

NATIONAL QUALITY FORUM

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MEASURE APPLICATION PARTNERSHIP POST-ACUTE  
CARE/LONG-TERM CARE WORKGROUP

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FRIDAY  
DECEMBER 12, 2014

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Carol Raphael, Chair, presiding.

PRESENT:

CAROL RAPHAEL, MPA, Chair  
JOSEPH AGOSTINI, MD, Aetna  
LOUIS DIAMOND, MBChB, FCP(SA), FACP, FHIMSS\*  
ROBYN GRANT, MSW, National Consumer Voice  
for Quality Long-Term Care  
ROGER HERR, PT, MPA, COS-C, American Physical  
Therapy Association  
BRUCE LEFF, MD, Johns Hopkins University  
School of Medicine  
MARC LEIB, MD, JD  
ALAN LEVITT, MD, Centers for Medicare &  
Medicaid Services (CMS)  
SEAN MULDOON, MD, Kindred Healthcare  
ALLEN NISSENSON, MD, FACP, FASN, FNKF,  
Kidney Care Partners  
ELIZABETH PALENA HALL, MIS, MBA, RN, Office  
of the National Coordinator for Health  
Information Technology (ONC)  
DIANNA REELY, Providence Health & Services  
PAMELA ROBERTS, PhD, OTR/L, SCFES, CPHQ,  
FAOTA, American Occupational Therapy  
Association

CLARKE ROSS, DPA, Consortium for Citizens  
with Disabilities

DEBRA SALIBA, MD, MPH

SUZANNE SNYDER KAUSERUD, PT, American  
Medical Rehabilitation Providers  
Association

CAROL SPENCE, PhD, National Hospice and  
Palliative Care Organization\*

THOMAS VON STERNBERG, MD

ARTHUR STONE, MD, National Pressure Ulcer  
Advisory Panel

MARGARET TERRY, PhD, RN, Visiting Nurses  
Association of America

JENNIFER THOMAS, PharmD, American Society of  
Consultant Pharmacists

LISA WINSTEL, Caregiver Action Network\*

NQF STAFF:

CHRISTINE CASSEL, President & CEO

HELEN BURSTIN

TAYLOR DAVIS

MITRA GHAZINOUR

LAURA IBRAGIMOVA

ERIN O'ROURKE

WENDY PRINS

ROB SAUNDERS

\* present by teleconference

# T-A-B-L-E O-F C-O-N-T-E-N-T-S

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

2 8:58 a.m.

3 CHAIR RAPHAEL: I just want the  
4 operator, Cathy, to know that we are beginning.

5 OPERATOR: Okay. I'll go ahead and  
6 transfer you now.

7 CHAIR RAPHAEL: All right. And let me  
8 just check on the three Workgroup members who  
9 were supposed to be on the phone. Lisa Winstel?

10 OPERATOR: Yes, she has joined.

11 CHAIR RAPHAEL: Okay. Carol Spence?

12 OPERATOR: She has joined also.

13 CHAIR RAPHAEL: Okay. And Lou  
14 Diamond?

15 OPERATOR: He joined, but he has  
16 disconnected.

17 CHAIR RAPHAEL: Okay. I'm going to  
18 hope that he gets reconnected. So let me start  
19 by introducing Chris Cassel, who's the president  
20 and CEO of the National Quality Forum and who  
21 would like to make a few opening remarks.  
22 Welcome, Chris.

1 DR. CASSEL: Thank you, Carol. And  
2 Carol knows, because she and I worked together  
3 many years when I was in New York, that this  
4 topic of today's MAP meeting is one that's near  
5 and dear to my heart as a geriatrician, and  
6 someone who's spent my career devoted to many of  
7 the issues that are before you today.

8 So I want to, in my role as president  
9 of NQF, welcome you here and thank you for the  
10 contribution that you're making to this important  
11 work. This concept of the multi-stakeholder  
12 consensus process is really essential to setting  
13 the standards that are going to be applied across  
14 the health care world, in so many different parts  
15 of health care, that ultimately really have to be  
16 effective in driving better quality and more  
17 affordability for the citizens of this country  
18 and the people who we serve in the health care  
19 system.

20 So these discussions are rarely, if  
21 ever, simple and straightforward. There are  
22 many, many complexities involved in them, and

1       that's the reason why we need all the  
2       stakeholders and perspectives around the table.  
3       And we really value your time, and particularly  
4       at this time of year when people are beginning to  
5       think about the holidays and other things. It's  
6       particularly valuable that you've joined us  
7       today.

8               The second thing I want to say is that  
9       we've worked very hard over the year to  
10       streamline the process and improve the materials  
11       that you have and to make your job go more  
12       smoothly and work better. And we had the  
13       hospital group with us earlier this week and got  
14       some quite positive feedback about the changes  
15       and we want to not prejudge what you think, but  
16       hope that you find that both the organization of  
17       the meetings and the kinds of materials that you  
18       received really are helpful and useful. But we  
19       also welcome your thoughts on what we could do  
20       better, what works, what maybe might be done to  
21       continue to improve this process. So let us know  
22       what you think.

1                   And the last thing I would say; and  
2           I'm sure this group knows this, is that this is a  
3           particularly interesting and, I was going to say,  
4           impactful time for post-acute and long-term care,  
5           because of course the IMPACT Act that passed just  
6           recently has many, many dimensions.

7                   But one of the important dimensions is  
8           that it does a lot to drive standardization of  
9           measurement across all post-acute settings. And  
10          hopefully to both enhance the information that  
11          goes to providers and provider organizations  
12          about their performance, but also to make more  
13          meaningful information available to consumers, to  
14          patients and their families.

15                   So let me just stop there and offer  
16          again my thanks. And I'm happy, Carol, to take  
17          any questions people might have.

18                   CHAIR RAPHAEL: Thank you, Chris. Are  
19          there any questions or comments that you would  
20          like to share with Chris?

21                   (No audible response.)

22                   DR. CASSEL: People are raring to go.

1 (Laughter.)

2 CHAIR RAPHAEL: They are.

3 DR. CASSEL: Right. Okay. Thanks  
4 very much.

5 CHAIR RAPHAEL: All right. Thank you  
6 so much. All right. I now am going to turn it  
7 over to Helen who is going to go through some of  
8 the important steps that we need to make sure we  
9 cover.

10 DR. BURSTIN: Good morning, everybody.  
11 Just to add my welcome to Chris'. I'm the chief  
12 scientific officer here at NQF and will be in and  
13 out with you most of the day. I have the  
14 responsibility this morning for helping you do  
15 disclosures of interest as part of our welcome.  
16 We know many of these familiar faces have been  
17 around our tables in the past. We do need to go  
18 through this process, because it's related to the  
19 specific work.

20 We'll combine disclosures with  
21 introductions just to keep it most efficient.  
22 And we'll also have to divide the disclosures



1       into those of you who sit as organizational  
2       members, versus those of you who sit as  
3       independent subject matter experts, because the  
4       disclosures are actually different. So for  
5       example, if you're an organizational  
6       representative, we fully expect you're here today  
7       representing your organization. You're wearing  
8       that hat in a way that's very different from the  
9       subject matter experts at the table.

10               So we'll only ask you one limited  
11       question in light of that for those of you who  
12       are in fact organizational representatives. So  
13       as part of your introductions please disclose if  
14       you have an interest of more than \$10,000 related  
15       to any entity potentially involved in the work of  
16       this Committee. We'll go around the table first  
17       for the organizational members and then we'll  
18       come back and do those of you who are subject  
19       matter experts. So with that, perhaps we'll --  
20       actually, Carol, are you organizational?

21               CHAIR RAPHAEL: I'm individual.

22               DR. BURSTIN: Individual. Okay. So

1 we'll come back to you. So we'll start with  
2 Joseph.

3 MEMBER AGOSTINI: Hi, I'm Joe  
4 Agostini. I'm a geriatrician and National  
5 Medical Director for Aetna Medicare. I'm an  
6 employee, full time, of Aetna. No disclosures.

7 MEMBER ROSS: Hi, I'm Clarke Ross.  
8 I'm employed by the American Association on  
9 Health and Disability. I'm here today  
10 representing the Consortium for Citizens With  
11 Disabilities, a 41-year-old national coalition  
12 with 113 national disability organizations. And  
13 I'm the liaison for the next 12 months between  
14 the Workgroup on Persons Dually Eligible for  
15 Medicare and Medicaid, and this Workgroup. Thank  
16 you.

17 DR. BURSTIN: Any disclosures?

18 MEMBER ROSS: And none. Thank you.

19 MEMBER NISSENSON: Hi. Good morning.  
20 I'm Allen Nissenson. I'm a nephrologist. I'm  
21 representing Kidney Care Partners, and I am a  
22 full-time employ of DaVita HealthCare Partners

1 where I'm Chief Medical Officer.

2 DR. BURSTIN: And if you could also  
3 just indicate if you have any disclosures, just  
4 as part of your interest.

5 MEMBER NISSENSON: Okay.

6 MEMBER REELY: Okay. Diana Reely.  
7 I'm the Vice President of Quality for Providence  
8 Senior and Community Services, which is part of  
9 Providence Health and Services, providing health  
10 care in Washington, Oregon, Alaska, California  
11 and Montana. And we have post-acute services  
12 including home health, hospice, long-term care,  
13 adult day health, many other programs. And I am  
14 an organizational representative, and no  
15 disclosures.

16 MEMBER HERR: Good morning. My name  
17 is Roger Herr. I'm a physical therapist, and I'm  
18 a board member of the American Physical Therapy  
19 Association, and I have no disclosures.

20 MEMBER THOMAS: Good morning.  
21 Jennifer Thomas. I'm an employee of Delmarva  
22 Foundation. I'm representing the American

1 Society of Consultant Pharmacists, and I am a  
2 pharmacist with no disclosures.

3 MEMBER LEVITT: Alan Levitt. I'm the  
4 medical officer in the Division of Chronic and  
5 Post-Acute Care at CMS, and other than being a  
6 taxpayer I have no disclosures.

7 (Laughter.)

8 MEMBER ROBERTS: I'm Pam Roberts. I'm  
9 the Program Director for Rehabilitation at  
10 Cedars-Sinai Medical Center and I'm here  
11 representing the American Occupational Therapy  
12 Association, and I have no disclosures.

13 MEMBER SNYDER KAUSERUD: My name is  
14 Suzanne Snyder Kauserud. I'm a physical  
15 therapist and I am the administrator at Carolinas  
16 Rehabilitations in Charlotte, North Carolina,  
17 which is part of Carolinas HealthCare System.  
18 And I'm also on the board of directors for the  
19 American Medical Rehab Providers Association and  
20 I'm here on behalf of the American Medical Rehab  
21 Providers Association as an organizational  
22 member. I have no disclosures.

1                   MEMBER LEFF: I'm Bruce Leff. I'm a  
2                   geriatrician at Johns Hopkins, here as an  
3                   organizational member for Johns Hopkins. I'm on  
4                   the board of the American College of Physicians  
5                   and the American Academy of Home Care Medicine.  
6                   I do some personal consulting for Abt Associates,  
7                   which has contracts with CMS on Medicare home  
8                   health payment issues.

9                   MEMBER MULDOON: Good morning. I'm  
10                  Sean Muldoon. I'm the senior vice president at  
11                  Kindred Healthcare, a provider of post-acute care  
12                  services from which I receive salary and  
13                  benefits.

14                 MEMBER STONE: Good morning. I'm Art  
15                 Stone. I represent National Pressure Ulcer  
16                 Advisory Panel. It's my first meeting and I look  
17                 forward to the day. And I'm one of the board  
18                 members for National Pressure Ulcer Advisory  
19                 Panel.

20                 MEMBER LEIB: I'm Marc Leib for --

21                 DR. BURSTIN: We'll come back to you,  
22                 Marc, because you're a subject matter expert.

1 MEMBER LEIB: Oh.

2 DR. BURSTIN: Thank you.

3 MEMBER TERRY: Good morning. I'm Peg  
4 Terry, a nurse, and I represent the Visiting  
5 Nurse Associations of America, which represents  
6 non-profit home health and hospices around the  
7 country. And I have no disclosures.

8 MEMBER GRANT: Good morning. I'm  
9 Robyn Grant. I'm the Director of Public Policy  
10 and Advocacy with the National Consumer Voice for  
11 Quality Long-Term Care, and we're a non-profit  
12 organization that advocates for quality long-term  
13 care across settings. This is also my first  
14 meeting, and I have no disclosures. I'm here  
15 representing the Consumer Voice.

16 DR. BURSTIN: We'll skip Tom. Liz?

17 MEMBER PALENA HALL: Hi, good morning.  
18 My name is Liz Palena Hall. I am the Long-Term  
19 Post-Acute Care Coordinator in the Office of the  
20 National Coordinator within Department of Health  
21 and Human Services. Again, this is my first  
22 meeting. I'm also a nurse. I have no

1 disclosures.

2 DR. BURSTIN: Wonderful. Thanks. And  
3 I know we have a couple organizational members on  
4 the phone, so Lisa Winstel, please?

5 MEMBER WINSTEL: Good morning. This  
6 is Lisa Winstel. I'm the chief operating officer  
7 for Caregiver Action Network. I'm an  
8 organizational member, and this is also my first  
9 meeting. Caregiver Action Network represents  
10 family caregivers across the life span, so  
11 whether they're caring for somebody for aging-  
12 related issues, chronic disabilities or diseases,  
13 we help the family caregiver.

14 DR. BURSTIN: Wonderful. Thank you.  
15 And Carol Spence, please?

16 MEMBER SPENCE: Yes, hi. This is  
17 Carol Spence. I'm Vice President for Research  
18 and Quality at the National Hospice and  
19 Palliative Care Organization. I am representing  
20 that organization and I have no disclosures.

21 DR. BURSTIN: Excellent. I think I've  
22 gotten all the organizational members. Did I

1 miss anyone?

2 Okay. So next for those of you are  
3 subject matter experts, this is a little  
4 different because you're sitting here as  
5 individuals. You bring your expertise to the  
6 table. So we would ask you to give a bit more of  
7 a detailed review of your background. You don't  
8 need to recite your résumé. We have too much  
9 work to do today, and we know how skilled you all  
10 are since we picked you.

11 So please if you could just give us a  
12 disclosure of any interests that you may have  
13 that relate directly to the work before this  
14 Committee today. Again, you sit as an  
15 individual. You may have organizational hats,  
16 but your role today is to sit here as an  
17 individual subject matter expert. And it's  
18 really not an issue of how much you're paid for  
19 those disclosures. We really want to understand  
20 any biases or conflicts that might appear. So  
21 with that, we'll skip to those of you -- let's  
22 begin with Marc.



1                   MEMBER LEIB: My name is Marc Leib.  
2 I am here as an individual, and I have no  
3 financial disclosures that bring any conflict  
4 here.

5                   DR. BURSTIN: Or any conflicts, or any  
6 additional work you're working on that might be  
7 coming before the Committee?

8                   MEMBER LEIB: Nothing that would come  
9 before NQF.

10                  DR. BURSTIN: Great. Thank you. Tom?

11                  MEMBER VON STERNBERG: Dr. Tom von  
12 Sternberg from HealthPartners. I'm here as a  
13 subject matter expert to contribute regarding  
14 technology and electronic medical record  
15 perspectives. I am involved in Web-based  
16 electronic medical record work and medical care  
17 through Virtuwel, which is a subsidiary of  
18 HealthPartners, where I work.

19                  I'm also on the advisory board for an  
20 organization called Healthsense which makes  
21 monitoring components for assisted living in  
22 homes for frail elders. And then I'm a medical

1 director at HealthPartners for nursing home,  
2 transitional care, home care, hospice and  
3 Government programs.

4 DR. BURSTIN: Great. Thanks, Tom.  
5 And, Lou, I believe you're on the phone. If you  
6 could give your disclosures?

7 MEMBER DIAMOND: Yes, thank you,  
8 Helen. So I've got three disclosures relating to  
9 volunteer work. I am related to the RPA, I am a  
10 delegate for RPA at the AMA House of Delegates.  
11 I'm in a leadership position with the End-Stage  
12 Renal Disease Networks. I'm on the board of  
13 directors of Network 5. And I serve in a  
14 leadership capacity currently and previously with  
15 HIMSS, the Health Information Management Systems  
16 Society.

17 On the consulting side, I have three  
18 that I would wish to disclose. I've received  
19 consulting engagements with Genentech,  
20 AstraZeneca, Merck, and Pfizer within the last  
21 two to three years. Secondly, I have a  
22 consulting arrangement with the Alliance for

1 Continuing Education in the Health Professions on  
2 a project to embed education into quality  
3 improvement. And thirdly, I have a consulting  
4 and strategic business relationship with See City  
5 that has an IT platform that facilitates quality  
6 improvement. Thanks, Helen.

