we can do right now with the data sources and the tools we have is to measure the visit.

Hopefully one day smarter people than me at least will be able to figure out how to bring quality into this. But right now it's

quantity.

And we have to ensure, it's beholden to us to ensure that we make sure that RNs and social workers are there at the end of life. What happens all the other days maybe they should be there too, I don't know. I don't know.

The reason hospice visits came up is not a CMS thing. This is, you know, this was a domain of interest for hospice care that predates me, you know, being here sitting at the table.

That result that it was important to have visits at the end of life. All we're telling you now based on the data that luckily we've collected, I mean, hospice care has been going on since I graduated medical school.

Has anybody actually looked to see what services really are important at the end of life? I've been in post-acute care. Services are our drug, you know, so to speak in terms of what we provide post-acute care.

You know, this is as far as I know, the first way of really looking and saying, okay,

what services do we really need in this one particular situation. And what we're telling you is that we need to have RNs and social workers there.

Now if you find that an insult to the interdisciplinary process that otherwise should be there for the entire hospice stay, I apologize. I can just tell you what needs to be there for these patients at the end of life.

I can also tell you that for the majority of hospice patients and for the majority of hospices themselves they are somehow able to identify close to the end of life, when they should be ramping up services.

They're even incentivized now for these services because if they do it CMS will pay them more for it as well. Will they sometimes be wrong? Of course they will.

Will they often be right? I hope they are. Sorry, I didn't answer all the other questions. But I think that was the main, you know, theme.

CO-CHAIR MERKELZ: I'll touch on some of those there. But I think this still ties in and I want to bring back in Jennifer Kennedy's comment regarding the interdisciplinary nature which you did a very good job in expanding on.

But truly to the context of holistic care spirituality and looking at this data chaplains aren't currently listed in the claims-based data.

So, when we're talking about the needs based on the data how do we merge that concept between the holistic nature and not having the data for chaplains?

MR. LEVITT: And again, we are just looking in the last three days of life. And chaplains may be important throughout the entire hospice stay.

But when it comes to these last three days of life they, what the social workers provide certainly appeared to be more. That's nothing to say against chaplains.

What we're trying to do here is we're

trying to incentivize and make sure that no matter what chaplains can still come, LPNs can still come, aides can still come. We've got to incentivize and measure what we know matters.

CO-CHAIR MERKELZ: I'm going to come back to Raj's last two points for clarification and again echoed by many in the room was regarding the prognostication and the difficulty for prognosticating the final three days.

MR. LEVITT: And again, I mean obviously we can agree to disagree. But again, evidence both from research that's been done and evidence from our experts and evidence as to what hospices are already doing in practice suggests that for the most part it can be done. Can it always be done? Obviously not.

CO-CHAIR MERKELZ: And finally, Raj, statistical analysis reviews completed where there were disparity numbers.

MR. LEVITT: Okay. And regarding disparities again, they were just rates. And what we do here is, what we really care about is

trends.

So, what we will follow in this, if there's one thing you've learned from us at least now it is we're going to continue to monitor and evaluate these measures. That's what we do.

We literally, you know, we do this on a regular basis. We will follow the trends of those rates. We don't, you know, we haven't done any statistical manipulation, anything like that.

But what we're hoping to see is that if there are differences in the rates that are there that hopefully they would decrease.

CO-CHAIR MERKELZ: Raj, was there anything other, that pretty much encapsulates?

MEMBER MAHAJAN: So, I could just have an operational question about claims-based reporting. So, although claims are there but you still have to manually report them into the system or --

MR. LEVITT: We're not really changing anything that's going on already.

MEMBER MAHAJAN: No, no, no. This is

a general question not about this particular measure.

MR. LEVITT: In terms of us or --

MEMBER MAHAJAN: For example, if you are a QRP program and your penalty is not to report. And if the only measures there are claims-based which are already there, so is there on top of them being available for everybody, do they still have to manually report them into the system and if they don't report then they get penalty versus --

MR. LEVITT: Okay. You know, claims-based is interesting because obviously the part about all health programs.

And again, in reality when we actually look and determine compliance or non-compliance we're really looking at the assessments that are completed or in the case of somewhere around the post-acute care programs the submission of NHS data to the CDC.

MEMBER MAHAJAN: Right.

MR. LEVITT: So, although they are

required to report they are already reporting because otherwise they won't get paid. I mean, we're just using the claims that otherwise we're submitting for payment.

CO-CHAIR MERKELZ: Kurtis, question from the American Academy of PM&R. What's really tying the measure towards outcomes? Is there a correlation between patient outcomes in the measure?

For instance, he said dyspnea. Pam also commented regarding is comfort achieved. So, is there a comment from you regarding the correlation between outcomes and the measure?

MR. LEVITT: Well, the only outcomes that we're looking at right now are the experience that the hospice patient had. They are broken down.

You know, part of that CAHPS measure is regarding some of the symptom management that was done or the symptoms that the individual patient had. We are, as some of you know and actually are helping us, we are in the process of

developing an assessment instrument for hospice patients.

One of our goals of that is to include assessment of symptoms within that instrument so that we could develop and build assessment based measures in that way so we could look better at symptomatic. So, that's a goal of ours.

But right now this is the best we can do in terms of looking at that sort of, these sorts of outcomes.

CO-CHAIR MERKELZ: And Pamela regarding Medicare Advantage data.

MR. LEVITT: And again, because this is a process based measure last year we had a very good discussion which has had us really rethinking some of the claims-based outcome measure development within hospice because Medicare Advantage patients even if they are fee-for-service during the hospice time you needed to be, for risk adjustment you needed it to be 12 months before which we didn't have.

Medicare Advantage patients are

included in this measure. This is a process measure based on the fee-for-service claim that comes in. So, they are actually in this measure.

CO-CHAIR MERKELZ: Gene raised a question regarding the day, what is a day as it's being defined in the measure?

MR. LEVITT: Again, we use again the definitions that are used for the filing of the claim.

One of the things that we did notice because like I was telling you one of the nice things, one of the things I felt very good about was the fact that I saw the hospices in terms of level of service of all the different disciplines went up, up, up, you know, the last really two, three days of life.

What we did see for certain disciplines was that last day it actually went down because they probably didn't have time to come in. And so, there probably is some affect being the fact that it isn't a full day.

You know, we're talking about the

number of hours that they have there that the hospice may have alive. But again, that's counted as a death.

CO-CHAIR MERKELZ: And for clarification, the day starts at 12:01, 12:00 a.m. So, if the patient dies at 1 o'clock in the morning it's the second day of service?

MR. LEVITT: Correct.

CO-CHAIR MERKELZ: So, they wouldn't get the visit intensity. Third day of death a death visit doesn't count towards the measure. It doesn't count as an RN visit.

MR. LEVITT: And again, that's included because it is again the two out of three. And you're, where are we going with this? Well, maybe what we'll see is the percentages will hopefully go up even better than they are already.

And so, that way hospice patients near the end of life are actually getting more of the services they deserve to get. Maybe one day I'll be back here talking about doing a three out of

three measure to come and then we can have the same exact conversation again for the three out of three measure because that's what we do.

We do this monitoring and evaluation. We're going to continue to look at the data. We're going to continue to help to decide what's the best course to take here with your help.

CO-CHAIR MERKELZ: And, Gene, I want to make sure I get your comment right regarding the potential for service, community based patients getting services at a lower rate as home health is required to discharge the patient prior to the patient coming onto hospice.

And it's not, application isn't still seen in the nursing homes. So, might there be a lower rate?

MEMBER NUCCIO: My question is, did you do just a stratification based on patients who were in an institutional setting versus community setting? And if so, does it really show a difference in rates?

MR. LEVITT: And to that, I go to T.J.

MR. CHRISTIAN: Yes, we did actually. So, I'm just looking at the numbers quickly. It looks like people in the home are doing a little bit better than in the nursing facilities.

So, in the, among people in the home, in their own home about 68 percent of people achieved the measure. In the nursing facilities it's down around like 60 percent.

MEMBER NUCCIO: Sixty?

MR. CHRISTIAN: 6-0 percent.

MEMBER NUCCIO: 6-0.

MR. CHRISTIAN: Yes. So, they have a little lower in the facilities. Assisted living is kind of more up kind of comparable to patient's own home, a little higher.

MEMBER NUCCIO: Okay, thank you.

CO-CHAIR MERKELZ: Ashish, I think already addressed some of the comments regarding the CAHPS. But just, you were asking regarding correlation with patient and family experience.

MEMBER SALIBA: I think what I was trying to ask was more why not just ask the

patients and families about the last three days of experience especially given these concerns about what's the right mix and how do we get the right mix and having a lot of RN -- I agree the substitution is probably the right answer for the LPN versus the RN thing. But, you know --

MR. LEVITT: And again, we're using, you know, I always say you can only bake the cookies with the ingredients you have in the pantry.

MEMBER SALIBA: Right.

MR. LEVITT: And we luckily have the hospice CAHPS survey which has been validated, which is reliable which we luckily have adopted in our program. Could there be other ways we could look at it in terms of other types of outcomes, perhaps.

But we have already this available data source that, you know, it's a good data.

CO-CHAIR MERKELZ: I'm going to continue then on with you, Debra, regarding any patterns among the groups that were not

reportable if that was looked at and is there any understanding among the 20 percent that was not reportable.

MR. LEVITT: And again, ones that would be not reportable would either have too low an amount or almost no amount. I'm not sure if we settle them together, if we look at say whether or not, what the rates were of the non-reporters together as a group versus that.

MR. CHRISTIAN: Yes. No, I mean basically as Alan said, it would be the smallest hospices that would be the ones we didn't have data for. They might be shown in the CAHPS hospices as well would be more likely to have data to validate.

So, just kind of go along with just smaller providers would be the, what we were going to have. We may want to have a formal look at that, yes.

MEMBER SALIBA: I just wanted to know if it's systematic and if it is systematic what's driving the systematic?

MR. LEVITT: Did we look at by hospice size, the results?

MR. CHRISTIAN: Yes, we would have left out the really small ones.

MR. LEVITT: Right. But it would give a trend in terms of where the ones that were 20 to 50, for example at a lower rate than 200 to 500.

MR. CHRISTIAN: Yes, it's not, this is kind of the medium ones is a little bit of a lower rate. So, one of the highest hospices, the more populous hospices there's a higher rate of these. But, yes.

MR. LEVITT: It's something, it can be part of our monitoring and evaluation.

MEMBER SALIBA: It was a friendly suggestion.

MR. LEVITT: No, no.

CO-CHAIR MERKELZ: And finally from Brock representing Rural questions regarding access to care and availability of personnel, some concerns regarding potentially also the

distance can become a problem in meeting the measure.

Certainly you showed us about over 70 percent meeting in the data shown. But certainly a concern over the availability of personnel in rural areas and I think the same availability carries over into even urban markets as well with many places only having seen social workers ability to provide seven day coverage would be a concern.

MR. LEVITT: And again, we'll continue to monitor that. We, regarding social workers, for example, seven day coverage we don't say it has to be one and one or two and two or whatever.

However it's done, it's done. But certainly as I've said before we are sensitive to, you know, continuing to follow rural versus urban statistics including that as part of our monitoring and evaluation.

If we did, you know, decide to adopt this measure and ended up coming back with a three out of three, it would be something again

that we would need to discuss with you especially if like you are considering is true.

CO-CHAIR MERKELZ: Did we have any other questions that came in over chat? Jennifer.

MEMBER KENNEDY: I just, just for future thinking, you know, if I were a patient and I was told this is the time for hospice care from a transparency standpoint if I'm referred to go hospice shopping on Hospice Compare and I was told that hospice is holistic, it's going to be a nurse and physician, a social worker, spiritual care counselor and I log on and all I see is nursing and social work and I don't see anything else that tells me about this hospice and their ability to provide a full cadre of services and what hospice is, I just want you to consider that moving forward because I don't think it represents -- and I hear what you're saying about interdisciplinary.

I do. But I don't think from a transparency standpoint it doesn't represent the

experience in the whole complement of services that are provided to a patient no matter when they come on to hospice service.

MR. LEVITT: We are, as we always do we're going to need help with messaging for any measures that we publicly report. But again, it should be publicly reported.

This is kind of like the ICU of hospice, those last three days. And that, you know, those last three days you get the right services in.

And so, that's the point is that the hospice may, you know, is, hopefully is the model for interdisciplinary care. But when we know that we need to pull in the right people we pull them in. We'll need help with that message.

MEMBER KENNEDY: Thanks.

MEMBER MANGRUM: I just want to make sort of a follow up comment. And the reason that I asked the question that I did about whether you had used a single item or had looked at all of the composites is that those composites in the

CAHPS measure really get at some of these issues that you're raising because one of the big composites I believe is around, you know, effective communication in the care team.

So, already there you have caregivers assessing whether or not there was communication and they were receiving the services that they want.

So, I am greatly reassured by hearing that, you know, when you look at this proposed measure that you're seeing a correlation between that number of visits and all of these different things that caregivers are being asked to assess about hospice.

You know, I'm also glad to hear, you know, continued monitoring goes on because there can always be these sort of unintended effects. And, you know, this is sort of a de facto standard that you're setting.

These are the services that people should receive in the couple of days of life. But in the theory of standardization there is

this odd thing that happens where sometimes the maximum becomes the minimum and the minimum becomes the maximum.

So, if you think about speed limit we set a speed limit of 65. Well suddenly that's not the minimum speed everybody travels. So, that could be one impact.

You know, minimum wage it's the opposite. You set the minimum wage and suddenly it becomes kind of the maximum that anybody offers.

So, when you set a de facto standard like this you kind of need to watch to see how does it behave when it gets into the hands of humans. Does it become that, you know, hospices are suddenly only providing these services in the last couple days of life and sort of saying we don't need to bring in chaplains and we don't need to do that?

If that happens that's something that has to be addressed. But you can't say based on the measure and the testing that you've done that

will or will not happen. You have to just observe and respond.

MR. LEVITT: Rikki, you're absolutely right. Unfortunately, there are unintended consequences to everything that we do here whether it's on a quality standpoint or from a payment standpoint.

As a reminder, those unintended consequences are already here because payment is already incentivized a social work and RN coming in. So, they are already incentivizing it which as an unintended consequence could deincentivize other services that may actually be necessary for that individual hospice patient.

That is true. And it is something we have to continue to monitor. One of the things we'll continue to monitor is like we've done is the frequency of the types of services that hospices are providing.

I mean certainly if we see a dramatic shift, for example, and suddenly no aides are coming in even a week or two weeks prior to that,

that would be a concern.

So, again in other words there has been such a shift that maybe we have over-incentivized one piece for one particular part of the stay and the unintended consequence has been that the patient is no longer getting services when they could have really used those services at the other part.

The key is monitoring. I mean, you know, it's not, you know, putting your head in the sand. And also coming here and admitting when something real, came here thinking we were doing the right thing with Measure 2.

And guess what, we weren't. And that's part of quality, part of all of our universe here, you know, whether we're inside CMS or outside world is we should be monitoring everything we do and when we find that something is wrong we don't ignore it, we fix it.

We continue to look from there. That's what we continue to do.

CO-CHAIR MERKELZ: At this time I

guess I'll turn it back to Amy looking at voting considerations for MUC2019-33.

MS. MOYER: So, we had a robust discussion around this measure. Just briefly from the preliminary analysis because I'm not sure we add anything to this discussion by reviewing it, I do want to talk about the staff recommendation which was conditional support for rulemaking.

And there are actually two conditions. Only one is listed in the discussion guide. One was removal of the existing measure so there is not the duplication in the program which CMS has already indicated they are doing.

The other is NQF review and endorsement, our standard. So, with that any questions on that as the starting point? I think we are ready to open for voting.

If anyone has issues with voting please raise your hand or let us know because we do want to make sure that we get everyone's vote accounted for.

MR. HIRSCH: Voting for MUC2019-33 Hospice Visits in the Last Days of Life. I do support the preliminary analysis of the Workgroup recommendation.

Again, the preliminary analysis was conditional support. Your options are yes or no. Voting is now open.

Voting for MUC2019-33 Hospice Visits in the Last Days of Life for supporting the preliminary analysis Workgroup recommendation is now closed. Nine votes for yes, six votes for no.

(Simultaneous speaking.)

MR. HIRSCH: So, the Workgroup has elected to take the preliminary analysis recommendation of conditional support.

MS. MOYER: I think it is time for a break. We'll reconvene in 15 minutes.

(Whereupon, the above-entitled matter went off the record at 2:05 p.m. and resumed at 2:23 p.m.)

CO-CHAIR LAMB: We're going to move

into the strategic considerations discussion. And two things Kurt and I would like to do to introduce this. One is to tell you about how excited we are to have this time to do this together. The other is just some suggestions about launching the discussion.

So first off, we have been, Kurt and I, have been talking with Amy and Janaki and Jordan about having a robust discussion about what are the gaps in post-acute long term care, where are areas that are priorities for alignment?

And for those of you who have been around this table for a number of years, you know, usually we have a lot of measures. And by the time we get to make recommendations, people are tired and they're just kind of, do this, do this, do this, do this.

So we were wanting, and here's our hope, is that if we can talk with focus for an hour about where should we be going, what's important in post-acute long term care to

measure. I mean, just look at the wealth of expertise around this room. An hour of focus? We will be thrilled to pieces. So we're just -- just so pleased to have this hour together to do this. What we're going to suggest is a couple of things. With Amy and Janaki and Jordan's assistance, is where we thought we might start this discussion -- and we're certainly open to your recommendations -- is to start with two things.

One is CMS's Meaningful Measurement 2.0 just to kind of do a reminder of what are CMS' priorities; what are the new priority areas? And then what we'd like to do is show you what are the leverage opportunities that we, as a group, in post-acute long term care identified last year and start from there.