7 DR. BURSTIN: Okay. Thank you. And,  
8 Deb, you walked in at just the moment to  
9 introduce yourself as a subject matter expert.

10 MEMBER SALIBA: I'm Deb Saliba. I'm  
11 a geriatrician and health services researcher in  
12 Los Angeles. I direct the UCLA Borun Center. I  
13 also work in the Veterans Administration in the  
14 geriatrics group at the VA and at the RAND  
15 Corporation.

16 It sounds like we're doing conflicts  
17 as well. I have several research projects funded  
18 by various government agencies and not-for-profit  
19 philanthropies, none from corporate or for-profit  
20 interests.

21 DR. BURSTIN: Great. Thank you. I  
22 think that completes everybody's -- oh, I haven't

1 done -- I'm sorry. I'm forgot about the Chair.

2 CHAIR RAPHAEL: It's all right. I  
3 don't have any financial interests or conflicts  
4 to disclose, but just in terms of my other  
5 affiliations, I have been on the board of the New  
6 York eHealth Collaborate, and the chair for six  
7 years. I'm the chair of AARP. I'm the chair of  
8 the Long-Term Quality Alliance. And I'm a senior  
9 advisor to Manatt Health Solutions.

10 DR. BURSTIN: She's very busy.

11 (Laughter.)

12 DR. BURSTIN: So just lastly, thank  
13 you to all of you for making that go so well.  
14 One of the really important things we want to  
15 emphasize is at any point during this meeting if  
16 you any discomfort that somebody is expressing  
17 bias or conflict, please come to Carol or myself  
18 or one of the senior staff.

19 We just learned over time it's much  
20 easier to kind of deal with those issues in real  
21 time, and then we can see if there's an  
22 opportunity for us to kind of resolves any

1 conflict or bias. So please speak up and let us  
2 know if you have any concerns. And in that  
3 spirit, does anybody have any questions or  
4 concerns about any of the disclosures that have  
5 been raised so far?

6 (No audible response)

7 DR. BURSTIN: Excellent. All right.  
8 Let's get to work. Back to you, Carol.

9 CHAIR RAPHAEL: Okay. Thank you. So  
10 let me just kind of briefly review what we're  
11 going to try to accomplish today. This is our  
12 annual meeting to review and provide our multi-  
13 stakeholder input on the measures that are under  
14 consideration for federal programs that are  
15 applicable to our post-acute long-term care  
16 settings.

17 We continue to identify and hopefully  
18 reduce the high-priority measure gap areas that  
19 exist. And we also will finalize our input and  
20 recommendations to the MAP Coordinating Committee  
21 which will be meeting in January. So that is  
22 what we hope to accomplish today.

1 I don't know, Mitra, is it possible to  
2 go to our kind of schematic and the key areas  
3 that we have constantly been emphasizing before  
4 we --

5 MS. GHAZINOUR: The core concepts?

6 CHAIR RAPHAEL: The core concepts.  
7 Just to make sure that -- we have a number of new  
8 members, they are aware of that.

9 MS. GHAZINOUR: Sure.

10 CHAIR RAPHAEL: Okay. Great.

11 MEMBER DIAMOND: So, Carol, this is  
12 Louie here. Do we have a WebEx today, because I  
13 did get Mitra's email from yesterday, which has a  
14 document attached to the email. Is there in  
15 addition a WebEx that I should be looking into?

16 CHAIR RAPHAEL: All right. Mitra,  
17 what should Lou be looking at? I have the slide  
18 deck.

19 MS. GHAZINOUR: Yes, that document  
20 that was attached to my email, that was the  
21 voting instructions and also --

22 MEMBER DIAMOND: Right.

1 MS. GHAZINOUR: -- there was a link  
2 for the updated Discussion Guide.

3 MEMBER DIAMOND: Right.

4 MS. GHAZINOUR: So we'll be looking at  
5 the Discussion Guide. We'll be screen sharing  
6 the Discussion Guide.

7 MEMBER DIAMOND: Okay.

8 MS. GHAZINOUR: Okay?

9 MEMBER DIAMOND: That's fine. Thank  
10 you.

11 MS. GHAZINOUR: Sure.

12 CHAIR RAPHAEL: So this is slide 20.  
13 Okay. So just to make sure that everyone is  
14 aware of the work that we have done, we have  
15 really tried very hard to zoom in on what we  
16 think are the most high-leverage and important  
17 areas in performance measurement in post-acute  
18 and long-term care.

19 And we came up with six key areas.  
20 And the key ones that we have constantly been  
21 emphasizing are function, and we include  
22 cognitive status function in that; goal

1 attainment and making sure that we include the  
2 patient and family and caregiver goals; patient  
3 engagement, and that includes the experience of  
4 care and shared decision making.

5 Care coordination, and we particularly  
6 are concerned about transition planning since  
7 many of the people in post-acute and long-term  
8 care have a number of transitions; safety, and we  
9 challenged ourselves to reduce safety to three  
10 core concepts, which were falls, which for us had  
11 traditionally been falls with injury, pressure  
12 ulcers, and adverse drug events.

13 And then I can't emphasize this  
14 enough, because in post-acute and long-term care  
15 you do have cost and access issues that differ  
16 from other parts of the system. So we have  
17 emphasized that and that includes avoidable  
18 admissions, infection rates and inappropriate  
19 medicine use.

20 So I just want to be sure that we all  
21 have this frame as we look at the measures that  
22 we're considering today, because this is really



1 overall where we are headed. And I think we in  
2 particular have contributed to the National  
3 Quality Forum by trying to emphasize two things,  
4 which is understanding the importance of chronic  
5 conditions and functioning in our population, and  
6 making sure that the patient experience is really  
7 central, that we just don't look at a disease, we  
8 look at the whole person.

9 So with that, we're now going to kind  
10 of circle back and Erin's going to describe the  
11 approach that we're going to be using as we  
12 consider the measures today. Erin?

13 MS. O'ROURKE: Thank you, Carol. So  
14 as Chris noted, NQF has been working to improve  
15 the MAP meetings based on input from a variety of  
16 stakeholders and we've made some changes to our  
17 meeting process. We've implemented a new voting  
18 procedure to allow the Workgroup to move quickly  
19 through its decision making process for  
20 straightforward and non-controversial measures,  
21 reserving your valuable time for discussion to  
22 build consensus on sensitive issues.

1                   We realized that we have used the term  
2                   consent calendar a bit loosely, so please bear  
3                   with me as I explain this. We did get some  
4                   feedback after the Hospital Workgroup that  
5                   perhaps consent calendar means something  
6                   different than we're assigning it, so we just ask  
7                   for your patience.

8                   So, for the first step Mitra and I  
9                   will review the consent calendars. These are  
10                  based on the results of the preliminary analysis  
11                  that staff put together using the MAP measure  
12                  selection criteria, the PAC/LTC core concepts and  
13                  high-leverage opportunities that you see right in  
14                  front of you, and the programmatic objectives  
15                  derived from the PAC/LTC Workgroups fall Web  
16                  meeting.

17                  These preliminary analyses are non-  
18                  binding. They're just a starting place for  
19                  conversation. They represent our attempt to take  
20                  all of your previous input and apply it to the  
21                  current measures under consideration, just to  
22                  give you a summary of how these measures right

1 relate to what you said in the past. We're just  
2 trying to digest all of the information out there  
3 and make it a little bit easier for you. But  
4 again, feel free to challenge any of these.

5 So the next step, Carol will ask the  
6 Workgroup if you'd like to pull any of the  
7 measures off the consent calendar presently under  
8 review for discussion and propose a different  
9 disposition for the measure under consideration.

10 So if we gave it a preliminary analysis of  
11 conditional support but you feel it should be  
12 fully supported, you can go ahead and say that it  
13 should be fully supported and note your reasons  
14 why. And we will then open it up for  
15 conversation among the Workgroup about where you  
16 think the appropriate categorization for that  
17 measure would be.

18 So after we go through each of the  
19 consent calendars, pull all the measures, re-  
20 categorize them as the group sees fit, we'll  
21 pause and Carol will ask for public comment from  
22 the audience members in the room and on the

1 phone. The Workgroup is not obligated to respond  
2 to these public comments, but we hope you'll  
3 consider them carefully in your deliberation and  
4 final vote.

5 Carol will then call for a vote on the  
6 consent calendar once we're all finished with  
7 conversation on it. The vote will be binary.  
8 You'll be asked to approve or not approve the  
9 consent calendar as it's presented to you. We'll  
10 need a 60 percent majority to confirm the  
11 preliminary recommendations. This will establish  
12 them as an official Workgroup recommendation that  
13 we'll pass along to the MAP Coordinating  
14 Committee for finalization.

15 If we reach 60 percent on the vote,  
16 discussion on those measures is concluded. If we  
17 have not reached the 60 percent consensus, the  
18 Chair will ask participants to identify the  
19 measures that are perhaps holding you back from  
20 supporting that consent calendar and we'll reopen  
21 discussion on those measures. We'll keep going  
22 through this process until we find the measures

1 that are holding us back and the group is able to  
2 come to a majority opinion on them.

3 We're going to try to push this group  
4 to reach a decision on every measure under  
5 consideration. We're really trying to avoid the  
6 split decisions that we've had in the past. That  
7 would mean we just kick it up to the Coordinating  
8 Committee without the benefit of this group's  
9 input. So as much as we can Carol's going to  
10 push you all to try to come to consensus on a  
11 preliminary recommendation for each measure under  
12 consideration so that the Coordinating Committee  
13 can have the benefit of your input on that  
14 measure.

15 So I think with that I can pause and  
16 take any questions, because I know that's a lot  
17 and it's very different from what we've done in  
18 the past.

19 CHAIR RAPHAEL: Okay. One other thing  
20 that as I went through this that I thought it was  
21 important to clarify. We have two categories of  
22 measures, those that are fully developed and

1 those that are under development. And I think we  
2 should just go over first of all what does that  
3 mean?

4 MS. O'ROURKE: Absolutely. I  
5 apologize. I meant to do that and then skipped  
6 it in my notes. So as Carol noted, this year  
7 we'll have two pathways, one for measures that  
8 are fully developed. We are considering that  
9 measures that have completed testing. They might  
10 not be NQF-endorsed, but they're on their way to  
11 that process. These will receive our traditional  
12 MAP recommendations of support, conditional  
13 support, do not support.

14 The change this year is we've  
15 developed a new pathway for measures that are  
16 still in development. We received some feedback  
17 that perhaps the MAP was being a little too hard  
18 on measures that are up an coming, if you will.  
19 They're not quite fully ready, that the group  
20 might have reservations about giving them a  
21 support or a conditional support, but we don't  
22 want to say do not support and stop the

1 development of a really innovative measure that  
2 could move the field forward.

3 So for these measures under  
4 development, we're just going to recommend that  
5 development continue and we'd encourage this  
6 direction, or we do not consider, or we would not  
7 consider -- we would not encourage further  
8 consideration of this measure. Basically the  
9 Workgroup feels this is not the direction we want  
10 to be going in. Don't continue to spend  
11 resources to develop this measure.

12 CHAIR RAPHAEL: Okay. So let me now  
13 turn to all of you and see if we have questions  
14 about the process that we're going to be using  
15 for the first time in the Workgroup. Okay. The  
16 other thing that I thought it might be valuable  
17 for Workgroup members to briefly understand is  
18 what is the endorsement process?

19 MS. O'ROURKE: Absolutely. Helen,  
20 would you want to take that? You're probably  
21 better equipped than me.

22 DR. BURSTIN: So when we describe the

1 endorsement process, what we're referring to is  
2 whether the measure has previously been submitted  
3 to NQF or it's been reviewed against our key four  
4 criteria of importance to measure import, which  
5 also includes evidence and opportunity for gap,  
6 opportunity for improvement. It includes whether  
7 the measure has in fact been tested and is  
8 reliable and valid, whether it's useable and  
9 feasible. So measures that pass that test are  
10 ones that will clearly be indicated as having  
11 been endorsed.

12 As you'll see for many of the measures  
13 under development many of them have not yet been  
14 submitted to NQF. Some of them are in that  
15 process, as you'll see. Some of them are  
16 sometimes very early concepts to give you an  
17 opportunity. And so the idea of splitting them,  
18 also, was to allow you the opportunity to speak  
19 favorably of a measure even though it's still  
20 very early in its development, if you want to  
21 encourage that continued development on the part  
22 of the developers.



1 CHAIR RAPHAEL: Okay. Thank you,  
2 Helen. All right. So if there are no questions,  
3 then we're going to begin. And we're starting  
4 with the Inpatient Rehab Facility Quality  
5 Reporting Program. And, Mitra, you're going to  
6 give us a brief overview of the quality reporting  
7 program and also the staff's preliminary analysis  
8 and recommendations.

9 MS. GHAZINOUR: Sure. Thanks, Carol.  
10 So we're reviewing the Inpatient Rehabilitation  
11 Facility Quality Reporting Program as the first  
12 program to consider. Just a brief description of  
13 the program. This is a pay-for-reporting program  
14 and the inpatient rehabilitation facility  
15 providers, they must submit data on quality  
16 measures to CMS to receive annual payment  
17 updates.

18 And failure to report quality data  
19 will result in a two percent reduction in the  
20 annual increase factor for discharges occurring  
21 during the same fiscal year. So also there's a  
22 plan for public reporting of quality measures,

1 and the providers will have an opportunity to  
2 review the data prior to its release. And no  
3 date has been specified to begin public reporting  
4 of quality data yet. The program goal is to  
5 address the rehabilitation needs of individuals,  
6 including their improved functional status and  
7 successful return to the community post-  
8 discharge.

9 So the statutory requirement for this  
10 program notes that measures should align with the  
11 National Quality Strategy priority relevant to  
12 IRFs and including patient safety, reducing  
13 adverse events, better coordination of care and  
14 person and family-centered care.

15 And also the new IMPACT Act requires  
16 post-acute care providers to report the  
17 standardized patient assessment data and also to  
18 create new quality measures that address domains  
19 such as functional status, medication  
20 reconciliation, incidence of major falls and  
21 resource use measures.

22 MAP had previously recommended that

1 the program measure set is too limited. And this  
2 recommendation is from previous years, and since  
3 then measures have been added to the program  
4 measure set. And so, MAP had felt that the  
5 measure set should include concepts such as care  
6 coordination, functional status, medication  
7 reconciliation and the safety issues that have  
8 high incidence in IRFs.

9 So, going back to the agenda. So for  
10 these programs we have five measures under  
11 consideration, and based on the staff preliminary  
12 analysis all the measures received conditional  
13 support.

14 The first measure to start with is  
15 venous thromboembolism prophylaxis, which is an  
16 NQF-endorsed measure, Measure 0371. This measure  
17 evaluates the number of patients who received VTE  
18 prophylaxis or have documentation as to why they  
19 have not received it. So this measure is part of  
20 a set of six nationally-implemented prevention  
21 and treatment measures that address VTE. And  
22 also its use in the Joint Commission's

1 accreditation process.

2 We have received six public comments  
3 on this measure. And as I mentioned, this  
4 measure received conditional support. So the  
5 preliminary analysis concluded that this measure  
6 addresses the NQF's priority of safer care, which  
7 is relevant to the priorities of IRFs. This  
8 measure would create alignment across programs.  
9 This measure is currently finalized for use in  
10 hospital IQR, Inpatient Quality Reporting  
11 Program, and also in meaningful use for hospitals  
12 and critical access hospitals.

13 And this measure is also under  
14 consideration for Long-Term Care Hospital Quality  
15 Reporting Program. However, this measure is not  
16 specified for inpatient rehabilitation  
17 facilities, so we have given conditional support  
18 to this measure.

19 In terms of public comments, they were  
20 mostly supportive of this measure and they noted  
21 that this is a audited standard of practice and  
22 it's inpatient rehabs -- they already provide

1 data on this measure. And the only concern that  
2 they had that this measure excludes stroke  
3 patients, and also patients who have length of a  
4 stay over 120 days.

5 So moving on to the next measures. We  
6 have four functional outcome measures: change in  
7 self-care score, change in mobility score,  
8 discharge self-care score and discharge mobility  
9 score for medical rehabilitation patients. And  
10 the preliminary analysis that was given to these  
11 measures were conditional support.

12 As mentioned before, functional status  
13 is the primary goal of rehabilitation and also  
14 this is a PAC/LTC core concept not currently  
15 addressed in the program. And it is a required  
16 measurement domain under the IMPACT Act and also  
17 functional status is a priority area for  
18 measurement for the duals population.