This is an open dialog. Anything that you want to recommended is on the table. So how does that sound, if we just do a quick reminder of CMS 2.0 and then look at our own leverage opportunities?

For those of you who looked at the different post-acute long term care programs, if you had a chance to look at where do we have measures in some key areas, where there are gaps, that might be something to bring up. Okay?

Like, for instance, in, with my other hat in patient experience, care coordination and function, what I mentioned before is in that committee, we have several function measures coming forward.

We have very few patient experience and care coordination measures coming forward. So with your expertise, to identify where do we have gaps, where might we make recommendations, particularly as we have our CMS colleagues here, measure developers here.

So how does that sound as a starting place? Is that good? Anybody want to add anything to it that they would like to kind of bring into this? Okay. Could we bring those slides up?

MS. SCHREIBER: Can I just make one comment, if I may?

CO-CHAIR LAMB: Sure.

MS. SCHREIBER: I'm sure there will be, really, lots and lots good ideas. I have no doubt about that. But I'd also ask us to think about the prioritization of those ideas so that we have some directionality of what really most important because we're never going to accomplish them all.

CO-CHAIR LAMB: Well, that certainly sets limits on our conversation. Obviously, we can't brainstorm everything.

All right, so you all heard Michelle's request that we also say what's most important. Okay, so here are the questions that we are posing to each other. What are important quality concepts? Does everybody have this in front of them on the table? So you have this.

MS. MOYER: There is a separate printout of this because we may bring some different things on the screen throughout the discussion. But we wanted you to have the questions handy. So it's in your stack of handout

materials.

CO-CHAIR LAMB: Okay, it's labeled as discussion questions. It's under your pile of materials.

MS. MOYER: And for people on the phone, this is in the slide deck for the new team, Slide Number 48 of the personal slides.

CO-CHAIR LAMB: Okay. So what we're going to be looking at is quality concepts, gaps, alignment across our post-acute long term care settings and priorities. Okay?

All right, you want to put up the meaningful measures? I think it's Slide 19 that we were looking at earlier today. And then if we could go back to Slide 15. So let me -- yeah. No, that our leverage -- this is CMS' meaningful measure areas. 19.

All right. And you should be able to see it at some around the room. We're not memorizing this, but just to go -- these are six core concept areas that you just want to get in your head: communication, coordination,

prevention, treatment, chronic illness, chronic disease, communities and healthy living, make care affordable, safer and patient and family or person and family engagement.

And communication, coordination, chronic disease, community and healthy living, affordability, safety and patient engagement.

And by all means, you jump in anywhere you see fit because this is a collaborative activity. If you would go back now to Slide 16?

Okay, and these are the priorities that Michelle and Reena and Alan spoke about, which is patient reported outcomes, the electronic clinical quality measures.

This is just again, to remind us what does CMS put priority on. Doesn't mean we have to align with that. This is our discussion. Opioids and avoidance of harm, nursing home infections, maternal mortality and I can't read that -- oh, sepsis.

MS. MOYER: Sepsis.

CO-CHAIR LAMB: Okay. Does anybody

need to review either of those? This is just sort of a reminder about what CMS says is their priority areas.

MR. MAHAJAN: Gerri, I would just add cost.

MEMBER HOPPE: I mean, I'm on the phone. I just had a question about why sepsis was removed from my category of nursing home infections. Is this meant to be the entire PAC continuum? And what do CMS or others think about sepsis? Obviously, they think it's appropriately recognized and treated.

CO-CHAIR LAMB: I think the question is why is sepsis a separate category of priority categories from nursing home infections?

MEMBER DUSEJA: Because of cost of care to continuing to -- yeah, so --

MEMBER HOPPE: Not just the cost of care.

MEMBER DUSEJA: -- every hospital -- well, we had some measures in the hospital setting and they were off, so it wouldn't be to

post-acute care.

CO-CHAIR LAMB: So this is across the continuum and this is across settings?

MS. SCHREIBER: Plus, for us, we actually view sepsis in a somewhat different category with different measure than infections. Infections is usually, you know, it's reported through NHSN CLABSI CAUTI, and sepsis is actually a distinctly different measure and almost process.

CO-CHAIR LAMB: Does that answer your question? Who was that, Dheeraj?

MR. MAHAJAN: That was Kurt.

MEMBER HOPPE: It does. To the clinician, the infection, certainly in multiple areas of post-acute care can be problematic. And I agree that in a skilled nursing facility, that it tends to go outside of the hospital setting, sepsis can be a profoundly important issue to recognize.

CO-CHAIR LAMB: Good question.

MEMBER HOPPE: But I was just

wondering if there was an answer, if there have been a separate issue with sepsis.

CO-CHAIR LAMB: Thank you. Thanks for the question. Okay, if you would put up now our leverage opportunities. These are the ones that our group identified last year as priorities for post-acute long term care.

MS. SCHREIBER: And for those of you who are on the phone and can see a computer -- I know some of you may be driving now -- this is Slide 14 from the orientation webinar. Public Deck Quality Forum deck for it, I want to say.

MS. PANACHAL: And if you're on the Web platform, I can share the link as well for -- with us.

CO-CHAIR LAMB: And for those of you who have limited vision like me, I'm going to have to stand right up close to that.

The key areas, if you remember those six areas for CMS Meaningful Measures 2.0, we also identified six areas. In my view, some of them overlap with CMS priorities. Some do not.

So what you have in front of you is -- oh, thank you, Amy -- is function. If you want a jot these down, because this is where we said we wanted to encourage the CMS to put energy -- function, and the core concept is functional and cognitive status and mental health.

Next one was goal attainment, and it's the achievement of patient family caregiver goals and advanced care planning and treatment.

Next one is patient and family engagement, experience of care, shared decision making, patient and family education.

Next one is care coordination: transitions of care transits, transmission of information.

Safety -- so there's seven of them -- safety: falls, pressure ulcers, adverse drug events, cost and access, inappropriate medicine used, infection rates, avoidable admissions.

And then finally, quality of life: symptom management, social determinants of health, autonomy and control and access to lower

levels of care.

So we had recommended one, two, three, four, five, six -- seven core concepts with some similar measures to what CMS has set as a priority and some different. So here is an opportunity to look at what do you believe is important.

You're representing organizations also as content experts. Where should we be heading? Is there any other information you would like before we just launch into a discussion?

MS. SCHREIBER: Can I ask a question?

CO-CHAIR LAMB: Of course.

MS. SCHREIBER: Can you just explain to me a little bit how goal attainment is maybe different than quality of life? Goal attainment wouldn't be something in quality of life? Or I just don't understand the difference.

CO-CHAIR LAMB: Does anybody remember the discussion? My thought on that was that it was such a dominant part of the conversation, we wanted it separated out specifically in terms of

goal setting with patients and patient involvement.

And it could also be part of patient and family engagement. So I don't know that it was as clean cut as you're thinking, Michelle.

MS. SCHREIBER: Okay.

CO-CHAIR LAMB: Does anybody remember any different?

MEMBER SALIBA: I think Michelle raises an important question. I think the difference is typically, then, that most of the quality of life surveys are just getting at our assumption of what constitutes your quality of life, right, so being for your pain, not being short of breath, you know, being able to spend time with family and friends.

But whereas the other would be you set the priority. You set the goal. And then it's measured. It's sort of a traditional difference, but, clearly, you can't have quality of life without your own priorities being met, so.

MR. STOLPE: I guess that this was --

is dated 2012. I'd be surprised if anyone --

CO-CHAIR LAMB: Oh, actually it is though.

MR. STOLPE: -- in the room can remember exactly what the intent was. But in our person-centered planning committee, we spent quite a bit of time talking about patient family caregiver goals, particularly to the relevance to back LTC settings with the idea being that person-centered planning is not just about the health and safety of the patient, but to take into account a variety of things related to the care that they receive, which may include goals that are entirely separate from what the patient's medical goals may be and that this is a necessary element of their care.

So just not --

CO-CHAIR LAMB: Thanks.

MR. STOLPE: -- not strictly focusing on quality of life per se, but getting more granular as to what the needs and desires, preferences of the patient actually are.

MS. MOYER: Ms. Lamb, this slide is not available to the work group, right? Or -- we didn't see it in our materials.

CO-CHAIR LAMB: It was part of our orientation seminar.

MS. MOYER: Okay.

MR. STOLPE: So it is available.

CO-CHAIR LAMB: It is available.

MR. STOLPE: It's just a separate presentation.

MS. MOYER: Got it. Okay, just note --

CO-CHAIR LAMB: But as Sam is pointing out, it's old.

MR. STOLPE: Old, right.

CO-CHAIR LAMB: So if your pleasure is such that, even where we are today, you see adjustments, go for it. So who wants to start the dialog? What do you see as important gaps that we need to address in post-acute long term care?

PARTICIPANT: Hi. This is Marie (phonetic), and I'm Acting Long Term Care

Coordinator at CMS.

And what you've already met, then, as far as patient engagement, coordination care, safety, we also are looking -- we'd like to see a gap or address the gap of nutrition. That tends to come up a lot in the industry to have that within our purview of what we are looking for.

And then also fragility is come up with frailty among the patient population. There are two other areas that we see some gaps in as well as the sepsis that's already been mentioned.

I think some of these fit into some the other categories that you mentioned. And as far as patient goals, we do have some of that already captured in a function measure. But it's not patient driven. It's more about clinician driven of what the patient can do as opposed to what the patient probably would like to do.

But those things could be married up moving forward.

CO-CHAIR LAMB: Brock?

MR. SLABACH: Thank you. One of the

concerns of the Rural MAP -- and we've talked and I mentioned it earlier -- is access to care. And looking at metrics that -- let's start to get a handle on the costs of not having care or the costs of inaccessible care in an area or a community.

I'm looking at the cost access line, the second from the bottom, and I'm not -- neither of those core major concepts really address the issue of access. It's mostly cost.

And when I look at states like South Dakota, where there's been in one fell swoop, nine nursing home closures, all in rural communities, those create real voids that are hard to measure. And the impact of that is really significant.

So I don't have any suggestions in terms of measures. This could be measure development, but I think it's an important conversation in terms of going forward.

CO-CHAIR LAMB: Raj?

MEMBER MAHAJAN: I just wanted to --

I mean, I definitely think the care coordination piece is really important. And from experience, really a lot hinges on information getting transferred more electronically than papers.

And since interoperability has been such a high on the CMS list when it comes to the position QPP that the whole meaningful use has been renamed as promoting interoperability, I would definitely like for CMS to look into having a proper interoperability-related measure in a cross-setting.

CO-CHAIR LAMB: Rikki?

MEMBER MANGRUM: Following up on something that Brock just referred to, and I come from a state where there are also these sort of deserts of care. It's not just for nursing homes but even for hospitals.

And so I think it's-- it was nice to be reminded that this is old because I feel like we've started to do more synthetic thinking about how these things are interrelated.

So when I think of access, I come now

to think more and more about how far are people having to travel for care. So that has a lot of knock-on effects. It can affect quality of life by limiting visitation from families and friends.

It affects care coordination if you have to no longer receive care from your preferred provider who may have been your doctor for decades. And it can also lead to sort of dropped balls in terms of even knowing what the patient and family's goals were, let alone being able to attain them.

So, to me, that's sort of a very simple way of measuring things. It's used for other types of care. But I've not seen it used much in post-acute and long term care, sort of good looking at those population statistics of, you know, how many counties are more than a hundred miles or 50 miles or whatever we might want to say is it is too far from a SNF or a nursing home.

There's been other discussion of it in terms of how far do providers have to travel for

care and how does that impact all of these categories.

CO-CHAIR LAMB: Heather?

MEMBER SMITH: I would just like to go on the record to say that I support Raj's suggestions. I'd like to see us really think about a measure around interoperability and care transitions. There's a lot of transitions that happen throughout this and, you know, between acute care and post-acute care settings as well.

The other thing I would mention -- and I know we've talked about it quite a bit -- talked about it a little bit earlier today and then, you know, in previous discussions over the past couple of years -- patient reported outcomes for these settings, I think are really critically important to bring the voice of the patient in.

And although this probably falls beyond the realm of this group in particular, I would really like to see us think about function as it relates to what is going on as they're transitioning out of acute care into post-acute

care, especially as we're starting to think about getting patients to the right level of care as they transition through these settings.

And all of the changes that are going on across the post-acute care continuum right now with payment policy changes and just structural changes as we move to, potentially going towards a unified payment structure, really thinking about level of function for those patients that are coming out of acute care and how that should drive appropriate level of care at the next setting.

So I realize that's probably a little bit beyond this because we're focusing on post-acute care, but I do think it's really important to start to connect these dots a little bit more.

CO-CHAIR LAMB: I'd like to add something to Heather's, which is I was looking at kind of the lists that we get of our post-acute long term care settings, trying to look at where we're -- where do we have similar measures across settings.

And one place that we do have some similar measures is the function -- exactly what you're saying, Heather -- but not all the same.

MEMBER SMITH: Right.

CO-CHAIR LAMB: So that may be a low hanging fruit one. And in looking at -- in some of them, we have things like mobility and ambulation and so forth. But there are some similarities there, that we might look at, moving them across all the settings.

MEMBER SMITH: I mean, I know that that was discussed in the IMPACT Act as well, and so I just wanted to bring that up.

CO-CHAIR LAMB: Yeah, because that's one for alignment.

MS. SCHREIBER: Can I just add a little bit to the alignment? So you're talking about aligning across post-acute care, but I'd also like us to be thinking about aligning across the continuum of care.

So are there post-acute measures that should be in the hospital and vice versa -- or in

the ambulatory setting or what have you? You catch the drift, is how do we know this across the community.

CO-CHAIR LAMB: Absolutely.

MR. STOLPE: Maybe in the long-term --

MEMBER HOPPE: This is Kurt Hoppe. I have a question about -- well, I'd like to see a more robust discussion of where we're all going with social determinants.

Because I think that that's a very rich area for a lot of research and a lot of discussion. I would like to see those social determinants of health to be sketched out in a broader perspective as well, probably get a lot more granular than we have now, and what effects that would have upon access and care provision across the entire post-acute care continuum as well as transition from acute care.

And I think that there's -- there are some avenues that providers may be able to address some of the issues that delay discharge or do not lead to outcomes that we all desire for

these patients.

But I think it really needs to have a lot more work before it's probably foisted on the provider community.

CO-CHAIR LAMB: Does anybody want to speak to social determinants?

MS. SCHREIBER: Actually, can I just speak for a second?

CO-CHAIR LAMB: Sure.

MS. SCHREIBER: I think your last point, that it needs more work before we foist it on people is really important because frankly, we are doing a lot of work within CMS.

ASPE is looking at social determinants. Actually, probably every group I know is looking at social determinants. And the issues are several.

Number one, there isn't consensus about what you look at and what you measure. Is it just dual status? Is it, you know, census data? Is it an area deprivation index? Is it food, transportation, literacy? I mean, you know,

the list goes on and on. And so I think that's one issue.

And then the second issue is there is a real philosophic disagreement in the quality community about what you do with that, because there's a group who says you don't just because you're really creating a two-tiered level of care. You're giving a buy, for example, if you adjust for this and then there's, of course, another group that says, no, you must. So I think some of these, A, operational and, B, philosophic issues almost need to be settled.

And then I don't -- I'm not proposing that we even have an answer. But I think there's a lot of work and it is ongoing. But I think it needs to be settled a little bit more first.

MEMBER NUCCIO: If I could jump in --

CO-CHAIR LAMB: Sure, go ahead.

MEMBER NUCCIO: Thank you. I'll take part of the blame for social determinants, so --

CO-CHAIR LAMB: All right.

MEMBER NUCCIO: So given those in NQF

that foisted that on the system, NQF does have a wonderful report on -- that outlines social determinants, socio-demographic characteristics are. The issue is -- I think it's a nice laundry list to start with.

The problem that we're having in terms of using that information with our measures is there's a lack of data at a granular level that will provide us with the information to adequately or to improve the models of prediction that we use for that.

It's getting better, but that is a limitation. Regarding the philosophical difference between should you adjust for it or shouldn't you adjust for it, that came up actually in the last scientific methods panel. And a measure was not approved, if you will, or sent back to the developers, because they said in their report, yes, it is very clear that there are social determinants health related to opioid use, but we're not going to adjust for it.

And we're like, really? And the point

is that you can do it. You can adjust for some of these factors and then see what else is going on. The difference is then, even after you've adjusted, points to what policy differences there are within the different states, for example, because it's a population measure.

But there's a difference in policy matters for different states and not by adjusting for social determinants of health and equalizing the footing, that you can see what else matters.

And in some of these what else matters that can, you know, push us in a, or push, perhaps advocacy groups tend to make changes in those areas. So I think that's my medical byte, I guess.

CO-CHAIR MERKELZ: Well, Gene, I appreciate that we finally have somebody to blame. Yes, I appreciate you owning that.

MEMBER NUCCIO: Yes.

CO-CHAIR MERKELZ: I think there is -- and there's a lot of -- there's far more questions regarding how to further venture in the

socio-economic determinants. But I think there's also some launching pads that we could look at.

And medication management comes back commonly. We see it across the board. We commonly see it in these measures. And as we look at the ability for providers to measure the same thing, whether it's from a hospital to a post-acute to keep a home health, even to a hospice, how patients get access to their medications, how they utilize their medications, how they monitor their medications, how they respond to their medications.

This does get into many of the socio-economic factors and actually it can become a very good cross-alignment measure to look at further.

CO-CHAIR LAMB: Rikki?

MEMBER MANGRUM: So for me, social determinants of health comes back to something, Michelle, that you talked about very early on, which is the notion that there needs to be greater partnership.

I think -- I feel -- agree that there is a lot of sort of important and also uncomfortable conversations that have to happen about what social determinants are, what impacts they have and how they should be addressed.