19 These four measures, they're all fully  
20 specified and tested for use in IRFs and also  
21 they have been submitted for NQF endorsement  
22 under the Person and Family-Centered Care Project

1 Phase II Project.

2 So we have received average of six to  
3 eight comments for each of these measures, and  
4 generally the comments were not supportive of  
5 these measures. Public commenters, they noted  
6 that the inpatient rehabilitation facilities,  
7 they collect data and report data through the FIM  
8 instrument part of the IRF pie for post-active  
9 payment system purposes. And introducing these  
10 measures, which will use the Care Tool, may  
11 create undue burden on the providers. And also  
12 they had expressed some concern about the risk  
13 adjustment methodology, testing and the sample  
14 size. So I think CMS would like to provide some  
15 comments on these measures before we open it up  
16 for discussion.

17 CHAIR RAPHAEL: Okay. Alan?

18 MEMBER LEVITT: Okay. Thanks, Mitra  
19 and Carol.

20 MS. GHAZINOUR: Sure.

21 MEMBER LEVITT: First of all, can I  
22 invite the leads up so they can also participate?

1 CHAIR RAPHAEL: Sure.

2 MEMBER LEVITT: Charles Padgett is the  
3 lead in the Inpatient Rehab Facility Quality  
4 Reporting Program and Tara McMullen, Dr. Tara  
5 McMullen is also the lead in our function work at  
6 CMS. So thank you for coming.

7 I want to first make a clarification,  
8 and it was noted in the public comments that  
9 there was some confusion about the change in the  
10 self-care and mobility measures as to what the  
11 numerator and the denominator are. As you might  
12 know from our readmission measures we use the  
13 terminology sometimes it's not a simple numerator  
14 and denominator, and that applies here as well.

15 The denominator that was listed here  
16 is really from the denominator statement which  
17 asks for the target population, and that's the  
18 target population that we're talking about in  
19 terms of the rehab patients. When you're really  
20 looking at the numerator and the denominator of  
21 the measure, it essentially is you -- take self-  
22 care, for example. You sum up the admission

1 self-care items and you sum up the discharge  
2 self-care items for an individual patient and you  
3 get a change in self-care for that patient over  
4 whatever episode we're looking at.

5 And you then also get -- based on a  
6 risk adjustment factors of the patient, you also  
7 get an expected change that you would have on  
8 that individual patient. And so now you have an  
9 observed individual change and an observed  
10 expected change. You take the average for a  
11 facility of all the observed changes. You get an  
12 average of that or a mean observed and then you  
13 get an average of all the expected changes, mean  
14 expected. And so then the measure is actually a  
15 ratio of the mean of the observed over the mean  
16 of expected. And then we multiply it by the  
17 national average so that when it's reported it  
18 makes sense to everyone.

19 Does anyone have any questions on  
20 that? I hope that cleared up the confusion on  
21 that.

22 CHAIR RAPHAEL: Do you want to add



1 anything, Charles or --

2 MEMBER LEVITT: Yes, Charles, is there  
3 anything else, or Tara, on that particular --

4 CHAIR RAPHAEL: Okay.

5 MEMBER LEVITT: Okay. I don't know if  
6 you want any particular individual --

7 CHAIR RAPHAEL: Why don't we --

8 MEMBER LEVITT: Okay.

9 CHAIR RAPHAEL: -- sort of see if  
10 there are questions, just general questions  
11 before we come to the issue of whether or not we  
12 want to pull any of these for more discussion?

13 I had one question, which was one of  
14 our criteria is parsimony, because we repeatedly  
15 hear from providers that they have so many  
16 measures that they have to report on. And I was  
17 just wondering as so why --- and this is terrific  
18 in terms of our core concepts in emphasizing  
19 self-care and mobility, but I was wondering why  
20 we needed it both for change in self-care, change  
21 in mobility and then discharge self-care score  
22 and discharge mobility score.

1                   MEMBER LEVITT: Well, and once again,  
2 we were trying to look at patients and trying to  
3 give information that we can report out and  
4 people can understand. It's really two different  
5 concepts. One is looking at really -- people can  
6 look at the change that patients have within a  
7 facility. The second type of measures are really  
8 to look at the percentage of patients that meet  
9 their expected score, so that it gives an  
10 understanding of what percentage of patients get  
11 where they should get. And so, it's two really  
12 different concepts.

13                   Once again, when we look at function  
14 and as we get into the IMPACT Act, we're trying  
15 to have people also understand differences in  
16 function itself in terms of what the deficits  
17 might be for a particular patient. It may be  
18 people who are looking at, well, most of the  
19 deficits are self-care, so I want to know how a  
20 facility does in that regard. Same thing for  
21 mobility. So again, it's really trying to help  
22 patients, consumers really understand the

1 different performance that facilities have.

2 CHAIR RAPHAEL: Okay.

3 MEMBER LEVITT: Tara, did you want to  
4 add anything? Charles?

5 MEMBER DIAMOND: So, Carol, when you  
6 have a chance, this is Lou here.

7 CHAIR RAPHAEL: Okay.

8 MEMBER DIAMOND: I wanted to ask a  
9 question, if I could.

10 CHAIR RAPHAEL: Thank you, Lou.

11 And don't be afraid to speak up if  
12 you're on the phone so that I'm sure to recognize  
13 you.

14 But, Tara, did you want to add  
15 anything?

16 DR. McMULLEN: Yes. Just to add on to  
17 what Dr. Levitt said --

18 CHAIR RAPHAEL: Is your mic on?

19 DR. McMULLEN: Oh, okay. Cool. I can  
20 hear myself, yes. Just to add on to what Dr.  
21 Levitt said, we also have four measures: the  
22 self-care, the mobility, one at admission, one at

1 discharge, to be able to link together a full  
2 episode of care. The point of the PAC-PRD, the  
3 development of the care tool and into the IMPACT  
4 Act is to be able to demonstrate looking at  
5 patient complexities and really uniformity of  
6 data, but across all episodes of care, multiple  
7 episodes of care, looking at those assessments.  
8 So we have those four measures to help delineate  
9 that and to really link and piece together.

10 MEMBER MULDOON: I find the change in  
11 mobility scores perfectly acceptable,  
12 particularly as it relates to the ratios of the  
13 observed and expected. I put that risk  
14 adjustment in the as good as it gets category,  
15 but when I get to the discharge score and see the  
16 statement meet or exceed an expected discharge  
17 self-care or mobility score, to what degree is  
18 that -- well, who sets that and to what degree is  
19 it standardized?

20 MEMBER LEVITT: It uses essentially  
21 the same type of risk adjusters to establish an  
22 expected score for the patient within whatever

1       that -- whether it's mobility or self-care. And  
2       then essentially it looks at the discharge score  
3       versus the expected score. And so the percentage  
4       is the patients who meet or exceed those expected  
5       scores.

6                   MEMBER MULDOON: So that is  
7       satisfactory, but I'm stuck with the redundancy.  
8       You're not going to capture everything that's  
9       important to someone, but is there a way to  
10      separate the high performers from the low  
11      performers? My guess is there's a fairly strong  
12      correlation between those two that we don't  
13      really need to tweak out at the general global  
14      level.

15                   MEMBER SNYDER KAUSERUD: I have a  
16      question kind of tagging onto what Sean said  
17      about the expected numbers. Is the expected  
18      number coming from the PAC-PRD study that was  
19      done or the analysis on the care tool? Is the  
20      database of where you're pulling expected from  
21      significant enough that it's capturing the entire  
22      -- it's descriptive of what the population would

1 do?

2 MEMBER LEVITT: Again, Tara, do you  
3 want to answer first? Okay. Rather than me  
4 answer, maybe we can -- is the phone open for  
5 Anne?

6 MS. DEUTSCH: This is Anne. Can you  
7 hear me?

8 CHAIR RAPHAEL: Yes, we can hear you.

9 MS. DEUTSCH: Okay. So, Anne Deutsch.  
10 I'm with RTI International and the Rehab  
11 Institute of Chicago, and I was part of the team  
12 work on the development of these measures.

13 So, Suzanne, to answer your question,  
14 the expected score is based on the risk  
15 adjustment, just like Alan said, so basically the  
16 patient characteristics and the coefficients from  
17 the regression models, which were based on the  
18 post-acute care payment reform demonstration data  
19 were used to calculate the expected values.

20 And just to I guess add on what Alan  
21 and Tara mentioned, consumers have, in previous  
22 research, found it difficult to understand what a

1 change in function is, and so consumers are more  
2 used to looking at information like the percent  
3 of patients who achieve certain things or have  
4 certain processes done. And so that was in part  
5 why the two different sets of measures are being  
6 put forward.

7 CHAIR RAPHAEL: Okay. Lou?

8 MEMBER DIAMOND: Yes, so, Carol, thank  
9 you. Just two quick questions, if I could. So  
10 this measure is for all-cause, all diagnostic  
11 categories and all patient populations, I  
12 presume. I'm not sure what the risk adjustment  
13 is. Is it risk adjusted by age and by primary  
14 disease and comorbid condition?

15 MEMBER LEVITT: Yes. I mean, there --  
16 Anne, you can answer, but again there are  
17 multiple risk factors that are involved including  
18 those that you mention.

19 MEMBER DIAMOND: So I guess --

20 MS. DEUTSCH: Yes, so we --

21 MEMBER DIAMOND: Sorry.

22 MS. DEUTSCH: Yes, so we do adjust for

1 age groups, comorbidities, primary diagnosis,  
2 prior functions.

3 MEMBER DIAMOND: So just an  
4 observation from someone who is not really  
5 immersed in this particular subject; and excuse  
6 me for then making the comment, but it does seem  
7 to me that this is potentially a very valuable  
8 measure for quality improvement purposes with  
9 feedback on a regular basis and actions that can  
10 then put in place improved patient outcomes.

11 But my question then is what do we  
12 know about the ability of the institutions that  
13 are being held accountable to impact on the  
14 outcome? Because this is a measure that's being  
15 proposed for public reporting, is that correct?

16 MEMBER LEVITT: Yes, it is.

17 MEMBER DIAMOND: So it's an unfair  
18 question to ask you but what do we know about the  
19 impact, whether these observed this as expected  
20 outcomes can be impacted by the institution that  
21 is being held accountable?

22 MEMBER LEVITT: Yes, that's correct.



1 MS. DEUTSCH: Alan, do you want me to  
2 get started on that?

3 MEMBER LEVITT: Sure. Sure.

4 MS. DEUTSCH: So currently the  
5 inpatient rehab facilities are paid under a  
6 prospective payment system. And over time length  
7 of stay has gone down. And some research has  
8 shown that as length of stay has gone down,  
9 functional improvement has decreased with some of  
10 the existing function data available. The  
11 results have been some research demonstrating  
12 differences in functional outcomes by different  
13 groups. For example, race, ethnicity groups,  
14 different groups based on payer status. So we do  
15 believe that there is an opportunity for  
16 improvement in these areas.

17 MEMBER DIAMOND: Okay. Thank you.

18 DR. McMULLEN: And this is Tara from  
19 CMS. It also should be noted, Lou, that we are  
20 building -- I mean, really with the advent of the  
21 IMPACT Act we're building and most of our post-  
22 acute care settings are monitoring evaluation

1 efforts. So in implementing a lot of these  
2 measures, it may possibly -- public reporting  
3 these measures in the future we will be tracking  
4 facility differences and changes in progress and  
5 patient status and things, discharge transitions,  
6 care coordination, things of that nature.

7 MEMBER DIAMOND: Thank you.

8 MEMBER ROBERTS: Just on the discharge  
9 scores, following up on what Sean said, is just I  
10 hope that we can pay attention to providing  
11 access for people that may make change, but not  
12 have high discharge scores and still are able to  
13 go home to the community, that people are coming  
14 in access because public reporting and having to  
15 have higher expected versus observed discharge  
16 scores.

17 MEMBER VON STERNBERG: Along that line  
18 I think there's been a trend at least in our  
19 community in Minneapolis that the acute rehab  
20 stay is also considered the initial aggressive  
21 therapy and that patient is then transitioned  
22 appropriately to SNF level for rehab, or, to the

1 previous comment, home for rehab. So how we then  
2 distinguish facilities that have supportive  
3 systems and continuums of care that will have  
4 end-point discharge function levels that may not  
5 be as high, shorter length of stay, possibly  
6 lower cost, higher satisfaction, or conversely  
7 monitoring our people forced along a continuum  
8 not in their wishes. So I think it's just an  
9 important element around the score, but as well  
10 connecting it to what were the consequences post-  
11 discharge?

12 CHAIR RAPHAEL: I have Debra next.

13 MEMBER SALIBA: So in speaking to the  
14 question of actionability of the measure, in  
15 nursing homes, at least, it's been shown now in  
16 randomized trials that a nurse/aide-based  
17 intervention actually does lead to functional  
18 improvements, even in long-stay nursing home  
19 residents. So aside from the issue that shorter  
20 lengths of stay mean less functional recovery,  
21 which still doesn't really disprove that this  
22 could have just been the natural history of the

1 progression of the event, this is really  
2 convincing evidence. And it's now been also done  
3 in post-acute care populations as well. So I was  
4 a skeptic that we could significantly alter this  
5 measure, but these studies are very convincing.

6 MEMBER ROSS: Hi, I'd like to talk to  
7 the general context of these proposed measures  
8 from the perspective of the Workgroup on People  
9 Dually Eligible, which is the only National  
10 Quality Workgroup focused on people, as opposed  
11 to settings. And so, I'd like to reinforce the  
12 purpose and intent of the proposal. I don't know  
13 if each measure actually measures what's  
14 intended, but a number of us on the Duals  
15 Workgroup, the moment anyone uses parsimony, it's  
16 one of a whole bunch of criteria. It's not the  
17 criterion.

18 So the reason I like this is because  
19 it promotes consumer understanding and clarity.  
20 That means engagement. That's helpful, if it  
21 promotes alignment across settings. One of the  
22 great frustrations of consumers is that the

1 nursing home tells me one completely different  
2 perspective and the rehab facility tells me  
3 completely different. That's all confusion to  
4 both the family and the individual with the  
5 condition.

6 So any alignment activity across  
7 settings is helpful to the individual. As we  
8 move with ONC to an integrated electronic health  
9 record, we want more alignment. We want less  
10 difference. I know it's going to cost both  
11 effort and money to make adjustments. Helen has  
12 emphasized over and over that we should be also  
13 focused on giving up measures. So most of the  
14 provider arguments I've heard here in two-and-a-  
15 half years are you're adding. And it's true, but  
16 what's not focused on is what can we give up  
17 that's not as meaningful in order to promote the  
18 additional new alignment consumer understanding  
19 issues?

20 So those are some contextual points I  
21 wanted to make. Thank you.

22 CHAIR RAPHAEL: To make sure everyone

1 knows that -- I believe, Clarke, you are the  
2 liaison between the Dual Eligibles Workgroup and  
3 the Post-Acute Long-Term Care Workgroup.

4 MEMBER ROSS: Yes, I'm here today, for  
5 the next twelve months as the liaison between the  
6 two workgroups. Thank you.

7 CHAIR RAPHAEL: Thank you. Alan?

8 MEMBER NISSENSON: I just want some  
9 clarification. It's actually on 0371. And so  
10 the recommendation from the staff is for  
11 conditional support, but right above there it  
12 says the measure is not ready for implementation,  
13 needs further development and testing in this  
14 setting. So how are those two things reconciled  
15 as opposed to being in a different category,  
16 which is needs further development?

17 DR. BURSTIN: So needs further  
18 development is only for measures that aren't  
19 already fully developed and tested. So in this  
20 instance it's a modification to the measure we  
21 think can be done and can be brought back to NQF  
22 for further approval. So we would put that in

1 the conditional category. Measures that are  
2 fully developed we don't put in the encourage  
3 continued development bucket. Is that right?

4 MEMBER NISSENSON: I understand what  
5 Helen said, but then this says it's not fully  
6 developed. So I'm just trying to reconcile, and  
7 maybe I'm just misunderstanding it.

8 MS. O'ROURKE: I think that might be  
9 a typo in the Discussion Guide. We moved that  
10 down late last night. So we apologize for that.  
11 This measure, we had reclassified it based on  
12 what Helen said, but this is a modification, not  
13 a measure still in development. It was tested  
14 and endorsed for hospitals, so now that it's  
15 being tested for IRFs, we just wanted to give the  
16 Workgroup that context and that perhaps you'd  
17 want to conditionally support it based on it  
18 coming back for NQF review for this expanded  
19 setting.

20 CHAIR RAPHAEL: Thank you. Liz?

21 MEMBER PALENA HALL: so thank you for  
22 your comments, Clarke. I appreciate that.

1           One thing I just want to point out for  
2 awareness of the group is there are now available  
3 health IT standards for cognitive function, and  
4 also for functional assessment. And so I just  
5 want to make you aware of that and encourage  
6 alignment as these measures are being developed  
7 so that you look at what is available for the  
8 health IT standards and provide any comments on  
9 any gaps. So as we're going forward if you could  
10 go with the impact legislation and future  
11 development. I just want to make sure there is  
12 an awareness and an alignment. Thanks.