And I think that there is now a growing recognition on all sides of the table or the roundtable, all angles of it about that. I mean, one of the things that I've noticed just in the last couple of years is that a lot of people in public health or organizations that actually work to address social determinants in the community don't even like the term anymore, and they just want to talk about equity.

And so, you know, that, to me, is bothersome because I've had a long career and I've been to a lot of these rodeos where we just argue about terminology for five years and then we start over with another disease --

(Simultaneous speaking.)

CO-CHAIR MERKELZ: It's easier to do that than face the issue.

MEMBER MANGRUM: Right, exactly. Exactly. But another comment that I hear very often is that it would be helpful to people who are trying to address these things if the big measures were just aggregatable so that you could really look at these different social and economic groups, racial groups, whatever you wanted to look at and see how they are performing.

And that gets back to the basic adage of, you can't change what you can't measure. And some of the measuring that I see going on by like a like grassroots organization is kind of sketchy. It would be good if they maybe were able to use the same kinds of measures.

Another sticky wicket, I think, is that there is a lot of distrust outside of the health care sector of the health care sector, because they have so much money and so much control.

And very often, and I agree that this is a realistic criticism of us, we focus a lot on

health care delivery and we talk about patients who are already sick. And so I've seen in the last ten years almost a more of a pulling away and wanting to not work with health care providers, which I don't think is healthy.

But I think it's something that can be addressed and that CMS can help the community world address by helping to facilitate partnerships and a rebuilding of trust.

CO-CHAIR LAMB: Along -- Rikki, along those lines, one of the questions I have, because I just became more aware of all the efforts going on to measure social determinants, and there's a lot.

And going back to what Michelle was saying, is there a lot of philosophical issues as well as measurement. Is this train out of the station and kind of like your five-year let's watch this happen is, it seems to me that there are organizations now that are proposing risk stratification for social determinants. They're doing use cases.

I'm just wondering if CBS needs to be involved in kind of that national movement to really help standardize it because it's moving.

MEMBER MANGRUM: No, I agree with you. It is. Look, I'm a primary care physician from the city of Detroit. These are very important to me. I mean, this has been my life.

And I wish we had the answers. We are working on them. Again, I know ASPE, because a big white paper that will be coming out with some recommendations. The Office of Minority Health within CMS is working on these.

I think you're right. We need to -- maybe it's just take a stab at putting something together and moving it forward. I think it's also going to help as more organizations are starting to collect this data.

So, for example, Abbott, the EMR vendor this year, in their latest upgrade has a whole host of social determinants that they're now starting to collect in a very systematic way. Once we/they have that data and can start looking

at it, I think it will help answer questions. But I think you're right. We kind of need to get ahead of it because the train has clearly left the station.

CO-CHAIR LAMB: Now should -- and I wonder if any of the rest of you see it or have a concern about a similar thing that I saw with care coordination, which is it moved from kind of very primitive measurement into coding, into payment.

And then we started trying to deal with attribution, but never really got very far with it. Meanwhile, only certain providers can be paid for it. And there's a cast of millions behind them who are not represented in the EHR.

And I see the same thing happening with social determinants potentially. And that's a concern as we've talked a lot about teamwork today and inter-professionalism with hospice. And our EHRs don't support that. Deb?

MEMBER SALIBA: Yeah. So. I guess my comment that Alan made earlier today that I would

like to go back to the framework of talking about, I call them social drivers -- sorry to get into the terminology, but determinant that go like this, this fixed thing that, no matter what you do, the outcomes are just always going to be worse for certain populations.

Whereas I do think driver is more of a way of recognizing that it's driving the outcomes for people. However, I think Alan made a really important point earlier today, and that is how are we going to use these?

Are we going to use them to let people off the hook for quality and accept that they are going to be quality differences with a different populations. Or are we going to use this to say, let's understand why these differences exist and look at the differences, which, obviously, the way I'm framing this, I'd prefer the latter.

And -- or we going to use these to say, well, you know what, it takes more resources to take care of certain populations. And so therefore, instead of letting people off the hook

quality wise, we are going to provide more resources if you're providing care for those people.

So I think we need to think about how we need to be very careful about how we plan to use these. That said, we definitely need good measures of what this is so that we can do those root cause analyses.

We can look at organizational literacy in the way that organizations approach folks. And so -- and that's been always one of my concerns when we get in here and we start talking about reliability of the measures and within group variation versus within provider variation as opposed to across provider variation.

Because if there are biases within organizations and how they treat different sub-populations, we're going to see large or poor reliability within organizational performance. And we're going to dismiss that as a bad measure when, fundamentally, the problem with the measure may just be that certain populations are getting

better care with a certain provider than other populations.

And so I think it's very important to be able to measure this, to be able to look at it. I would be not at all support risk adjusting quality measures for it until we're much, much further down the path.

MS. PROCTOR: This is Joan Proctor, and I've been troubled for many years now regarding this discussion about social determinants --

CO-CHAIR MERKELZ: Joan, could you raise your voice?

MS. PROCTOR: I said I've been troubled for a while --

CO-CHAIR LAMB: I still don't -- I still don't -- could you raise your voice.

MS. PROCTOR: I've been very troubled. Just, to me it almost appears that it's taking on a life of its own in this discussion in recognizing that there are disparities of care among the various segments of our society.

But I think it's -- to me it's almost like it's stating the obvious and that the real focus needs to be, if we originally go back to what our real focus is health care, which is improving the quality of care across the spectrum.

This issue gets subsumed within that. It wouldn't take much for me to tell you some nightmare stories that I've seen over the years with health care and that all of us seen in areas in which there is an obvious difference in the quality of care available to a patient based upon their zip code.

And so that type of analysis, you know, it's sort of like -- and I go back to the old ways, as the way my grandmother used to describe things. You know, you think that's sort of what her response was when it was very obvious what the answer was.

We know what the problem is, but I think it's systematic of something that's bigger. It's a symptom of something a lot larger than

healthcare. And if I, from my perspective believe that those nuances that exist need to be addressed into totality of quality of care, and what that is.

Because to me, as an African-American, my medical needs are no different from anyone else, from any cultural group. So assuming that they are the same, I believe the approach -- the only way to make the approach fair and to be comprehensive is to look at it from that perspective of everyone's need for quality health care.

And I'll get off my soapbox here. Probably not very popular at this moment, but that's just, you know, that's sort of the thinking that has been coming at this is, is why are we making this distinction with how many of us haven't been to a poor hospital and said to ourselves, we couldn't wait to get out of there because we knew that the family member wasn't going to get good care there?

Well, the truth of the matter is that

hospital doesn't have the same resources as some of the nicer hospitals do. It's not a mystery as to why the outcome would be different. So I don't know if this conversation, if CMS, as a fellow agency, is really ready for this type of conversation that we've involved in health care.

Michelle, I'm just saying it, just sharing my thoughts here that, you know, this is where I'm coming from. This is my perspective.

MS. SCHREIBER: I don't think what you're saying is that different from what other folks are saying today. I think there is a recognition that, you know, we've been describing disparities for a very long time.

I do disagree that we might not know the root of all the disparities. I think we need to understand how to fix it and how to go in and really make it better. And is it more resources? I don't know. I might be.

I mean, clearly, these are under-resourced communities and under-resourced facilities. Is that enough? Is that going to

deal with, you know -- I mean, we, you know, in the Veterans Administration, we see less disparities, but there's still disparities, even in the VA where everyone is getting paid -- you know, the payment doesn't vary based on somebody's social determinants, drivers at all.

So I think it's complicated, but you're right. It's not just about describing the differences. We need to go in and fix them. And that's what everybody's saying. It's just a matter of, you know, what's the best way to do it, so I don't think you're going to get fired yet.

MS. PROCTOR: Hopefully not.

CO-CHAIR LAMB: Al?

MEMBER LEVITT: I've been here for seven years now. We were having the same discussion, unfortunately, seven years ago. This is a challenge, something we really do look at every day.

I mean, you know, and it reminds me evaluation because it is something that does keep

some of us up at night, you know, trying to make sure that when we have the right thing in our measures.

And, to me, sometimes our measures are our measures, and it's not the measures themselves. It's how they end up getting used. And maybe we should be looking more at that and saying, okay, well, you know, these are the particular results that we're getting within whatever subset. Do we ever want to subdivide them?

And then looking at that and saying, okay, well, these are the measure results and whether we categorize them, whether we put different sorts of schema on them to recognize that there are certain challenges that providers of health care within certain -- taking care of particular groups of patients have different challenges.

Whether it's the resources they have or the patients' abilities to get medicines or, you know, all the other multiple factors, whether

we should be really approaching it more that way. I, too, don't believe we should kind of risk adjust away the results of them because then we don't -- we no longer can even identify them up front.

So at least if we don't risk adjust them we continue to look at them. And then we just take the next step, take those results and then we analyze the results themselves in terms of how we use them, approach it more that way, and I'm not on the risk adjustment side of things.

MEMBER DUSEJA: I just want to add to Alan his comments. We do have examples within CMS, hospital-based programs, for example, HRT, where we actually adjust at the program level when it comes to payment.

So similarly, with MIPS, we also have like a complex of adjustment for providers, to add additional an bonus for those providers. And I think that that's another consideration. I'm curious to hear from the reaction from the work

group that that's the way we should be thinking about it.

Instead of controlling or trying to adjust away at the measure, but to do it from a standpoint of the incentive structure. Certainly we could affect payments. We could think through ways to provide more resources when we identify certain facilities are poor performing.

Just wanted to get your thoughts because we have examples of that across the other sites.

MS. MOYER: Hi. I said I'd interrupt now, but four months ago was running pay for performance programs and had a lot of discussions with providers around things. Sometimes I worry the more complicated an adjustment we make the payments for things that we risk kind of obfuscating the costs.

And you know, one of the things we'll hear as well, this costs so much because of that. Well, then let's allocate those costs and allocate those payments and put things so we can

see what things really cost and what money needs to go where to have the effects we want to.

And so sometimes I worry it just all becomes so complicated. It's just all theoretical and not tied to any of it. It's hard to kind of make it real.

CO-CHAIR LAMB: Any other areas that anybody would like to speak to? So I think what we will do is kind of put up what we've listed so far and just see if there's any agreement on some priorities to share with CMS.

One thing that I would like just before we move into that, Rikki, I've been thinking about your comment from this morning, which is that we need a new way to look at patient preferences and getting the patient into this story.

Can you speak a little bit to what you're thinking there?

MEMBER MANGRUM: Yeah, so, I mean, this even is applicable to this conversation

about social determinants because one argument that gets made there with some groups is that a lot of the measures that we use are already biased against certain social groups because of the way that we go about making measures.

And so that, along with some other experiences I've had over the last ten years, has really made me wonder if we haven't reached a phase in which we need to do some real intellectual navel gazing at how we go about making measures, how we go about evaluating them.

And is it really a one size fits all proposition? Because I'm not sure that it is. And I know a couple of years ago NQF talked about it or maybe has already implemented sort of a new dimension of examining quality of measure by looking at its implementation.

I think to your point, Reena, how people behave around measures, I think, is something we need to spend more time looking at, because that's where all of the unintended -- not all of them, but many of the unintended

consequences tend to occur.

So I just recently watched a weird YouTube video by a physicist who talked about some particle that sort of goes along in space and it's rotating like this, and the second you measure it, it stops.

(Simultaneous speaking.)

MEMBER MANGRUM: And I thought, what a beautiful metaphor for the problems of measuring things, right, like the second you measure it, its behavior changes. And that's not something that we see a lot in what we do.

And I think it's because we've been through this phase in health that I think that has the social determinants that equity folks are in right now of producing lots of measures and sort of throwing lots of darts and waiting to see what sticks to the wall.

And then you go through a period of tearing your hair out, saying, we need a personal --

(Simultaneous speaking.)

MEMBER MANGRUM: And that has made me wonder whether the piece of the puzzle we haven't been missing is looking at how the process and the existence of metrics actually changes the way people behave and understanding what looks like.

So that's what's been in my mind a lot. And I think another point that I was making specific to patient reported outcome measures, is that we have a lot of them for which we don't really know what we should know about the foundation of that measure in terms of the patient voice.

So, you know, you see a paper where they say, well, we had some focus groups and we talked to some people who look like this and they told us these things, and here are themes. I've got to the point now where I want to see your transcripts.

You know, we have very good systems for how we clean up and share quantitative data with each other. We need to do the work on figuring out how to do that with qualitative

information and doing a better job. You know, I have a side gig as an editor for the qualitative report, which is a qualitative methods journal.

And you wouldn't believe the quality disparity we see where the method section is this long and you say, well, that's just not enough information. No one can replicate this. We don't know what you've done. You've given us some quotes there out of context.

And I think that, from my perspective as a qualitative researcher, this is a huge gap in what we do. We don't have really rigorous and robust and consistently adhered to standards for how this type of information gets reported so that it's also usable for the purposes of building and testing out new measures, right, because we keep having focus groups of people about their pain and interviews about them, with their fatigue and what is depression like for you. And that's because we don't have good methods for atomizing this data being able to share it and use it.

CO-CHAIR LAMB: I'm really impressed that you are that articulate at 3 o'clock in the morning.

(Laughter.)

CO-CHAIR LAMB: It's just so --

(Simultaneous speaking)

CO-CHAIR LAMB: Anyway, all right. So we've generated a list of things that you all have mentioned. And in our last, before we kind of sum up the meeting, Jordan, are you ready to put it up?

MR. HIRSCH: Just one moment.

CO-CHAIR LAMB: One moment. And what we're going to do is just look at the list, see if there's anything else you want to add, because look at this, it's 2012 and we're about to create the 2019 version. Now if we'll only prove it right, that's a good thing.

MR. HIRSCH: It'll be on in just a moment, back.

(Off-microphone comments.)

MR. HIRSCH: Well, we can make it

bigger if anyone needs to.

CO-CHAIR LAMB: All right, so these are the areas, the concepts and priority areas that we've all mentioned. One is access to care, for example, availability of resources, travel distances.

Another is the care coordination, data set, a measure set, interoperability, patient reported outcomes, social determinants/drivers. And there also was a call for looking at alignment across the continuum, particularly in the area of functionality.

Is there anything that you'd like to add to this before we put any priorities? Understanding this is not a complete list. It's sort of a think list. This will not -- I would assume go into posterity at this point, but it'll be our thing work together.

MS. AMIN: Gerri?

CO-CHAIR LAMB: Yes.

MS. AMIN: Just add to, that I heard, well, first about fragility and nutrition, I

think were also added on.

CO-CHAIR LAMB: Okay, now were those from -- those are CMS priorities. So those did not come up in this group.

MS. AMIN: Oh, okay. Yeah, thanks.

CO-CHAIR LAMB: Okay, important, but not from this group.

MS. AMIN: Okay, that's correct. Thank you.

CO-CHAIR LAMB: Raj?

MEMBER MAHAJAN: One of the things that we have discussed last few years that some of us believe is the reason why this whole quality concept in post-acute long term care is not progressing, is because of the practitioners -- i.e., physicians, practitioners.

Their incentives are not aligned with the incentives for the facilities. And I would -- there is somewhere on the table, somewhere the concept of, through the MIPS program, enabling facility-based reporting within post-acute long term setting.

I'm not sure where that work is. It's fairly complicated, not as simple as hospital where you just use your VBP score. So I would love to bring that back on a high priority list where we can harmonize the measurements for the facilities and the practitioners.

And some of the possible funding out there could be channeled as to that work.

CO-CHAIR LAMB: Give us the language that you'd like to have added to this.

MEMBER MAHAJAN: Let's say aligning facility and practitioner measures.

MR. STOLPE: And post --

MEMBER MAHAJAN: And post-acute long term care.

MS. MOYER: May I ask a question related to that? With being new to this program, is reporting within this program at the physical facility level? Is there kind of an aggregate level, like an MPN that lists the hospitals?

I'm just thinking about usability of the data to like patients and families. They're

looking for an actual, I'm going here versus I'm going to the system.

MEMBER MAHAJAN: Yes. Yes, but focus --

MS. MOYER: Okay, thanks.

CO-CHAIR LAMB: Okay, so Raj, that captures what you wanted in?

CO-CHAIR MERKELZ: As far as language.

MEMBER MAHAJAN: Yes. I mean, incentives or measures is same --

(Simultaneous speaking.)

CO-CHAIR LAMB: Okay, Gene?

MEMBER NUCCIO: Under alignment of function, across the function, I think we need to recognize that the different providers work with different kinds of patients.

And alignment of function should represent the entire continuum of what we believe our patients should be from the time that they're most in need and most debilitated to the time that they're fully functioning.

And if we only represent a small

portion of that, then we're going to be using -- my analogy is we're going to be using a one-foot ruler, okay, to measure how tall each of us is, and we only get to measure -- use the ruler once.

Okay, that doesn't work. So we have to get -- it's a function across the continuum of patient function. So that, I just to -- that was the only --

MEMBER SALIBA: Yeah, this where the EMR could be helpful. We're not talking about my negative comments today, and that is to build in Al and Debbie's approach using the IRT or, you know, whatever you posit, but it's basically IRT, to have robust set of items within the limit, what any particular provider is, for one thing.

And, you know, Mark could really help you do that by using the CAD and the IRT kind of approach.

CO-CHAIR LAMB: Ed?

MEMBER DAVIDSON: So I'm trying to think where this -- you know, you made a comment about medication management. And this, it's in

the background of a number of these things.

And I thought originally care coordination, but if I look at it, it really, under concepts of priorities, it falls under access to care. Can the patient afford the medications?

Care coordination is the right, you know, are the medications being managed between all the different specialists as they transition to different settings?

Interoperability, if we had good interoperability, we wouldn't have the scope of medication related problems that we have now when someone moves from the hospital to home or hospital to skilled because those formularies would line up.