13           CHAIR RAPHAEL: Suzanne?

14           MEMBER SNYDER KAUSERUD: I have a  
15 question, a clarifying question and then maybe a  
16 comment or two.

17           I'm confused about our process here.  
18 Are we talking about all of these five measures  
19 that are being presented, or were we just --

20           CHAIR RAPHAEL: What I had hoped to do  
21 was to just take questions. And then what I was  
22 going to ask was whether or not we're comfortable



1 with moving ahead on all five of them, or we  
2 wanted to pull any of them from the bundle of  
3 five and really have a discussion about them.  
4 But it's sort of like bled into the other here.  
5 So let's just keep going.

6 MEMBER SNYDER KAUSERUD: Okay. Well,  
7 one quick comment on the VTE prophylaxis one.  
8 They mentioned already that stroke was excluded  
9 in the hospital measure and that perhaps in the  
10 IRF measure it should be included. And I would  
11 support that.

12 The other thing that kind of threw us  
13 off was the 120-day exclusion for patients who  
14 are in the facility longer than 120 days. And  
15 unfortunately in some states, mine included, we  
16 do have some difficulty discharging certain types  
17 of patients. And so, even though the patient  
18 might not need 120 days of inpatient rehab care,  
19 we find at 120 days the are still in our  
20 facility. And so, I would think at 121 days,  
21 getting a DVT is just as bad as getting it on day  
22 10. So I'm not really sure what that exclusion

1 was there unless it's applicable in acute care.

2 DR. BURSTIN: Just a quick comment on  
3 that. It's actually included only in the  
4 hospital measure, just to keep this in mind. So  
5 this could be potentially one of the issues you  
6 would like the developer to explore as this  
7 measure gets adapted for IRFs.

8 MEMBER SNYDER KAUSERUD: Right. And  
9 then for the functional measure I think the  
10 public comments really stated the case for the  
11 industry quite well. I think the most alarming  
12 thing that we have is the concern about there  
13 being two measure scales, two very similar  
14 measure scales. One a six-point scale and one a  
15 seven-point scale measuring very similar things  
16 between our required documentation for payment,  
17 which is the claim tool, and then the required  
18 documentation for quality, which would be in this  
19 case the care tool.

20 And so if you're coding transfers, you  
21 have the same clinician coding transfers for  
22 payment and then one for quality, the opportunity

1 for confusion is very high. And then the  
2 opportunity for the quality of both data sets to  
3 be lessened is there. And so I think just more  
4 concern than anything.

5 And I know that there's a lot of  
6 moving parts on this, but just if there was a way  
7 for the changes to be -- if we are going to go to  
8 the care tool, which again that's a whole other  
9 issue in the field -- but if we did move that  
10 way, that they in some way be coordinated to  
11 lessen the burden of having to teach two scales  
12 at the same time and maintain competency and data  
13 integrity on two scales at the same time.

14 CHAIR RAPHAEL: Okay. Liz, did you  
15 want to say anything else? All right. Then let  
16 me ask at this point whether Workgroup members  
17 would like to pull any of the measures; and there  
18 are five here, out of the consent calendar and  
19 really have discussion on that measure. Pam?

20 MEMBER ROBERTS: I'd like to pull the  
21 falls off for the consent for discussion.

22 CHAIR RAPHAEL: Okay. Which number is

1 that?

2 MS. GHAZINOUR: The fall rate. That  
3 measure is no longer under consideration for this  
4 program.

5 CHAIR RAPHAEL: All right. So let me  
6 just kind of go around and see if any Workgroup  
7 member wants to pull any of the five measures for  
8 further discussion and review.

9 All right. Bruce? Sean?

10 MEMBER MULDOON: I would be in favor  
11 of grouping the four rehab ones together and kind  
12 of being an all or none, because they're highly  
13 related. The VTE one in and of itself has five  
14 categories, or five sub-measures, which adds  
15 complexity to that.

16 CHAIR RAPHAEL: Mm-hmm

17 MEMBER MULDOON: So if I was a  
18 splitter, I would say let's take the VTE out.

19 CHAIR RAPHAEL: Okay. All right.  
20 Art, anything?

21 MEMBER STONE: No.

22 CHAIR RAPHAEL: Okay. Marc, can you

1 just --

2 MEMBER LEIB: I agree with ---

3 CHAIR RAPHAEL: And then the VTE  
4 separately? Okay.

5 Peg, anything here? Robyn? All  
6 right. Let me just go to this side. Joseph?

7 MEMBER AGOSTINI: I wouldn't anything  
8 right now.

9 CHAIR RAPHAEL: Okay. Clarke, I think  
10 we got your views.

11 Deb?

12 MEMBER SALIBA: I agree with this one.

13 CHAIR RAPHAEL: Okay. Dianna?

14 MEMBER REELY: Same.

15 CHAIR RAPHAEL: Anyone else who  
16 disagrees?

17 All right. So then let me now put  
18 forth the Nos. 2, 3, 4, and 5, and see if we have  
19 a motion to approve those four measures for  
20 conditional support.

21 Okay. Suzanne?

22 MEMBER STONE: I would so move.

1 CHAIR RAPHAEL: You would move? Do I  
2 have a second?

3 All right. Suzanne?

4 MEMBER SNYDER KAUSERUD: And again,  
5 the clarifying question that -- conditionally  
6 support is we support the direction, but we're  
7 not saying that it's ready to roll at this point?  
8 It's not ready to be implemented as is?

9 CHAIR RAPHAEL: Okay. So let's just  
10 clarify. What do we mean by conditional support?

11 MS. O'ROURKE: So, yes, conditional  
12 support means that we support moving forward with  
13 this measure but we will note all of these  
14 conditions that would need to be met before we  
15 would really recommend this measure going into  
16 the program. So as we noted, NQF endorsement  
17 resolving these data concerns between the current  
18 tools and the care tool and all these caveats, if  
19 you will, to the measure.

20 CHAIR RAPHAEL: Do you think you have  
21 the key kind of conditions that we have come to  
22 agree upon? You have? Okay, fine.

1 All right. Then let me take a vote.  
2 All those in favor of -- oh. Oh, we use our  
3 devices? Oh, wow. Oh, my goodness. All right.  
4 So run us through this, Laura, so we do this  
5 properly.

6 MS. IBRAGIMOVA: Okay. So my name is  
7 Laura Ibragimova and I'm the project analyst here  
8 on the PAC/LTC Workgroup, and I'm just going to  
9 give you some voting tips.

10 If you're a voting member, then you  
11 all received a clicker. And for the purposes of  
12 today you will only be pressing either button 1  
13 or button 2.

14 So you can only vote when the screen  
15 is in full screen. And bear with me because  
16 we're going to -- depending on the way the  
17 discussion is going to go, I'm actually going to  
18 be live editing, like I just was. For the  
19 purposes of the record I'm going to be reading  
20 the slide that we'll be voting on and then  
21 reading the question and then telling you to vote  
22 either one or two. One yes, two no. We'll cast

1 the vote and then I will read the results.

2 If you happen to change your vote, you  
3 can do so and only the last button that you press  
4 will be captured. So if you press a button by  
5 accident, then you can change it really quick if  
6 you need to.

7 So shall we go into vote?

8 CHAIR RAPHAEL: Yes. So we're going  
9 to No. 2.

10 MS. IBRAGIMOVA: So voting on a  
11 specific measure?

12 CHAIR RAPHAEL: On No. 2, because we  
13 pulled No. 1.

14 MS. GHAZINOUR: One is yes, two is no.

15 CHAIR RAPHAEL: Are you reading  
16 something to us or --

17 MS. IBRAGIMOVA: Yes, I'm going to be  
18 reading the consent calendar --

19 CHAIR RAPHAEL: Okay.

20 MS. IBRAGIMOVA: -- and then you're  
21 going to be voting on the consent calendar.

22 CHAIR RAPHAEL: Okay. Do not vote



1 yet.

2 MS. IBRAGIMOVA: So consent calendar  
3 1, Inpatient Rehabilitation Facility Quality  
4 Reporting Program, conditional support: IRF  
5 functional outcome measure, change in self-care  
6 score for medical rehabilitation patients; IRF  
7 functional outcome measure, change in mobility  
8 score for medical rehabilitation measure; IRF  
9 functional outcome measure, discharge self-care  
10 for medical rehabilitation patients; and IRF  
11 functional outcome measure, discharge mobility  
12 score for medical rehabilitation patients.

13 CHAIR RAPHAEL: Okay. Should we vote  
14 now?

15 MS. IBRAGIMOVA: So this is the voting  
16 slide.

17 CHAIR RAPHAEL: Okay.

18 MS. IBRAGIMOVA: So do you agree with  
19 consent calendar 1, Inpatient Rehabilitation  
20 Facility Quality Reporting Program conditional  
21 support calendar? One yes, two no.

22 (Voting)

1 MS. DAVIS: And when voting can you  
2 point your clickers toward Laura and not the  
3 screens is where it will capture. A number  
4 should pop up on your clicker. Toward Laura.

5 MS. O'ROURKE: And for members on the  
6 phone, staff can cast your vote as a proxy. So  
7 if you could send us a chat through the Webinar  
8 platform, we can cast those for you. If you're  
9 not on the Webinar platform, if you're  
10 comfortable just saying your vote, we'll log  
11 them.

12 CHAIR RAPHAEL: All right. Let me  
13 just check in with Lou, Carol and Lisa.

14 MEMBER WINSTEL: Hi, this is Lisa and  
15 I was just now sending my vote to Mitra through  
16 chat.

17 CHAIR RAPHAEL: Okay.

18 MEMBER WINSTEL: So they can confirm  
19 if that works or not.

20 MS. GHAZINOUR: Yes, I got your vote.  
21 Thank you.

22 CHAIR RAPHAEL: Okay. Lou?

1 MEMBER WINSTEL: Oh, okay. Thanks.

2 MEMBER SPENCE: This is Carol. I did  
3 the same.

4 CHAIR RAPHAEL: All right. And, Lou,  
5 are you still there?

6 MEMBER DIAMOND: Yes, I'm still here  
7 and I'll vote in the affirmative, yes.

8 CHAIR RAPHAEL: Okay. And Lou voted  
9 yes.

10 MS. IBRAGIMOVA: So the slide didn't  
11 capture your votes, so if you can recast your  
12 votes.

13 CHAIR RAPHAEL: So we should all  
14 recast our votes?

15 MS. IBRAGIMOVA: Yes.

16 CHAIR RAPHAEL: All right. We should  
17 aim them at you again?

18 MS. IBRAGIMOVA: Yes.

19 CHAIR RAPHAEL: All right.

20 MS. IBRAGIMOVA: So the results are 89  
21 percent yes and 11 percent no.

22 CHAIR RAPHAEL: And our bar is 60

1 percent, so this carries. Okay.

2 All right. So now we're going to go  
3 back to No. 1, the venous thromboembolism  
4 prophylaxis measure. Are there any comments that  
5 anyone wants to make on this one?

6 All right. Pam?

7 MEMBER ROBERTS: Just a clarification  
8 question. So for some of the comments that were  
9 brought up for additions to the measure, how does  
10 that work?

11 MS. O'ROURKE: So we'll capture those  
12 as the conditions for your support when we put  
13 together the table of all of the Workgroup's  
14 decisions. So we'll capture Suzanne's concerns  
15 around the 120-day exclusion criteria and the  
16 previously noted that this should be retooled for  
17 use in IRFs and resubmitted for NQF review.

18 MEMBER LEVITT: Yes, I just want to  
19 note that CMS read the public comments and we  
20 will be going through the measure and specifying  
21 it with our experts to make it an IRF-appropriate  
22 measure.

1 CHAIR RAPHAEL: Sean?

2 MEMBER MULDOON: Alan, just a we got  
3 that covered would be okay, but when these come  
4 to mind, I'm thinking that 10 years from now will  
5 we still agree over what "overlap" means and will  
6 we still agree on what frequency of platelet  
7 count monitoring is necessary and will we still  
8 agree with what discharge instructions entail, or  
9 will they -- is built that into that the  
10 flexibility to over time through regulation  
11 change what those individual parameters are?

12 MEMBER LEVITT: Well as you know,  
13 Sean, every measure that's NQF-endorsed goes  
14 through maintenance and through maintenance that  
15 would be reviewed. And again, depending on the  
16 review, NQF would look at those measures, and if  
17 they are a measure that has a substantive change,  
18 we would put that through rulemaking.

19 MEMBER MULDOON: So the goal here is  
20 for every single patient, because the denominator  
21 is every patient, to be asked the question, and  
22 if the answer is just then to go through the

1 subsequent ones of monitoring, overlap and  
2 instructions.

3 DR. BURSTIN: Well, just a  
4 clarification. This is only one element of those  
5 various Joint Commission measures. This is only  
6 the one on VTE prophylaxis is my understanding.  
7 VTE 1 only, right. We do regularly update those  
8 measures as the evidence has changed and new  
9 drugs have come on line, et cetera.

10 MEMBER ROBERTS: I just want to make  
11 sure that -- so the comments with the stroke and  
12 being included would be looked at?

13 CHAIR RAPHAEL: Yes. Okay. I'm going  
14 to call the question. Do I have a motion to  
15 approve the VTE measure?

16 MEMBER SALIBA: So moved.

17 CHAIR RAPHAEL: Second?

18 Okay. So now, Laura, we turn to you.  
19 Are you ready? You're going to read this?

20 MS. IBRAGIMOVA: Yes. Consent  
21 Calendar 2, Inpatient Rehabilitation Facility  
22 Quality Reporting Program for conditional

1 support, venous thromboembolism prophylaxis.

2 So don't vote yet.

3 So do you agree with Consent Calendar  
4 2, Inpatient Rehabilitation Facility Quality  
5 Reporting Program conditional support calendar?

6 One yes; two no.

7 (Voting)

8 CHAIR RAPHAEL: Okay. We have Lisa,  
9 Lou and Carol.

10 MS. GHAZINOUR: Okay. I just  
11 got --

12 CHAIR RAPHAEL: You got that? And,  
13 Lou, do you want to say how you vote on this?

14 MEMBER DIAMOND: I will vote yes.

15 CHAIR RAPHAEL: Okay. Thank you. So  
16 Lou is yes.

17 MS. GHAZINOUR: Do you want to all  
18 just vote one more time just to make sure --

19 CHAIR RAPHAEL: Bruce is out of the  
20 room.

21 MS. IBRAGIMOVA: Oh, okay.

22 So the results are 100 percent yes,

1 and 0 percent no.

2 CHAIR RAPHAEL: Okay. Cathy, we're  
3 now going to turn to any public comment on  
4 Inpatient Rehab Programs and Facilities.

5 OPERATOR: Okay. At this time if  
6 you'd like to make a public comment, please star  
7 then the number one.

8 (No audible response)

9 OPERATOR: There are no public  
10 comments at this time.

11 CHAIR RAPHAEL: Thank you very much.

12 So we're going to go on to pre-  
13 rulemaking input on the measures under  
14 consideration for ESRD Quality Incentive Program.  
15 And we have three reactors with us: Andrew Narva  
16 from the National Institutes of Health; Peter  
17 Crooks from Kaiser Permanente Southern  
18 California; and Tom Manley from the National  
19 Kidney Foundation. I believe they're all on the  
20 phone. But are they on the phone, because we're  
21 early?

22 DR. BURSTIN: Operator, could you



1 please check if those individuals are on the  
2 line?

3 OPERATOR: Okay. One moment. I'm not  
4 showing them on line.

5 CHAIR RAPHAEL: Too early. So what do  
6 you recommend that we do?

7 MS. GHAZINOUR: So we may want to do  
8 the skilled nursing facility.

9 CHAIR RAPHAEL: So do you want us to  
10 flip and do skilled nursing at this point? But  
11 is Rabia Khan on the phone from CMS?

12 MS. GHAZINOUR: No, Rabia will be for  
13 the Medicare Share Savings Program, not for this  
14 one.

15 CHAIR RAPHAEL: Oh, okay. Not for  
16 this? Okay.

17 So then if you can bear with us, we're  
18 going to go to what was in the afternoon session,  
19 which is measures under consideration for Skilled  
20 Nursing Facilities Value-Based Purchasing  
21 Program, and come back to ESRD.

22 All right. And, Mitra, you're going

1 to provide an overview of this program and the  
2 staff analysis and recommendations.

3 MS. GHAZINOUR: Sure. So this is the  
4 new program, the skilled nursing facility value-  
5 based purchasing, newly established program on  
6 the Protecting Access to Medicare Act of 2014, or  
7 PAMA Act. And it directs the secretary to  
8 establish a SNF Value-Based Purchasing Program  
9 under which value-based payment incentives are  
10 made in fiscal year to facilities beginning in  
11 fiscal year 2019.

12 And also this act requires that, no  
13 later than October 1st, 2015, the secretary shall  
14 specify a skilled nursing facility all-cause,  
15 all-condition hospital readmission measure for  
16 this program, and also not later than October  
17 1st, 2016, the secretary shall specify a measure  
18 to reflect an all-condition risk-adjusted  
19 potentially preventable hospital readmission rate  
20 for SNFs.

21 So going back to the agenda, looking  
22 at the measure -- now it is included in the

1 Discussion Guide. So the measure under  
2 consideration is a skilled nursing facility all-  
3 cause 30-day post-discharge readmission measure.  
4 And it's submitted for endorsement. The number  
5 is 2510. This measure estimates the risk  
6 standardized rate of all-cause unplanned hospital  
7 readmissions for patients who have been admitted  
8 to a SNF within 30 days of discharge from their  
9 prior proximal hospitalization.

10 And so based on the staff preliminary  
11 analysis, this measure addresses an important  
12 PAC/LTC core concept, which is avoidable --  
13 unavoidable readmissions and is a required  
14 measure for this program under the PAMA Act. MAP  
15 had reviewed and supported the direction of the  
16 measure concept. This measure was a concept in  
17 2013 when MAP reviewed this measure and MAP  
18 supported the direction of this measure.

19 This measure is currently under review  
20 for endorsement and it's in the final stages of  
21 receiving endorsement. And also this measure was  
22 recently finalized for use in a Medicare Shared

1 Savings Program in the physician fee scheduled  
2 final 2015 rule. The preliminary analysis  
3 result is to support this measure for this newly  
4 established program.

5 We received one public comment for  
6 this measure which was very supportive of the  
7 measure.

8 So now I would like to turn it back to  
9 the Workgroup.

10 CHAIR RAPHAEL: Okay. Let me see if  
11 there are questions on this measure.

12 (No audible response)

13 CHAIR RAPHAEL: Well, I had a  
14 question. How does this measure compare to the  
15 readmission measures that we have for other post-  
16 acute and long-term care settings?

17 MEMBER LEVITT: Okay. Well, first of  
18 all, I don't know if Joel Andress -- if we want  
19 to invite him up. He's our readmission lead.

20 But to answer the question, the  
21 readmission measures that you're talking about,  
22 the other measures, are measures that really are

1 looking at care coordination, and those are  
2 readmission measures that are post-discharge. So  
3 in other words, 30-day post-discharge measures.

4 This is a different measure. This is  
5 30-day during a SNF measure. It's primarily an  
6 in-stay measure. It may also include post-  
7 discharge if the patient gets discharged during  
8 that 30 days. But the goal of the measure was  
9 really to harmonize with the hospital-wide  
10 readmission measure, which is a 30-day measure as  
11 well.

12 CHAIR RAPHAEL: Okay. Question --

13 MEMBER LEVITT: Does that answer?

14 Okay.

15 CHAIR RAPHAEL: Okay. Let me take any  
16 questions from the Workgroup on this. Sean?

17 MEMBER MULDOON: So this is Sean from  
18 Kindred. We're pretty happy with this because it  
19 seems to have rung a couple good bells. One is  
20 that the clock starts when you get to the SNF,  
21 not after discharge. So that harmonization is  
22 correct. Just want to make sure you've thought

1 through the gap that you're allowed to have  
2 between the short-term discharge and the SNF  
3 admission. We think of that as the next day, but  
4 not always.

5 And it is important that the fee for  
6 services or the managed Medicare is taken out of  
7 this so that they can more creatively use post-  
8 acute care not just from those groups that are  
9 coming directly from short-term hospitals. So  
10 we're good with this one as written.

11 CHAIR RAPHAEL: Thank you.

12 MEMBER AGOSTINI: I had two questions  
13 if anyone can answer. One was for the exclusions  
14 for the planned readmissions, is that a similar  
15 list that's already been developed for other  
16 admission/readmission measures to the hospital?  
17 That was one question.

18 MEMBER LEVITT: Yes, that's correct.  
19 I mean, we use the I guess Yale planned  
20 readmission algorithm so to speak that is our  
21 basis, but then we've also added planned  
22 readmissions that may be more appropriate for the

1 SNF setting.

2 MEMBER AGOSTINI: Thank you. And then  
3 the second question was around cancer diagnoses.  
4 I see any medical diagnosis for cancer was in the  
5 exclusion from the denominator. I'm just trying  
6 to understand the thinking around that because  
7 there still could be unnecessary readmissions for  
8 people with cancer. What's the rationale there?

9 MEMBER LEVITT: Joel's walking up.  
10 Joel, do you want to answer this one, or you want  
11 -- this is Joel Andress, our lead here. It's  
12 about the cancer exclusion.

13 MR. ANDRESS: All right. Okay. So we  
14 started off in developing this measure, as Alan  
15 said, with the intent to align it with the  
16 hospital-wide readmission measure as much as we  
17 possibly could, primarily in terms of what we  
18 considered to be appropriate exclusions and what  
19 we considered to be the guiding principles of  
20 what the measure was trying to accomplish.

21 So we started with the exclusion  
22 criteria that the hospital-wide readmission

1 measure included. One of those is, as you  
2 mentioned, for certain cancer patients. We  
3 should note that cancer patients are not  
4 themselves excluded from the measure, but what  
5 you're actually looking at are discharges for  
6 particular cancer-related admissions and  
7 discharges.

8           The way that this was put together is  
9 that we started off with a clinical team looking  
10 at the kinds of issues that we believed would be  
11 appropriate for exclusion. We ran analyses  
12 starting off originally with the hospital team  
13 running analyses trying to identify what kinds of  
14 admissions should be excluded or what kinds of  
15 patients should be excluded, and then we put it  
16 through our standard system.

17           So I would say that as we do that  
18 there's typically a balance with these codes  
19 because there's a recognition that some of these  
20 codes will include patients who are appropriate  
21 to capture as a readmission as being a failure in  
22 care. And there are other patients within the



1 codes who are less clearly so. And there's  
2 inevitably a bit of noise. So we try to balance  
3 that noise out with clinical expertise in terms  
4 of whether or not you're capturing a greater  
5 weight of readmissions, which is important,  
6 without also potentially incentivizing poor  
7 behavior on the part of providers who may attempt  
8 to game the system of the readmissions.

9 So that's how we approach it in  
10 general. Did you have a specific exclusion in  
11 mind that you were particular concerned with?

12 CHAIR RAPHAEL: The question was  
13 raised about a specific one.

14 MR. ANDRESS: Why but within --

15 CHAIR RAPHAEL: Why that cancer was  
16 specifically excluded.

17 MR. ANDRESS: Oh. So cancer  
18 specifically was excluded because in the original  
19 development of the hospital-wide readmission  
20 measure the population was stratified among five  
21 groups and -- or, I'm sorry, originally seven  
22 groups, one of those being cancer. And what they

1 found was that cancer patients are typically very  
2 different from other patients in terms of  
3 readmissions patterns, and it was deemed by the  
4 development team and later by CMS that in  
5 including them in the measure, you were  
6 essentially capturing a different course of  
7 events from the other populations within the  
8 readmission measure.

9 And so, a cancer readmission was seen  
10 to be as noise in a particular kind of population  
11 that actually muddied the waters in trying to  
12 assess the performance of the facilities in  
13 providing treatment to those patients. And so we  
14 decided to exclude them from the hospital-wide  
15 readmission measure.

16 In reviewing for the SNF measure, we concluded  
17 that the same issues were also present in the SNF  
18 population, and so we decided to retain the same  
19 exclusion.

20 CHAIR RAPHAEL: Joseph, you want to  
21 respond?

22 MEMBER AGOSTINI: Well, I mean, I'd

1 like to hear from others. I hear the point. My  
2 point is just around the concern for there are  
3 avoidable readmissions potentially within the  
4 oncology -- the medical diagnoses for cancer. So  
5 I know there may be noise. I just want to be  
6 concerned for that population of patients, that  
7 we still are concerned about unnecessary and  
8 avoidable readmissions.

9 CHAIR RAPHAEL: Okay. Robyn?

10 MEMBER GRANT: So my question is  
11 whether in developing the measure and testing it  
12 anyone looked at the potential unintended  
13 consequence of this impeding the ability of  
14 residents who really, really need it to get  
15 hospitalization when they're critically ill.

16 We hear all the time from family  
17 members who've been in the situation where their  
18 loved one has been the nursing home. They can  
19 tell something is seriously wrong and they are  
20 asking for the resident to be sent to the  
21 hospital and that for a variety of reasons, the  
22 facility will not accommodate that request and

1 refuses to send them there with the subsequent  
2 result that the resident suffers harm or in fact  
3 dies.

4 And so, I think our concern very much  
5 is that that's what we're hearing is happening  
6 now without something that incentivizes nursing  
7 homes not sending residents to the hospital. So  
8 we're very concerned that this could impede  
9 residents getting the care they need. So I just  
10 wondered if that had been looked at and  
11 considered.

12 MR. ANDRESS: So this is something  
13 that was also raised when the hospital  
14 readmission measures were originally developed.  
15 I think the particular concern was that  
16 readmissions would drop down because hospitals  
17 would refuse to readmit patients and they would  
18 simply die as a consequence of that. So one of  
19 the things that CMS did at the time was to  
20 develop partnered condition-specific mortality  
21 and readmission measures.

22 And so, since we started developing

1       those measures we've watched in hospitals, which  
2       for this measure essentially -- this measure is  
3       essentially a slice of the population that  
4       hospitals are discharging. We've looked for  
5       that. And what we found is that there is not a  
6       strong -- you would expect to find a strong  
7       negative correlation between the two measures if  
8       hospitals were dropping their readmission rates  
9       at the expense of greater mortality of patients,  
10      and we don't see that. In fact, there tends to  
11      be a fairly positive correlation in hospital  
12      performance for this.

13               Now we don't have a partnered measure  
14      for the SNF setting. I think that's certainly  
15      something that we've talked about as something  
16      that we'd like to push forward. Current  
17      statutory limitations would prevent us from  
18      implementing it in the SNF Value-Based Purchasing  
19      Program, but that doesn't mean that there aren't  
20      other avenues where it could potentially be  
21      reported on. Of course, a mortality measure for  
22      the SNF population carries its own difficulties

1 in specifying.

2 MEMBER GRANT: Thank you.

3 CHAIR RAPHAEL: Okay. Dianna?

4 MEMBER REELY: Can you speak a little  
5 bit to the timeliness of reporting this measure,  
6 because the risk stratification will be part of  
7 establishing the measure? Oftentimes  
8 organizations wait a long period of time to see  
9 what the results will be. And we can calculate  
10 the results internally, but not always knowing  
11 all of the elements of the risk stratification.  
12 It is challenging for organizations. So just  
13 length of the measure, you know, will it be 12  
14 months post-the actual hospitalization  
15 occurrence, or will the measure be something  
16 that's reported more timely than that?

17 MR. ANDRESS: So I would say the risk  
18 stratification is actually not the primary reason  
19 that there's a lot of time that goes into  
20 producing -- a lag in producing the measure.  
21 That tends to be more a lag in developing the  
22 measure. It takes time to put together the

1 model, but once you have the model, it's simply a  
2 matter of obtaining the data. But really, lag is  
3 a consequence of the use of claims data.

4 Now typically, that is because we  
5 recognize that at the end of a particular year,  
6 you still have up to a year to correct claims  
7 that are submitted to CMS. And so we allow for a  
8 runout of -- well, I mean it can vary, but I know  
9 there are groups that use three months. We use  
10 six months to allow the claims data to mature, to  
11 ensure that we've got as correct of data as we  
12 possibly can, recognizing that we can't wait --  
13 waiting a full year gives us as complete a data  
14 as we're going to get, but of course, it causes  
15 lag.

16 I think the current lag in reporting  
17 is roughly -- we're looking at what I'll call a  
18 year following the end of a particular data  
19 period. So we're using one year --

20 MEMBER LEVITT: At six months, I  
21 think.

22 MR. ANDRESS: Well, the runout, the

1 runout is.

2 MEMBER LEVITT: Yes.

3 MR. ANDRESS: But in terms of actually  
4 calculating and producing the measure and being  
5 able to put it up for reporting, the lag is about  
6 a year from the end of a particular data period.  
7 So if we're looking at calendar year 2013, you're  
8 probably looking at the end of December in 2014  
9 before we would be able to produce the measure.  
10 And then, of course, it's a matter of the time  
11 lines for whatever vehicle you're reporting the  
12 measure on.

13 MEMBER LEVITT: And in terms of -- if  
14 you actually read the section 215 of PAMA, it  
15 really specifies this measure is supposed to be  
16 by October 1, 2015, provide feedback reports by  
17 October 2016, public reporting of that by 2017,  
18 and then the actual VTE program is October of  
19 2018. And so, you know, there is a time line for  
20 it.

21 CHAIR RAPHAEL: Okay. Tom?

22 MEMBER VON STERNBERG: I think in



1 follow up to Joe's question of December 30, your  
2 answer about cancer exclusion just didn't work  
3 for me at all. But having said that, my reason  
4 to comment that is a patient with cancer who gets  
5 transferred to SNF, who gets PE because they did  
6 not have adequate anticoagulation, pretty seminal  
7 event, pretty important. I can't see why we  
8 would exclude it. Cancer is different in many  
9 ways, but it's still highly in need of  
10 coordination and attention.

11 I think the -- I resonate somewhat  
12 with the challenge of a facility that doesn't  
13 understand it needs to readmit somebody. I still  
14 think though that doesn't mean we shouldn't  
15 measure there. But one of the questions I have  
16 is as we get harmonization with a hospital's 30-  
17 day readmission rate to the SNF, I think that's  
18 very helpful. The challenge at the SNF level,  
19 however, is I'm receiving admissions from  
20 hospital A, hospital B, and hospital C. And the  
21 connectivity, the safety of the transition, the  
22 communication, information, can vary.

1           So is the SNF at a higher degree of  
2 risk of score based on where they're receiving  
3 folks from? Now granted that would incent them  
4 to perhaps ask for better communication and  
5 partnership. The hospital doesn't have that same  
6 additional burden of things in the same manner.

7           Can we reconcile the fact that a SNF  
8 measure will include many hospitals whereas a  
9 hospital will be just one hospital?

10           MR. ANDRESS: So I would point out  
11 that -- this is actually something else that came  
12 out in the development of the hospital measures.  
13 We have looked at -- we looked at that hospitals  
14 -- I should say that one of the complaints that  
15 we got early on was that when we were looking at  
16 hospital readmissions, we weren't risk adjusting  
17 for where the patients were going to, right? And  
18 the rationale for that was one, the hospital is  
19 part of making the decision about where a patient  
20 is being discharged to. And that was partially  
21 the hospital's responsibility.

22           I think for SNFs, you have a -- you

1 have a balancing act to make in terms of risk  
2 adjustment. Risk adjustment, frankly, is  
3 frequently that. You're making a judgment about  
4 what kinds of things should be risk adjusted for  
5 in a particular measure.

6 In this case, I think it's  
7 inappropriate to risk adjust for the hospitals  
8 who are coming in precisely because we want SNFs  
9 to be reaching out to those particular hospitals.  
10 And because that coordination is a shared  
11 responsibility between the two facilities. And I  
12 think we're hesitant except under particular  
13 circumstances -- under specific circumstances to  
14 include that in the risk adjustment model because  
15 we're typically hesitant to risk adjust for  
16 things that we consider to be under provider  
17 control or under the decision-making processes of  
18 providers.

19 I think what you point out, too, is  
20 one of the glaring inherent complexities of  
21 dealing with care coordination is that our  
22 measures are typically designed to assess a

1 single provider type and a single provider at a  
2 time. But of course, care coordination is very  
3 much dealing with the interaction of multiple  
4 providers and this is one of the issues, I think,  
5 that we face and will continue to.

6 MEMBER VON STERNBERG: The follow up  
7 would be 72 hours, is also an important, perhaps,  
8 distinction of readmission rate around that short  
9 window about truly chaotic transitions. Any  
10 interest or any conversations about a submeasure  
11 of within 72 hours of bounce backs?

12 MR. ANDRESS: So we've actually  
13 received the opposite that maybe we should  
14 exclude the first 72 hours because anything that  
15 happens should be the responsibility of the  
16 hospitals. We don't ascribe to --

17 MEMBER VON STERNBERG: I would agree  
18 there's this conversation.

19 MR. ANDRESS: Oh, there is  
20 conversation. I think our fear is that that's  
21 -- when the patient is most at risk for  
22 readmission is the point at which you have to

1 include -- or you want to avoid excluding them  
2 from the readmission measure.

3 In terms of a submeasure, we have  
4 looked at different time periods, 30 days, 15  
5 days, 7 days. I don't know if we looked at 72  
6 hours specifically. But we could go back and  
7 take a look. I think what we found is that  
8 typically for the rating of SNFs, it doesn't make  
9 a lot of difference which of those time periods  
10 we use. The ratings tend to be fairly consistent  
11 regardless of the time period.