The lists would be aligned and the patient wouldn't be confused when they got it home and they open that bag up of prescriptions.

Patient-reported outcomes, a lot of times patient adherence is related to patients having bad symptoms due to medication. And we

don't realize that they've been non-compliant until they go to the ED.

And social determinants of health, again, do they understand the medications that they're taking? Do they have access to them? Do they have access to providers that can write the prescriptions that they need for their diabetes and their heart failure and other things?

So I just, I think medication management fits in there somewhere. I'm not -- maybe it's in all of those categories. Or maybe it's another item.

CO-CHAIR LAMB: How would you feel about putting it under alignment across the continuum and say that it's cross-cutting, that you can see how it relates to all the priorities?

MEMBER DAVIDSON: I think that works. I think that works.

CO-CHAIR LAMB: Because your holistic thinking related to medication management might make it an interesting prototype for looking across the continuum, and is it capturing the

right thing?

Anything else before we do a quick. Oh -- Alan, sorry, didn't see yours up. Go for it.

MEMBER LEVITT: Blaming it on the live computers because telling us what we should be doing.

(Laughter.)

MEMBER LEVITT: But I am also somebody with a chronic disease and chronic ailments that maybe I get to speak a little bit. But I thought Gene was going to take me there so I wouldn't have to do it.

But, you know, and there was a Wall Street Journal essay that was out this week and, about two health care systems in America, one the system of disease and the other the system of illness.

And in post-acute care, we actually cross both places where we deal -- you know, some are with diseases of getting things, getting better. But we also deal a lot of illness, with kind of the chronic care of somebody for a long

time where our outcomes are not the outcomes that everybody else, tomorrow or the next day or all the people, the sexy topics of the world are looking at.

Our outcomes are different. They may not be hospice outcomes, but they're in between. And when we think of concepts and priorities, although some of those things attach, you know, trying to develop better measures or approaches for measures for the care, just the chronic care of the patients within a population, I think, should be somewhere up there.

CO-CHAIR LAMB: So allowing Alan to take off his CMS hat and just be one of the rest of us, how do you feel about adding that to our list?

MR. STOLPE: Under concepts and priorities.

CO-CHAIR LAMB: Cool. All right. Would you please add chronic illness?

MEMBER LEVITT: Dealing with a chronic illness or just really, it's essentially the

care. You know, the outcomes of care are not, you know, improvement; are not, you know, care coordination should be part of it.

But, I mean, it's really, you know, quality of life more within whatever realm that would be.

CO-CHAIR LAMB: I might add that in that list from 2012, that was under a little bit of quality of life. And that speaks to me of sometimes we need to pull out important stuff because it's getting lost in our overarching concepts.

Heather?

MS. SMITH: Yes, so I would echo Alan's comments. I think this is a struggle so I'm going to put my physical therapist hat on and tell you this is a real struggle in our community because many of the functional measures look at improvement.

And again, in certain conditions it's not improvement, it's preventing decline when you've done a -- we haven't really done any job

at trying to address that.

And in fact, many providers are really concerned about being able to deliver good care to patients where the end goal is preventing further decline or, you know, making sure they're safe at home and staying on as much of a stable trajectory as possible for as long as possible with those conditions.

I do think that that has crossover to patient goals. Again, because here those goals may be, you know, being able to function longitudinally as long as they can at that level of function.

And so I do think that this crosses a number of areas. And so I just wanted to bring that up because it is definitely something we have struggled with -- our practitioners have really struggled with.

And worry that indicating that we're doing care for those patients, you know, has a different level of scrutiny because we're always looking for this improvement where it just isn't

always the goal or the reality of a patient's situation given a disease or a disease process or condition. So I just wanted to bring that up.

(Simultaneous speaking.)

MEMBER LEVITT: Including the payment structure has not been incentivized to do that.

MS. SMITH: Correct. Correct. And we get questions all the time from our practitioners about what do we do and what are -- I mean, what's appropriate care. So I do think it's an area that's important for us to think about addressing.

MEMBER HOPPE: This is Kurt Hoppe on the phone. And first of all, I agree with Heather and Alan that maintenance of good health in the face of chronic illness is of critical importance, making sure that we have good patient outcomes.

I think we forget about the fact that some things aren't cured, but some quality of life can be maintained. The second issue that I have is I'm not sure exactly where this fits, and

this goes into fairly of care and of care for chronic illnesses, is the issue of drug interactions, because that becomes a major issue as a chronic illness progresses.

It's not unusual for us to see patients with 20 to 30 medications, all prescribed by different practitioners for different reasons in different care settings. And I think that needs to find a home somewhere in our particular list or else we're going to have patients that don't function well.

We don't know why, but we probably have two cooks stirring the pot here and have major medications interactions. That's -- sometimes people don't feel comfortable dealing of with because of either lack of primary care or it's treatment by multiple specialties.

And the last issue is should the use/misuse and provisions abuse for opiates be a separate category? This is an area that is so moving so fast and involves so many players, from regional to state to federal players.

And those of us who are clinicians sometimes feel caught in the middle here, especially when we're discharging patients or trying to help patients work through the pain of surgery or simply the pain of having a chronic illness.

CO-CHAIR LAMB: Okay. Kurt, would you like to add that to the list, which is another area, is substance use and opiates.

MEMBER HOPPE: Yeah, specifically opiates because, certainly in the press, it's been highlighted, all the problems around the country. And in fact, in those I would suggest that in those parts of the country that also probably have a poorer or worse social determinants of health that that becomes an issue in and of itself.

But it's moving so fast, and for providers to have someone who's getting the alignment with quality measurements may be particularly helpful.

CO-CHAIR LAMB: Great. Thank you. And

may I ask, is it opioids? Or is it mental health or -- Debra, did you want to --

MEMBER SALIBA: Can I say something? I mean, I agree with -- the direction your question's going, I think, is an important one.

I would be very concerned to make it just about opiates. At the very least, it should be pain management that looks at other approaches to managing the pain in addition to opiates or mental health, which despite, supposedly, the requirements for equity, there doesn't appear to be equity with medical care, both in terms of access and in terms of payment by insurers.

So I would say both. I would say that pain management is such an incredibly important topic and issue right now, albeit difficult and challenging, that I will pull it out, but I think mental health is also really important too.

CO-CHAIR LAMB: Kurt, are you willing to take an amendment from Deb in changing that to pain management? And, Deb, did you want a separate category on mental health?

MEMBER SALIBA: I think so. I mean, I think that, you know, I see some heads bobbing about that as well. So I would suggest that.

(Simultaneous speaking.)

MS. AMIN: It's both physical and mental health, and psycho-social.

CO-CHAIR LAMB: Right. Jennifer?

MEMBER KENNEDY: I just wanted to leap frog off of Alan's statement. If we're talking about chronic illness, chronic illness that turns into serious illness, and we're not quite at hospice yet, but we're in that gap. So I would propose that we add serious illness in terms of palliative care provision as well.

CO-CHAIR LAMB: How should we put that, Jennifer?

MEMBER KENNEDY: Can we either piggyback off of chronic illness or -- I don't know, what do you think? Maybe get palliative or serious illness, a separate category under concepts?

MEMBER LEVITT: I guess serious and

certainly some chronic illness concept.

(Simultaneous speaking.)

MEMBER KENNEDY: Somebody could have a serious illness but not, you know, I think they would be separate.

CO-CHAIR LAMB: I think so. Can we add that, serious illness?

MS. MOYER: Is that somewhat? I kind of want to lump and I kind of want to not lose. It feels a little like we're kind of talking about appropriate care meeting the patient where they're at across a broad continuum again, kind of like we were talking about the broad continuum of function.

You know, there's this broad continuum of care where a patient may be and making sure that we're matching them or providing or somehow moving with them or meeting them where they're at. Is that an appropriate lump or am I losing all kinds of granularity there?

MEMBER KENNEDY: I think it's part of the lump, but I think, you know, there's a point

in an individual's disease trajectory where, you know, just going, bouncing back to home health isn't going to cut it. You know what I mean?

They need a different care approach, which is palliative care management. But they're not in the six-month or less window. So, I mean, I think your concept of the right care at the right time in the continuum is extremely valid.

But if we're going to pay attention to chronic illness, I think we equally have to paid attention to serious illness as well.

CO-CHAIR LAMB: Michelle, did you have -- no? Okay. All right. So we're trying to figure out how to respond to Michelle's request for priorities, because these -- it's an important list. Isn't it?

So how about if -- let's make this up as we go along. If you would look at the list that Jordan has up there and, in your head pick, if CMS us could only do a couple things -- is that fair, Michelle?

In the next period of time, this is

what you think really is important and should be part of the Meaningful Measures portfolio. Is that fair? Yeah?

MS. SCHREIBER: Perfect.

CO-CHAIR LAMB: All right. So how about you pick your top three? And let's see what we get. Is that good?

MR. KIRSCH: I think that's fair.

CO-CHAIR LAMB: All right. And we're just going to go through -- just put up your hand and we'll count. And Jordan will put numbers next to it. All right. And who do we have on the phone?

MEMBER HOPPE: Kurt Hoppe.

CO-CHAIR LAMB: Kurt. Anybody else?

(Off-microphone comments.)

CO-CHAIR LAMB: What would you put -- it's going to probably take another ten minutes to do that. Do you want us to do a summary while Jordan's doing that? We'll vote at the end? It's up to you all. We can either vote by hand or we can do a poll. I put my computer away. How about

we vote by hand?

MS. MOYER: It seems like we just have Kurt.

CO-CHAIR LAMB: Kurt's another one? Okay, Kurt, how about if you go out? Okay? All right.

MEMBER HOPPE: I'd be happy to scream.

CO-CHAIR LAMB: Good. That'll be great, Kurt. Thank you. All right. So we're just going to go through it. Put up your hand if it's one of your top three.

MEMBER SALIBA: Can you tell us what's the difference in Category 2, Item 1 and 3 are?

CO-CHAIR LAMB: Say that again, Deb. I'm sorry.

MEMBER SALIBA: Category 2 and then Item 1 and 3, they seem like they're the same.

CO-CHAIR LAMB: Yeah, they are. So let's take out 1. Under Category 2, take out Number 1, Function, because we have Function under 3. There you go. Very cool. All right, of course.

Let's see how complicated we can make this. We should -- all should be good at this. All right, so we have concepts and priorities and we have alignment across the continuum.

So I'm just wondering if we should group those together or keep them separate. Kurt? Let's see where we get.

All right, so access to care, for whom is that a -- one of your top three?

Okay, zero. Kurt, remember to yell out. Care coordination? Got it? All right. And remember, you only get three votes.

Interoperability?

MR. HIRSCH: Do you have two arms up there?

(Laughter.)

CO-CHAIR LAMB: I almost cheated and voted on that. But none voted. This is going to be hard enough to put up votes on all of them.

Patient-reported outcomes?

Okay. Social determinants? Okay, it looks like a zero.

Chronic illness care? Quality of life? Okay, pain management? Mental health? We all expended our votes early on. Can we vote --

MEMBER KENNEDY: Give it a 1.

CO-CHAIR LAMB: Give it a 1?

Serious illness? Okay, Kurt.

MEMBER KENNEDY: Kurt, are you able to hear us?

MEMBER HOPPE: Am I able to what?

MEMBER KENNEDY: Are you able to hear us? Are you, have you voted yet on any of them?

MEMBER HOPPE: Yeah, I am. No, I haven't. I was going to wait till the end because I don't --

CO-CHAIR LAMB: Oh, okay. Smart man, smart man. All right.

MEMBER HOPPE: That's fine, Deb.

CO-CHAIR LAMB: All right, now we have to vote to the second tier? Or have you shot all your votes?

(Simultaneous speaking.)

CO-CHAIR LAMB: All right, aligning

facility and practitioner measures and incentives?

(Simultaneous speaking.)

CO-CHAIR LAMB: Put a 1 there, yeah.

Function across the continuum -- the individual patient's continuum of care. Yeah, I need more votes.

(Laughter.)

CO-CHAIR LAMB: Medication management, cross-cutting? Tier 2.

All right. We need a promise from CMS you're going to take this with a grain of salt, because we're killing ourselves here, wanting to raise our hands for everything.

MS. SCHREIBER: Yes.

CO-CHAIR LAMB: Kurt, what are you choosing?

MEMBER HOPPE: I'm going to go for care coordination, pain management -- since I brought up the subject -- and then I'm going to also go for function across continuums.

CO-CHAIR LAMB: Very good. Very good.

All right. So this will be our working list and we'll continue to have a dialogue together.

MS. PROCTOR: So just to make sure I have it, the winners are care coordination, interoperability and patient-reported outcomes as the top three? Am I correct in reading it?

CO-CHAIR LAMB: That is correct. Thank you. And then the cross-cutting one is Function.

(Off-microphone comments.)

MS. SMITH: Can I just --

CO-CHAIR LAMB: You can't stand it, Heather. Go for it.

(Laughter.)

MS. SMITH: I just want to note that I do think that there is quite a bit of overlap in this list. Obviously, I think if we think about this, I think we can find some real natural alignment for some of the ones that got lower votes.

For instance, I think function across the care continuum requires interoperability. And so, I mean, I think there's a number of natural

harmonizations here, so.

MEMBER KENNEDY: You can't manage serious illness without managing medication.

MS. PROCTOR: Absolutely. That's right.

CO-CHAIR LAMB: All right. Michelle, you have the whole list? Okay.

MS. SCHREIBER: And I'm trusting NQF to send to people.

CO-CHAIR LAMB: And you will. Okay, perfect. Later, we are in our agenda here.

MR. HIRSCH: We'll have a whole report for you.

MS. SCHREIBER: Can't wait.

CO-CHAIR LAMB: All right. We're supposed to do public comment?

MS. PROCTOR: That's a good idea.

CO-CHAIR LAMB: Okay, Janaki, public comment?

MS. PANACHAL: Yeah. So we're going to open the lines for public comment. If anyone has a comment, free to shout out or also just type in

the chat box and we'll read it out loud.

I mean, we can start with people in the room. If anyone has a comment we'll take it down.

CO-CHAIR MERKHELZ: Anyone on the phones?

MS. PANACHAL: We have one in the chat box.

CO-CHAIR MERKHELZ: Very good.

MS. PANACHAL: So we have one from Jessica French. Sorry. Go ahead, Jessica.

MS. FRENCH: Hi. This is Jessica. Can you hear me?

MS. PANACHAL: Yes.

MS. FRENCH: Great. I just wanted to mention, because there was a nice discussion about goal-based care and how it differs from quality of life.

And I wanted to make sure people are aware that -- and TQA is doing some research right now on what we're calling patient driven outcomes. But it's an approach to both delivering

care that reflects what's most important to the patient, as well as measuring quality based on implementation to that approach, but ideally also attaining outcomes identified by the patient as their priorities.

So I'm happy to talk with folks about it offline. But I wanted you to be aware of the work.

CO-CHAIR LAMB: Thank you. That's great to know. Any others?

MS. PANACHAL: None in the chat box.

CO-CHAIR LAMB: Okay. All right, we're up to summary of the day. Do you want to start?

CO-CHAIR MERKHELZ: Yeah, well, we certainly want to thank everybody for their participation. Certainly the, all the communication from CMS, very, very helpful, very enlightening.

I certainly, personally, came into the process with some different understandings that matured and I think evolved during the discussions. I certainly think -- thank you for

your fruitful discussion that was provided.

And again, just the importance and the value of this type of work and the work that we're doing, thank everybody for being here. Gerri?

CO-CHAIR LAMB: Ditto. That's great. I really look forward not only to the review of the MUC measures. And I really appreciated the thoughtful conversation, the input from CMS, the passion and the concern for measuring the right things.

And I really look forward to the strategic discussion, so thank you for doing that as well. Good meeting. I look forward to kind of continuing this dialogue together about what we're reviewing and what's important to patient care.

So thank you all. Amy, it's in your court.

MS. MOYER: Sure. So just as like a quick summary of today, we had a discussion, a lot of discussion around meaningful measures on

measure alignment.

We reviewed the two measures from the MUC, and we'll be sending those both to the coordinating team with recommendations -- I've forgotten; it's been a long day -- conditional -- thank you -- what was the words.

MR. HIRSCH: Yeah, conditional support for rulemaking.

MS. MOYER: Conditional support for rulemaking, thank you. And that meeting happens in January. And I'm probably closing in on the next steps, which, actually, Jordan is going to go over.

MR. HIRSCH: Thank you, Amy. So obviously we are in the December parts of the middle portion of this arrow with the in-person working group for NAPPAC, obviously again today, and tomorrow will hospital. Thursday will be clinician.

We move later into December with public commenting period will be open. And then the middle of January, the 15th, the coordinating

committee will have their meeting and then pre-rulemaking deliverables will be provided in either the end of January or middle of February.

Moving forward, extension of public commenting on the work group recommendations for all maps will be open from December 18th until January 8th.

Coordinating Committee's in-person meeting will be January 15th and final recommendations will be due to CMS on January 24th with the PAC LTC and hospital reports being sent out on February 15th and the clinician report on March 15th.

If anyone would like further information, go to the public page at qualityforum.org and search for any post-acute care, long term care work group. You can visit the SharePoint site at share.qualityforum.org and you can email the PAC LTC team with any questions that you have. Thank you all.

MS. MOYER: So thank you all for all of the work that went in today and the discussion

and for joining us and bearing with the strategic discussion. And thank you, Gerri and Kurt, for your leadership and getting us through this. Appreciate it. Thank you.

(Applause.)

CO-CHAIR LAMB: We also acknowledge this was Amy's first meeting. So she is now well seasoned. Thank you all. Have a wonderful day.

(Whereupon, the above-entitled matter 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.

Neal R. Gross

Court Reporter