12 CHAIR RAPHAEL: Marc?

13 MEMBER LEIB: I'm still a little  
14 concerned that there might be what I'll call  
15 checks and balances of this. It echoes a little  
16 bit of what Robin said. Prior to this measure  
17 coming up, if a hospital discharged a patient on  
18 the early side and the patient went home or  
19 somewhere else and required rehospitalization,  
20 the only institution that suffered a ding, shall  
21 we say, was the hospital because they discharged  
22 them early.

1                   Now you've got both places where the  
2           patient might be at risk for a negative mark,  
3           neither one of which wants to suffer that. And  
4           so the hospital is not going to want to take the  
5           patient and the nursing facility is not going to  
6           want to send the patient and this patient is  
7           going to languish somewhere in between until  
8           they're so sick that there's no doubt about where  
9           they have to go or they go out horizontally. And  
10          I'm really concerned that when a patient goes  
11          home, the family will take the patient back to  
12          the ED, but the SNF is going to be incentivized  
13          not to bring them back to the hospital with this  
14          negative measure here, so there's no check and  
15          balance in the program when you have both sides  
16          being negatively affected on a readmission.

17                   MR. ANDRESS: Well, so I'll just note  
18          that in the case of hospitals, they are also held  
19          responsible for 30-day mortality for a number of  
20          commissions. And of course, if the patient dies  
21          within 30 days because they weren't readmitted to  
22          the hospital, and those measures are part of the

1 hospital value-based purchasing program as well.

2 For SNFs, I agree that I would want to  
3 see something like that in programs and again for  
4 the value-based purchasing program you have  
5 statutory limitations you're running up against  
6 for the -- in terms of measure development, I  
7 think mortality is a measure that needs to be  
8 addressed. We simply haven't had the opportunity  
9 to develop a measure for it yet.

10 That said, I think that care  
11 coordination, in and of itself remains something  
12 that we need to pursue, particularly among post-  
13 acute care facilities. I think this is -- the  
14 transitions of care are critical ones for these  
15 patients. And while I agree that more needs to  
16 be done in the process of assessing quality and  
17 developing the programs that these measures are  
18 incorporated into, I think the question then  
19 becomes do you wait -- do you then not assess  
20 care coordination at all until you feel like  
21 everything that could be in place is in place or  
22 do you move forward with the program? I think

1 from that perspective we feel very strongly that  
2 we need to start addressing care coordination in  
3 SNFs and other settings.

4 CHAIR RAPHAEL: Okay, Bruce?

5 MEMBER LEFF: Yes, just a  
6 clarification, can you describe what the  
7 statutory limitations are in terms of including  
8 mortality? That's mystical to me.

9 MR. ANDRESS: Sure. So the SNF value-  
10 based purchasing program allows for two measures.  
11 The first one we believe should be this measure,  
12 which is why we submitted it.

13 CHAIR RAPHAEL: Could you speak a  
14 little louder?

15 MR. ANDRESS: Sorry. So the SNF  
16 value-based purchasing program from the pending  
17 legislation allows for two measures. The first  
18 is this measure which we -- well, I should say we  
19 believe it should be this measure which is why we  
20 presented it here. But it also requires the  
21 development of a potentially preventable  
22 readmissions measure, which is essentially this



1       measure -- well, I think it will probably end up  
2       being this measure with additional exclusions for  
3       readmissions that are not considered to  
4       potentially preventable. That's not something  
5       that we've managed to define yet, so we don't  
6       have that measure to present here.

7               But the intention of the legislation  
8       is that ultimately that measure will replace this  
9       measure once it's been developed and it's ready  
10      for implementation, but there's no -- we have no  
11      authority to implement measures beyond those two  
12      in the program.

13             MEMBER LEFF: There's no way to  
14      somehow account for SNF-based mortality in the  
15      formula for the measures you have statutory  
16      authorization to pursue? Is that a correction  
17      based on mortality or something else?

18             MR. ANDRESS: So I won't say that  
19      there's no way; I'll say that it's not something  
20      that we've considered as an element of our  
21      readmission measures as a goal. This measure was  
22      developed before we had the SNF VTE language to

1 go by. That might have been something that we  
2 would have looked to address had we been aware of  
3 the limitation at the time the measure was being  
4 developed.

5 For now, there's not currently an  
6 adjustment for morality in the measure. That  
7 said, the fact that we are resisting the measure  
8 fairly robustly is one of those protections that  
9 goes in. That's the entire point of risk  
10 adjustment is that facilities are on the level  
11 playing field so that if they do have patients  
12 who are sicker than you might find at other  
13 facilities, they are assessed fairly. That's the  
14 entire point of a risk adjustment in the first  
15 place. So I'll say it's not entirely ignored,  
16 but we didn't specifically go out and add a  
17 correction for mortality rates at the facility  
18 level.

19 CHAIR RAPHAEL: Alan?

20 MEMBER LEVITT: Yes, just to add on to  
21 what Joel just said that again, there are the  
22 statutory requirements and you know, you read the

1 law and again, by no later than October 1st, 2015  
2 the Secretary shall specify a skilled nursing  
3 facility all cause, all condition, hospital  
4 readmission measure. And so it's specific in the  
5 language. And then we will be back. You can  
6 look at the IMPACT Act and you can look at this  
7 legislation and you can predict what we're going  
8 to be talking about at this table in the future  
9 because it says not later than October 1, 2016,  
10 we will be specifying the measure to reflect an  
11 all condition, risk adjusted, potentially  
12 preventable hospital readmission rate for skilled  
13 nursing facilities. So again, very specific and  
14 those are the two measures. The second will  
15 replace the first.

16 MEMBER NISSENSON: This is a question  
17 for Joel. It's a variation on Tom's comment and  
18 question.

19 How confident are you about the  
20 ability to attribute the rehospitalization to  
21 this setting? What work has been done to look at  
22 the specific causes of the readmission and then

1 to see whether they're actually attributable to  
2 something that has gone on in the skilled nursing  
3 facility?

4 MR. ANDRESS: So I think that the  
5 first thing to point out is that this is an issue  
6 that has come up in NQF a couple of times,  
7 particularly in looking at post-acute care  
8 settings because frankly most of the readmissions  
9 work that has been done has been done for  
10 hospitals. So for most of the post-acute care  
11 settings, the number of studies that have looked  
12 specifically at intervention for readmissions at  
13 post-acute care settings is fairly limited. SNFs  
14 are actually one of the strongest of those.  
15 There have been a couple SNFs, which I will not  
16 attempt to recite from memory, but which we have  
17 available in the measure documentation that we  
18 can provide for you if you're interested in  
19 looking at it.

20 That indicates that SNFs do have a  
21 capacity to reduce readmission rates among their  
22 patients. From that, there's -- apart from that,

1       there's a simple matter of face validity that you  
2       have patients who are going to a SNF who are  
3       being treated following an acute care stay who  
4       have obviously been sick in the very recent term  
5       and have been judged appropriate for the setting,  
6       which means that there's some degree of  
7       continuing care that is necessary for the patient  
8       before they go home or to another setting.

9               And from our perspective, we see the  
10       fact that you have this transition of care from  
11       acute care to a post-acute care setting is  
12       indicative of the fact that you have a patient  
13       who still needs care and that care may either be  
14       good or bad. And that there may be consequences  
15       for that patient's outcomes depending on the  
16       quality of the care that is provided. And for  
17       that reason, as well, we think that our  
18       readmission measure for this particular  
19       transition for SNFs is certainly appropriate and  
20       called for.

21               DR. BURSTIN: Just a brief comment.  
22       This has been an issue, obviously, in many years

1 at NQF through both the endorsement and the  
2 selection functions at MAP. And I'll say that  
3 prior work of the hospital MAP group and other  
4 groups and the querying over the years have made  
5 the case that the best approach here is to, in  
6 fact, have readmission measures across the widest  
7 range of settings. So it's less about  
8 attributions of what happens to a single  
9 institution, but instead if we have measures  
10 across multiple different settings of care, do we  
11 get a more complete picture recognizing that  
12 it's, in fact, very difficult to tease out what  
13 happens where and that it is really about shared  
14 accountability and shared attribution.

15 And you know, certainly having had the  
16 scars of looking at readmission measures over the  
17 years at NQF, this is an issue I think the more  
18 we have -- the hospitals have certainly taken the  
19 first hit on much of this. I think there is now  
20 a sense that the hospital plus the other groups  
21 together would provide a better picture of what's  
22 happening now.

1 MEMBER DIAMOND: Carol, this is Lou  
2 again.

3 CHAIR RAPHAEL: Lou --

4 MEMBER DIAMOND: Can I ask a question?

5 CHAIR RAPHAEL: Hang on. I have Pam  
6 and then we'll come back.

7 MEMBER DIAMOND: Okay, thank you.

8 CHAIR RAPHAEL: Go ahead.

9 MEMBER ROBERTS: One, I have a  
10 clarification question, and one, if you look at  
11 the original documents from the readmission group  
12 on SNF, there are some studies that have been  
13 done that have been published regarding SNF and  
14 the opportunity for readmission. So they are  
15 clearly laid out in there.

16 The question I have was the recent  
17 consensus standard approval approved this  
18 readmission measure with conditions. So would  
19 this quality metric include those conditions?

20 DR. BURSTIN: Yes, it has not gone  
21 through our board yet for final approval, but  
22 yes.

1           MEMBER ROBERTS: Right, but if it was  
2 approved, then that's the way it would be?

3           DR. BURSTIN: Absolutely. And if you  
4 want, I'll just state those two conditions one of  
5 which is that all the measures that went through  
6 the admission/readmission project would go back  
7 to that standing committee to consider whether  
8 some of those measures might be appropriate for  
9 SES adjustment, how that NQF has put forth that  
10 report indicating we have a willingness now to  
11 consider measures with that level of adjustment.

12           And secondly, a requirement for a one-  
13 year lookback for any concerns about unintended  
14 consequences. And since that's already been  
15 raised at this table, I want to put that --  
16 ensure that as well.

17           CHAIR RAPHAEL: And I was just a  
18 member of that committee, so I just want to  
19 reiterate that we did spend a lot of time on the  
20 SES adjuster, as well as wanting to keep these  
21 measures constantly under the microscope that we  
22 just don't end all work and move on, but that we



1 are constantly getting feedback and reassessing.

2 All right. Lou?

3 MEMBER DIAMOND: Yes, thank you.

4 Thank you, Carol. In your earlier comments about  
5 dual accountability is obviously right on the  
6 mark. I guess my question is how can we get to  
7 the dual accountability reporting piece? Am I  
8 correct that we're not actually reporting based  
9 on the dual accountability concept. Is that  
10 correct?

11 DR. BURSTIN: Not reporting it, but  
12 each entity is held accountable, so there is a  
13 sense of each -- if a hospital has a measure and  
14 a SNF has a measure and they're both being held  
15 accountable, that would be the logic, but they  
16 don't necessarily share that accountability in  
17 each individual measure. I'll defer to CMS on  
18 anything further.

19 MR. ANDRESS: So I'd also note that  
20 most of the information that we use for this is  
21 obtained through claims data. There's nothing  
22 that we use from the NDS for the SNF readmission

1 measure. The risk adjustment data are obtained  
2 through claims data, Part A claims data, I should  
3 specify. And so there's no additional reporting  
4 burden one way or the other.

5 Now we've talked -- we actually talked  
6 about it again during the NQF project about the  
7 possibility of creating a hybrid model that used  
8 both NDS and readmissions data. We had some  
9 concerns with regard to that because there was a  
10 -- there are other -- there is a possibility to  
11 do that, but in order to do that, you end up with  
12 some limitations in terms of what you're able to  
13 do, do with the measures.

14 One of our greater concerns,  
15 obviously, is matching up the NDS data with the  
16 claims data, which when you have two separate  
17 data sources that can always be adventurous. So  
18 it's not something we've incorporated. Of  
19 course, when we started out from this, we were  
20 basing it again on the hospital-wide readmission  
21 measure, which is a self-claims based.

22 I think one of the advantages to the

1 measure is that it doesn't require an additional  
2 report burden from the facilities. And when we  
3 think about shared accountability, we don't  
4 generally think about accountability, or at least  
5 I don't, in terms of having to report data.

6 My concern of shared accountability is  
7 that if there's an event where a patient is  
8 inappropriately transitioned from one area of  
9 care to another, the providers who are  
10 responsible for that transition of care are aware  
11 of it and they can improve upon a few tractions  
12 to ensure that that doesn't happen again or as  
13 usually the case as frequently as it has in the  
14 past.

15 CHAIR RAPHAEL: Okay, Sean?

16 MEMBER DIAMOND: Real quick, can I  
17 just follow up?

18 CHAIR RAPHAEL: Go ahead.

19 MEMBER DIAMOND: Is it a fact that we  
20 had reporting across multiple settings on these  
21 readmission rates and that the patient  
22 populations that are being reported on and the

1 time frames are all similar so that we, in fact,  
2 are getting a proxy for shared accountability or  
3 variable difference? Do you understand what my  
4 question is?

5 MR. ANDRESS: I understand what your  
6 question is. So there are some differences. I  
7 would say that's more in effect a consequence of  
8 the development for a lot of these settings,  
9 measure development in a lot of these settings  
10 being in its infancy.

11 For instance, and I'll give you an  
12 example here, the LTCH and IRF settings have  
13 readmission measures that cover transition after  
14 the discharge of a patient from the LTCH or to  
15 the IRF, which is different from this measure.  
16 We're actually undertaking development efforts to  
17 develop within the same measure that is roughly  
18 analogous to the SNF measure that we have  
19 currently. So our goal is to address that. It's  
20 simply a matter of getting the resources in place  
21 to develop it.

22 So there are some differences in the

1 current measure suite, but we're working to  
2 address that.

3 MEMBER DIAMOND: But Carol, it does  
4 seem that the committee may want to consider this  
5 as a recommendation to CMS. And since we all  
6 know this is a very important issue, but it's  
7 also a very contentious issue in terms of who is  
8 accountable for what. And the notion of the dual  
9 accountability, but based on what Helen said,  
10 it's a virtual dual accountability that we are  
11 promulgating at this stage of maturation. And  
12 some kind of effort to align the time frames of  
13 the patient populations across these multiple  
14 measures would be very helpful it seems to me.

15 CHAIR RAPHAEL: Helen, did you want to  
16 chime in?

17 DR. BURSTIN: Just to point again in  
18 addition to the details reported, they are the  
19 same time frames, they are all 30 days. And they  
20 are based on the basic model of the work that's  
21 been done to date on the hospital model. Is that  
22 correct, essentially?

1                   MR. ANDRESS: That is correct. Right.  
2                   So to clarify when I say within the same measure  
3                   for, for instance, the IRF or LTCH, it's the same  
4                   transition. You've been discharged from a  
5                   hospital. You're going to an IRF or an LTCH, and  
6                   then the question is are you readmitted to the  
7                   hospital within -- well, I'll say we're actually  
8                   talking amongst ourselves whether it's within 30  
9                   days or limited to the stay. Because if you do  
10                  30 days, then there's a potential that that and  
11                  the measure that already exists will actually  
12                  double count an individual patient. And so we're  
13                  talking about the potential consequences for that  
14                  as we develop the measures.

15                 CHAIR RAPHAEL: Sean.

16                 MEMBER MULDOON: My comment is related  
17                 to the risk of the perverse incentive of not  
18                 transferring a needy patient. We have been  
19                 measuring a very similar measurement for about  
20                 two years and had the same concerns going in.  
21                 But what we have learned over the last couple of  
22                 years is that in the absence of this metric, all

1 the incentives are to transfer. When someone  
2 starts to look bad, if you -- when you transfer  
3 them you avoid getting the doctor involved when  
4 he or she doesn't want to. You avoid having to  
5 go to a lab that's not on site. You avoid  
6 calling in a radiologist and you avoid turning an  
7 inexpensive patient into an expensive one.

8 So with all those incentives saying  
9 send them, this one says not dig in your heels,  
10 but just whoa. Stop and think. Is there another  
11 way to do this for this particular patient? And  
12 then when you step back, are there systems we can  
13 put in place that can catch these things when  
14 they're small rather than big?

15 So although I am sure that there are  
16 some patients or places who have dug in their  
17 heels on the issue, that has not really borne  
18 itself out in our two-year experience.

19 CHAIR RAPHAEL: Okay, thank you.  
20 Dianna.

21 MEMBER REELY: Very similar to Sean's  
22 comment. On behalf of Providence, for at least

1 the last couple of years, in alignment with our  
2 hospitals in the system on our skilled nursing  
3 facility site, we too, have been putting  
4 processes in place to reduce readmissions and  
5 primarily because it's the right thing -- we  
6 believe it's the right thing to do and also  
7 because other non-Medicare payers have asked us  
8 to do that and are basing their decisions on who  
9 to contract with based on one indicator being  
10 readmission rates including even large employers  
11 now as we work on developing accountable care  
12 organizations.

13 So my comment is that this is not  
14 necessarily something new for skilled nursing  
15 facilities, particularly in all of our regions,  
16 but it would allow for more consistency in the  
17 definition of how readmissions are calculated and  
18 reported.

19 CHAIR RAPHAEL: Thank you. Clarke?

20 MEMBER ROSS: Just an observation from  
21 the consumer beneficiary perspective. This  
22 discussion reinforces for me the need to



1 accelerate measure development in continuity of  
2 care, care coordination, and transition planning  
3 which is really what this is all about, but  
4 because of legislators and people want to save  
5 money, we're focused on readmission rates, which  
6 we have to do. But to me, we should just  
7 accelerate these more important, larger concepts  
8 and do what you have to do with this, but get on  
9 with the bigger picture.

10 CHAIR RAPHAEL: Robin?

11 MEMBER GRANT: I realize that there is  
12 the review for unintended consequences, I think.  
13 When you said SES, since I'm new, is that socio-  
14 economic status?

15 CHAIR RAPHAEL: Yes.

16 MEMBER GRANT: So I guess my question  
17 was just up front was there any examination of  
18 the impact that this might have on low income and  
19 minority residents, who may often be found in  
20 facilities that are predominantly minority? And  
21 we know from research that predominantly minority  
22 facilities often have far poorer quality of care

1       than dominantly white, so I'm just wondering if  
2       anything had been done to look at that?

3               CHAIR RAPHAEL: Alan, do you want to  
4       say anything or Joel?

5               MEMBER LEVITT: Well, I'll let Joel  
6       answer that and then I have a comment to make.

7               CHAIR RAPHAEL: Okay. Joel?

8               MR. ANDRESS: Sure. So to clarify,  
9       we've not included SES as part of the risk  
10      adjustment in our measures. But we do -- you've  
11      come to anticipate that we're going to be asked  
12      about it, obviously, so we do look at it.

13              Our findings actually across settings  
14      seem to be fairly consistent on this point.  
15      There tends to be a relatively small gradient in  
16      that facilities that have large numbers of  
17      patients with low SES, tend to have a slightly  
18      higher rate on these measures and it's a fairly  
19      modest gradient. But what we've also found and  
20      we've also found that a similar gradient, I  
21      believe, for instance, where you see facilities  
22      with larger numbers of African American patients,

1 the main point that we've made though is that in  
2 addition to looking at the gradient or the  
3 correlation between the two -- the SES and race  
4 and the facility rates is that we've looked at  
5 the variation within those groups.

6 And what we find is that the variation  
7 within those groups is fairly wide and that they  
8 almost entirely overlap each other. And what  
9 that means is that you have facilities that treat  
10 large numbers of African American patients who do  
11 very poorly on the measures. And you have  
12 facilities that treat large numbers of African  
13 American patients who do very well on the  
14 measures. And then you have facilities who have  
15 relatively few African American patients who are  
16 also on both ends of the spectrum.

17 And so what we've argued, and I think  
18 what we've concluded from this, is that yes,  
19 there is some potential for impact, but it's also  
20 clear that the fact that a facility treats large  
21 numbers of what are traditionally considered  
22 disadvantaged populations, that does not

1 necessarily prevent those facilities from being  
2 able to provide a high quality of care as it's  
3 indicated through readmissions.

4 CHAIR RAPHAEL: Alan, you have the  
5 last word.

6 MEMBER LEVITT: Okay, and just to add  
7 to what Joel said, in the measure submission  
8 there are, if you want to look in the appendix we  
9 have tables. We really did look at this, and as  
10 Joel said there were effects that were seen, but  
11 again, there was such a wide gradient that it  
12 showed that clearly, there were facilities that  
13 did quite well and facilities that did not  
14 actually in both categories.

15 Just to make the final comment, again,  
16 this is an outcome measure and outcome measures  
17 are very difficult. Everybody has their own  
18 opinion as to what should be in and what should  
19 be out. CMS does not have the expectation that  
20 there should be no readmissions to the hospitals,  
21 that this -- there is obviously things that are  
22 out of anybody's control that will cause

1 readmissions, but that there is a piece of those  
2 readmissions that we can influence.

3 Thank you, Dianna, I mean I hope  
4 everyone is doing what you are doing, really  
5 looking at their programs and trying to decrease  
6 the readmission rate.

7 CHAIR RAPHAEL: I was just told that  
8 Lisa, who is on the phone, may have a question.  
9 So let me just do a check in. Apparently not.

10 We now move to a vote on this skilled  
11 nursing facility value based purchasing all cause  
12 readmission measure. And do I have a motion to  
13 approve the recommendation which is support?

14 CHAIR RAPHAEL: Motion seconded?

15 Any further discussion? Okay, Laura.

16 MS. IBRAGIMOVA: So consent calendar  
17 skilled nursing facilities value based purchasing  
18 programs support calendar; skilled nursing  
19 facility all cause 30 day post-discharge  
20 readmission measure. Do you agree with the  
21 skilled nursing facility value-based purchasing  
22 programs support calendar? One, yes. Two, no.

1 CHAIR RAPHAEL: Lou? Lou, Carol,  
2 Lisa, are you still on the phone?

3 MEMBER DIAMOND: Yes, Carol. This is  
4 Lou here. I'm going to vote yes.

5 CHAIR RAPHAEL: Okay. Lisa, are you  
6 still on the phone?

7 MS. IBRAGIMOVA: I got Lisa.

8 CHAIR RAPHAEL: Clarke?

9 MEMBER DIAMOND: I apologize. I'm  
10 going to vote no.

11 CHAIR RAPHAEL: You're voting no. Lou  
12 is voting no, to record that.

13 MS. O'ROURKE: I think we'll need to  
14 take a revote so that we can properly account for  
15 Lou's change of heart. So if we could do a  
16 revote when Laura gives you the --

17 MS. IBRAGIMOVA: You can vote.

18 MS. O'ROURKE: Looks like we're  
19 missing one vote. Could everyone make sure you  
20 hit your clicker and point it towards Laura?

21 CHAIR RAPHAEL: Should we do it one  
22 more time?

1 MS. O'ROURKE: One more time.

2 MS. IBRAGIMOVA: The results are 68  
3 percent yes and 32 percent no.

4 CHAIR RAPHAEL: Okay, and our  
5 threshold is 60 percent for approval, so this is  
6 approved.

7 Thank you, everyone, for a really, I  
8 think very productive discussion.

9 We are now going to take a short five-  
10 minute break.

11 (Whereupon, the above-entitled matter  
12 went off the record at 11:08 a.m. and resumed at  
13 11:17 a.m.)

14 CHAIR RAPHAEL: All right, we are  
15 moving on to the ESRD area. Let me just make  
16 sure that we have our three reactors on the  
17 phone. Andrew Narva?

18 MR. NARVA: I'm here.

19 CHAIR RAPHAEL: Thank you.

20 MR. NARVA: Can you hear me?

21 CHAIR RAPHAEL: Yes, we can hear you.  
22 Peter Crooks?

1 MR. CROOKS: Good morning, I'm here.

2 CHAIR RAPHAEL: Thank you. Tom

3 Manley?

4 MR. MANLEY: Yes, good morning. Hi,  
5 everyone.

6 CHAIR RAPHAEL: Okay. So we're going  
7 to begin with Mitra giving us a brief overview of  
8 the ESRD quality improvement program, and the  
9 preliminary analysis and recommendations from the  
10 staff.

11 MS. GHAZINOUR: Thank you, Carol. So  
12 the end stage renal disease quality incentive  
13 program is a pay-for-performance program as well  
14 as a public reporting program. Under this  
15 program, payments to dialysis facilities already  
16 used, if facilities do not meet or exceed the  
17 required total performance score which is the sum  
18 of the scores for established individual measures  
19 during a defined performance period.

20 Payment reductions are on a sliding  
21 scale which could amount to a maximum of two  
22 percent a year. A facility performance in the



1 end stage renal disease quality incentive program  
2 is publicly recorded to three mechanisms:  
3 performance score certificate, the dialysis  
4 facility compare website and ESRD QIP dialysis  
5 facility performance information.

6 The program goal is to improve the  
7 quality of dialysis care and produce better  
8 outcomes for beneficiaries. The critical program  
9 objectives include the statutory requirement for  
10 this program which notes that the program measure  
11 set should include measures of anemia management  
12 and also dialysis adequacy patient satisfaction  
13 and other concepts important for dialysis  
14 facilities.

15 MAP had previously recommended that  
16 the measure set should expand beyond dialysis  
17 procedures to include non-clinical aspects of  
18 care such as care coordination, medication,  
19 reconciliation, functional status, patient  
20 engagement, pain, falls, and measures covering  
21 comorbid conditions such as depression. And also  
22 MAP has recommended to explore whether the

1 clinically-focused measures could be combined in  
2 a composite measure for assessing optimal  
3 dialysis care.

4 And so going back to the measures  
5 under consideration, we had seven measures under  
6 consideration for this program and we have  
7 grouped the first set of measures in one consent  
8 calendar and as you might notice, this group we  
9 have two different decision category. One of the  
10 measures has received support and the three  
11 others, they have received conditional support.  
12 However we grouped them together because we felt  
13 that they were kind of related.

14 So starting with the first measure,  
15 cultural competency implementation measure, this  
16 measure is NQF endorsed and this is an  
17 organizational survey designed to assist  
18 healthcare organizations in identifying the  
19 degree to which they are providing culturally  
20 competent care and addressing the needs of  
21 diverse populations as well as their adherence to  
22 12 of the 45 NQF endorsed cultural competency

1 practices prioritized for the survey.

2 And so -- the staff's preliminary  
3 analysis concluded that this measure addresses a  
4 critical program objective which is to expand the  
5 measure set to include other aspects of care such  
6 as patient engagement, culturally competent care  
7 in groups, patient engagement issue is also a  
8 priority of national quality strategy.

9 This measure is not publicly reported.  
10 However, it could be used as a means of  
11 evaluating whether standards for providing  
12 culturally competent care are being met. And  
13 specifically, the degree to which healthcare  
14 organizations are adhering to the NQF endorsed  
15 preferred practices for providing culturally  
16 competent care.

17 So we gave this measure support based  
18 on our preliminary analysis and I believe that we  
19 have received one comment on this particular  
20 measure and this comment, it's not supportive of  
21 the measure for the reason that the commenter  
22 indicates that this measure is not adequately

1 validated in dialysis facilities which, in  
2 general, are smaller than the institutions in  
3 which the majority of testing has occurred.

4 Follow up to that, there is a similar  
5 measure in the set, measure number two, cultural  
6 competency reporting measure. This measure is  
7 designed to collect data needed to score the  
8 first measure, NQF 1919. And the comment was  
9 similar for this measure and based on our  
10 preliminary analysis, we have given this measure  
11 conditional support. We think the concept is  
12 important. However, we recommend that this  
13 measure would serve as an important first step in  
14 implementing the cultural competency survey. So  
15 MAP would encourage the rapid implementation of  
16 NQF 1919 which is the first measure, the cultural  
17 competency implementation measure.

18 Moving onto the third measure,  
19 documentation of current medications in the  
20 medical record. This measure is also NQF  
21 endorsed and this measure is percentage of  
22 specified visits for patients age 18 years and

1 older who reach the eligible professional attest  
2 to documenting a list of current medications to  
3 the best of his or her knowledge and ability.

4 So the staff supported this measure  
5 conditionally. The condition is the measure  
6 currently is tested for at a clinician level. So  
7 this measure needs to be tested at the levels  
8 appropriate for ESRD facilities. And it also  
9 addresses a critical program objective that the  
10 measure should include other aspects of care such  
11 as medication reconciliation. And this measure  
12 is also included -- is in the MAP 2 standards so  
13 it's a priority measurement for the duals  
14 population as well.

15 It promotes alignment. This measure  
16 is used in clinician programs such as PQRS and  
17 meaningful use and was recently finalized for use  
18 in medication savings program.

19 We received one public comment for  
20 this measure. So the commenter supports this  
21 measure under certain conditions and the  
22 commenter recommends that the testing for this

1 measure of the timing and strategy when the  
2 reconciliation or documentation happens should be  
3 identified, should be clarified when the testing  
4 happens.

5 The fourth measure is a version, is a  
6 reporting version of the NQF endorsed medication  
7 documentation measure and this reporting measure  
8 is also designed to collect data needed to score  
9 the above measure in the ESRD QIP. And the  
10 public comment is the same for this measure and  
11 the preliminary analysis concluded that this  
12 measure is important. The concept is important.  
13 However, if this reporting measure needs to be  
14 quickly converted to the actual NQF endorsed  
15 measure in the ESRD QIP, if that NQF endorsed  
16 measure is tested and is specified for ESRD  
17 facilities.

18 So that concludes the first measure  
19 set, the first consent calendar.

20 CHAIR RAPHAEL: Okay, so let me just  
21 turn to CMS and see if you have any comments that  
22 the work group should be aware of.

1                   MEMBER LEVITT: Well, first of all,  
2 Carol, it should be noted that the first measure,  
3 if the MAP doesn't think it has an influence on  
4 CMS, the first measure was brought to our  
5 attention at last year's MAP and so you do make a  
6 difference in terms of note, the discussion.

7                   CHAIR RAPHAEL: How heartening that  
8 is. I will convey that message to the entire  
9 MAP.

10                  MEMBER LEVITT: I think it's very  
11 important. We did -- we were hoping that the  
12 reporting measure for that cultural competency  
13 measure would also be fully supported.

14                  Joel wears many hats at CMS and he's  
15 also the ESRD lead. Joel, did you want to say  
16 something about why we would hope that that would  
17 be approved?

18                  MR. ANDRESS: Right, so first of all,  
19 I think this is the last topic that you're going  
20 to have to listen to me about, so in terms of the  
21 reporting measure, so we essentially submitted  
22 the same measure twice. One as a measure that

1 has -- in both cases, a measure that's been  
2 endorsed by NQF, and second as a reporting  
3 measure. Now this is a reflection of the  
4 structure of the QIP which includes both clinical  
5 performance and reporting measures and its  
6 implementation. We received a suggestion from  
7 our own legal office that we should consider  
8 submitting these as both reporting measures and  
9 clinical performance measures for review.

10 I think our expectation with the  
11 reporting measure is essentially that you would  
12 be collecting -- as with all of our reporting  
13 measures, if we propose this as a reporting  
14 measure, it would be collected not to assess  
15 facility performance, at least as a reporting  
16 measure, but to collect the data and get data  
17 from facilities so that one, it's emphasizing  
18 that facilities should be paying attention to  
19 this, and two, allows us to get a sense of where  
20 we are in terms of cultural competency without  
21 also then financially penalizing facilities for  
22 the measure.



1           So I think in terms of its role in a  
2       program, the reporting measure from our  
3       perspective has a number of advantages. In terms  
4       of how it assesses a support or conditional  
5       support, we found that when we go through the  
6       rulemaking process that on occasion, the  
7       distinction between the two can have some impact  
8       on the extent to which we can implement this in a  
9       program, not just here, but in others as well.

10           So I think the question that I  
11       actually put before you is if you believe that  
12       the performance measure is supportable, do you  
13       not -- is there a particular reason that the  
14       reporting measure which simply collects the same  
15       data, but does not penalize facilities for it in  
16       a value based purchasing program would also be  
17       supportable under the same circumstances. And  
18       that was our primary concern that we wanted to  
19       raise with regard to this measure.

20           CHAIR RAPHAEL: Before we turn to our  
21       reactors, is there anything more you want to say  
22       as to why it's different between support and

1 conditional support for the two cultural  
2 competency measures?

3 MS. O'ROURKE: Just to explain the  
4 staff's perspective of why we did the conditional  
5 support for the reporting measures and to caveat  
6 the work group is welcome to make a motion to  
7 change these out to full support.

8 We thought that based on previous MAP  
9 input, MAP would want to get to the outcome  
10 measure, if you will, and get that up and running  
11 and fully publicly reported. We recognize the  
12 reporting measures are a very important first  
13 step to getting that information, but wanting to  
14 send a signal to our colleagues at CMS that MAP  
15 strongly encourages outcome measures and getting  
16 that information out to the public.

17 CHAIR RAPHAEL: Let me turn now to our  
18 reactor panel members and to ask them to provide  
19 input on these four measures that have to do with  
20 cultural competency and current medications and  
21 documentation of that.

22 Andrew Narva.

1 MR. NARVA: Sure. Can you hear me?

2 CHAIR RAPHAEL: Yes, we can hear you  
3 very well. Whatever you're doing we want to  
4 expand because we haven't heard anyone as well as  
5 we're hearing you today.

6 MR. NARVA: Well, I'm delighted to be  
7 a reactor although I'm sometimes known as a hot  
8 reactor, but so I think both of the -- these four  
9 measures address two very, very important issues.  
10 I think my concerns are that implementing a tool  
11 that is not ready for prime time might be worse  
12 than having a better tool implemented a little  
13 bit later.

14 My concerns about the cultural  
15 competency tool and having spent most of my  
16 career taking care of dialysis patients in the  
17 Indian reservations, this is clearly a big issue.  
18 I have concerns about -- I don't know a lot about  
19 the RAND survey and it's not a lot I could find  
20 in the literature or even on Google, but there  
21 are several sections in that survey which are  
22 concerning and some that may not really be

1 helpful in dialysis.

2 The RAND survey suggests the CEO of  
3 the core organization sign off on the assessment.  
4 I'm not sure how that would work in current  
5 dialysis organizational structure. And it may be  
6 that this needs to be more adapted. The piloting  
7 of this measure says that they approached seven  
8 dialysis units in Texas and the response rate was  
9 ten percent. So it appears then that we're  
10 moving forward with an implementation assessment  
11 based on experience of its administration in one  
12 dialysis unit in Texas. I may have misunderstood  
13 what I read.

14 I think it's important that whatever  
15 measure is used can maybe show some difference  
16 after there's an assessment. And I wonder if the  
17 idea of reporting could be -- might be endorsed  
18 as a way of sort of getting people to pay  
19 attention to this issue and defer the tool until  
20 it's refined a little bit better and maybe better  
21 validated in the dialysis setting. I can also  
22 tell you that there's sort of a cadre of young

1 investigators who are really starting to look at  
2 a lot of these issues in a very rigorous and  
3 creative way. And I think that there may be some  
4 insights and new science developing in the next  
5 couple, three years, that may help produce tools  
6 which can really address this barrier to better  
7 care in a way that may actually improve outcomes.

8 I can also comment on the pharmacy  
9 issue, if you want me to go ahead and do that  
10 now.

11 CHAIR RAPHAEL: Why don't you do that?

12 MR. NARVA: Okay, again, this is  
13 incredibly important. I also have had a lot of  
14 experience trying to develop systems in Indian  
15 Health Service especially to assure that there's  
16 a single medication list available both to the  
17 dialysis unit and the hospitals and clinics that  
18 care for those patients. And again, I'm a little  
19 worried about doing something that's not optimal  
20 now versus -- that might be worse than sort of  
21 delaying and doing something better.

22 This appears to be kind of a high

1 workload, sort of check-boxable metric. And I'm  
2 not sure that it's going to improve medication  
3 reconciliation.

4 Looking at the specifics of this  
5 measure, the metric that percentage of specified  
6 visits, you know, that may not be the right  
7 metric. Frequency may not be the right metric.  
8 And I'm not sure that's going to achieve  
9 medication reconciliation which is a fairly  
10 involved process.

11 I'm afraid that what might happen is  
12 it might be handled just as posing a single  
13 question to the patient at each visit, "have any  
14 of your medications changed?" which is often what  
15 happens.

16 And you know, then the person who does  
17 this would need to have some specialized  
18 training. Medicine reconciliation is tricky and  
19 again, I'd be worried that just a yes/no question  
20 might fail at meeting the measure. It's also  
21 important to include over-the-counters, herbals,  
22 all the non-prescription medicines and that

1 involves patients bringing all of their meds and  
2 to do that -- so this is a lot more involved than  
3 you might think.

4 Also, comparing the list of external  
5 medications obtained for a patient or hospital or  
6 another provider with what the dialysis unit has  
7 is rather involved. And the question is who  
8 would be an eligible professional, and who is  
9 going to do that. In other performance measures  
10 related to dialysis, it implies an advanced  
11 practitioner. And I just -- it's not clear who  
12 is going to do this. Is this going to be the  
13 nurse or the dietician or who? And again, in  
14 addition to having the technical skills, the  
15 ability to communicate on these specific issues  
16 is really important.

17 So you know, my response is that  
18 there's a lot more -- this is an incredibly  
19 important thing to address effectively. It's  
20 very complicated to address effectively and I  
21 just worry that putting a measure in place that  
22 really isn't going to get to the problem may not

1 be that helpful and may make it harder to  
2 implement something that may have a bigger impact  
3 later on. Thank you.

4 CHAIR RAPHAEL: Thank you, Andrew.  
5 Peter?

6 MR. CROOKS: Can you hear me now?

7 CHAIR RAPHAEL: Yes, we can hear you.

8 MR. CROOKS: Okay, am I as clear as  
9 Andy?

10 CHAIR RAPHAEL: Yes, pretty clear.  
11 We're doing great.

12 MR. CROOKS: All right. Very good.  
13 Could I ask a question first before I react to  
14 the competency? Actually, this applies to both.  
15 Why does this get into a reporting measure and an  
16 outcome measure? I'm not clear what the -- how  
17 they work together and what the need is for both  
18 of them. Can someone briefly explain that to me?

19 CHAIR RAPHAEL: Okay. That's a good  
20 question. And CMS to answer. Joel.

21 MR. ANDRESS: So in the past, we've  
22 presented measures as performance measures that



1 we then later propose through rulemaking as  
2 reporting measures. And basically, our lawyers  
3 told us that we needed to present them as  
4 reporting measures to the MAP. So we presented  
5 it in both forms because we weren't entirely sure  
6 we agreed with that, but we were absolutely sure  
7 we didn't want to argue with our lawyers about it  
8 next year.

9 So we presented them here in both  
10 forms. I think we're not looking at them in  
11 competition with one another. We see them as --  
12 and just to respond to Andy's concerns, I think  
13 Andy raises some very good points about both  
14 measures, about why we would consider them for  
15 reporting measures as opposed to as performance  
16 measures, at least initially.

17 I think that there's -- I think I  
18 disagree to some extent that I think there is  
19 some value in pursuing reporting measures for  
20 these kinds of issues when we don't have the  
21 perfect or even just a really good performance  
22 measure that we would like to have. In the case

1 of something like cultural competency, we really  
2 don't have a good sense of where ESRD is on this  
3 except that we kind of assume it's probably not  
4 where we'd like to be. And this gives us the  
5 opportunity to grasp with that. The thing about  
6 it being tested in a handful of Texas facilities  
7 -- well, I hope after looking at the SNF, you get  
8 an idea of what kind of testing I like to see in  
9 the measures that I take anywhere with me.  
10 That's not what I would consider ideal, but I  
11 think the fact is that this measure addresses  
12 something that is as Andy raises a very critical  
13 topic.

14 I think we are fortunate enough in the  
15 QIP to have a mechanism by which we can address  
16 it without then fiscally penalizing facilities  
17 for something that we don't have a good  
18 performance grasp on.

19 With regard to medication  
20 reconciliation, the logic is essentially the same  
21 as was mentioned. This is actually a PQRS  
22 measure that we're looking at to address a

1 similar issue that's relevant for dialysis  
2 patients.

3 Clarke, as you raised before, a lot of  
4 care coordination deals with readmissions. This  
5 is, I think, an opportunity to address something  
6 -- a key component of that that's relevant,  
7 that's important to this population which tends  
8 to have a lot of medications and a lot of  
9 providers that they're trying to juggle at the  
10 same time.

11 So that's really the rationale for why  
12 we decided to present reporting versions of these  
13 measures. I think -- I don't want the one to be  
14 ignored because of the potential for the other to  
15 be used. And we're kind of looking for them to  
16 be assessed individually, to potentially be  
17 implemented in a quality program in the future.

18 CHAIR RAPHAEL: Okay, Peter, back to  
19 you.

20 MR. CROOKS: So to see if I understand  
21 that. The measures are similar. The one --  
22 reporting measure, does that refer to the measure

1 is if you report or not, or is it reporting as in  
2 public reporting?

3 MR. ANDRESS: It's reporting as in --  
4 well, I mean the particular structure depends on  
5 the language in the rule, but it generally means  
6 that you get credit for having reported the data  
7 --

8 MR. CROOKS: Okay.

9 MR. ANDRESS: -- to CMS.

10 MR. CROOKS: Okay. And whereas the  
11 original measure 1919, does that take the data  
12 and actually does an evaluation of what's  
13 submitted, or is that also basically just scoring  
14 on whether they report or not?

15 MR. ANDRESS: So the measure is a  
16 facility-level survey. So once a year each  
17 facility fills out a set of survey items and then  
18 submits them. And there's a --part of the survey  
19 that RAND developed is a scoring algorithm for  
20 those items that --

21 MR. CROOKS: Okay.

22 MR. ANDRESS: -- is part of the

1 endorsed measure.

2 CHAIR RAPHAEL: Okay.

3 MR. CROOKS: Okay. Thank you. Okay.

4 So regarding the cultural competency, I agree  
5 that it's a very important issue to look at. I  
6 think it's fine at this point to just reward for  
7 reporting, because I don't think we know how the  
8 data can be interpreted or used in ESRD  
9 facilities. I think it's great and important to  
10 take a look at that. And so I think rewarding  
11 for reporting is sufficient at this point, if  
12 that's the difference between the two measures.

13 I don't have a lot more to say on the  
14 competency metric other than saying that this is  
15 an area that is important and it's time to start  
16 looking at it.

17 But medication reconciliation, I agree  
18 with Andrew it's very, very important and I'd  
19 like to share some experience I've had both with  
20 using this metric as it currently is used for the  
21 electronic health records, and also the  
22 experience that I've had with Medicare or CMS

1 ESRD demo projects some 15 years ago, and how we  
2 approached that, and with what I think was a very  
3 effective approach that might be looked at in  
4 future programs.

5 So, in terms of the effectiveness we  
6 were in Kaiser Permanente and our electronic  
7 health record had recently been told that we have  
8 to do medication reconciliation with every visit  
9 with every patient. And after a month of so of  
10 running this up and down the organization and the  
11 lawyers we concluded that as long as you check  
12 the check box, you can close the encounter.

13 It was programmed in such a way that  
14 you cannot close the encounter without checking  
15 the check box. We were also informed that we  
16 only needed to worry about medications that we  
17 were managing. So for instance as an  
18 nephrologist, I'm seeing a patient, I'm managing  
19 their anti-hypertension medications, maybe their  
20 cholesterol medications, and whatever medications  
21 I've dealt with. I didn't have to try to  
22 eliminate all the old medications or deal with

1 medications that were not my responsibility to  
2 manage.

3 So on the ground that's what's  
4 happening. And I presume that whoever is looking  
5 at these metrics understands that, yes, it's a  
6 far from perfect metric, but it is a check box  
7 metric. Providers are forced to check it off to  
8 close the encounter. And so I think it is  
9 important to be focused on medications, but I  
10 have some doubts about how effective that's going  
11 to be at really helping patients out.

12 So I'd like to just take a minute or  
13 two to talk about our experience with the ESRD  
14 demonstration project back in 1999. 1998-'99 we  
15 started enrolling a thousand Medicare patients  
16 into Kaiser as part of a Medicare demonstration  
17 project. And then our model -- those on the  
18 panel may be aware that in ESRD there's sort of a  
19 multi-disciplinary team approach.

20 Medicare expects that dialysis  
21 facilities will have social workers seeing  
22 patients, as well as dieticians. We added to

1       that team pharmacists, we call them the renal  
2       pharmacists, in our programs. And so at each of  
3       our 12 medical centers in Southern California we  
4       knew that team had a social worker, a dietician  
5       and a pharmacist.

6               And every three months the dialysis  
7       patient would come in for a visit with the multi-  
8       disciplinary team. This is a visit in addition  
9       to their regular hemodialysis treatment, which  
10      are usually don't at contracted units. And so  
11      each team member would see the patient. And the  
12      patient was instructed to bring in all of their  
13      medications in a big brown bag, and they would  
14      spend time with the renal pharmacist, up to 20-30  
15      minutes, going through that bag of medications.  
16      And I always made sure the pharmacist saw the  
17      patient before I did, because that was really the  
18      toughest part of the visit.

19              And you may know that dialysis  
20      patients tend to be on a lot of medications.  
21      Typically 20 or more medications are on their  
22      list. And as our pharmacist would go through



1       these bags of medications, it was amazing.

2       Patients were taking duplicate medications.

3               And these were patients who were now  
4       getting into the Kaiser system where we have some  
5       ability to coordinate care, but patients were  
6       still getting prescriptions from all sorts of  
7       different doctors. And so we'd find duplicate  
8       medications. We'd find incorrect doses for  
9       patients with ESRD. And by the time the patient  
10      would leave, their brown bag would be half as  
11      full as when they came in.

12             Now, in the demonstration project the  
13      patients at Kaiser Permanente had a decrease in  
14      mortality of 40 percent, which was not that great  
15      at the other main state in Southern Florida. And  
16      the evaluators headed by CMS could never really  
17      figure out what was the difference in the  
18      mortality rate. And without other data, but just  
19      in this experience, I've always suspected that  
20      this medication reconciliation that went on every  
21      quarter with every patient with a pharmacist was  
22      really contributing to this mortality advantage.

1  
2           So I would just like to put it out  
3 there for those from CMS and other measure  
4 developers in the room that in a patient complex  
5 with a dialysis patient who is often in an  
6 uncoordinated care position, it really does take  
7 somebody like a renal pharmacist, or somebody who  
8 can sit down and really go through the  
9 medications one at a time and knows interactions  
10 and knows dosing can really make a difference.

11           I'd like also like to point out that  
12 we talk about what lists are we reconciling, and  
13 this measure would be I guess end up reconciling  
14 the medication list at the dialysis unit, but  
15 most patients also have a medication list, some  
16 electronic health record somewhere, the  
17 physician's office, the hospital. The patient  
18 has their own list. And then the pharmacy where  
19 they get their medications has their own list.

20           So there's at least four different  
21 lists of medications out there that are probably  
22 never reconciled, in most cases, completely. So

1       this is quite a challenge. I think it's  
2       incredibly important and I think I'll limit my  
3       comments there. Thank you.

4               CHAIR RAPHAEL: Okay. Thank you.  
5       Thanks a lot, Peter. Now we're going to go on to  
6       Tom, Tom Manley.

7               MR. MANLEY: Yes, I think the National  
8       Kidney Foundation's positions on these measures  
9       are very similar to what Andy and Peter just  
10      expressed. We applaud. We think there's  
11      tremendous value in the cultural competency  
12      measure. Obviously there's a very diverse  
13      population in the dialysis place, so the idea of  
14      developing culturally-appropriate health care is  
15      wonderful.

16              And we also appreciate the need for  
17      continuity of measures across health care  
18      organizations, but we're wondering about the  
19      specificity of this measure to dialysis units,  
20      and in particular we're concerned about the  
21      burden of implementation in some of the smaller  
22      dialysis units. I think that the large dialysis

1 organizations could take this on quite easily,  
2 but there's still a large number of small  
3 dialysis units which would have difficulty with  
4 some of the implementation in this measure.

5 So the idea of a sequential  
6 implementation of the measure is where we first  
7 start with reporting and then going to an  
8 implementation measure may be appropriate way to  
9 evaluate this. And again, as Andy expressed, it  
10 doesn't appear that this has been well tested or  
11 validated in dialysis units and we would like to  
12 see that in advance, I guess, as well.

13 And I don't think I have anything to  
14 add in terms of the medication reconciliation.  
15 We would definitely be supportive of that. It's  
16 a very valuable measure and I think it would be  
17 nice to have a frequency defined and maybe have  
18 that validated in a dialysis unit, the frequency  
19 of the reconciliation. I'm not sure that with  
20 every dialysis session that this is appropriate,  
21 but maybe if you did it on a monthly basis with a  
22 renal pharmacist that might be a way of looking

1 at this and be better at affecting care. So I  
2 think that's all I have to add.

3 CHAIR RAPHAEL: Thank you to our three  
4 reactors. We really appreciate that. I would  
5 just say, looking back to our last meeting, one  
6 of the areas that we as a workgroup did spend a  
7 good deal of time on was how to insert more non-  
8 clinical metrics into kidney dialysis centers,  
9 because we really felt they were a complex  
10 population with multiple chronic conditions, in  
11 some ways overlapping with some of the dual  
12 eligible population, that they have many issues  
13 and really go to those centers with frequency.

14 And we really were grappling with what  
15 more could be accomplished when they are spending  
16 a lot of time at these dialysis centers and is  
17 there more that could be done in the primary  
18 care, non-clinical care realm. So that was kind  
19 of a tension we heard from dialysis center  
20 providers, that they really don't have the  
21 resources nor the bandwidth to do a lot of these  
22 other things that may be desirable. So I think

1 in a way this reflects an effort of this  
2 Workgroup to begin to move in that direction.  
3 And we've heard some of the issues that accompany  
4 that effort.

5 The other thing that we've always had  
6 as a principle is if you find a problem, react to  
7 the problem. Because we've always said don't  
8 just screen for depression. There has to be some  
9 intervention after the depression. So we've  
10 really tried to avoid any identification that  
11 doesn't have some follow-up action.

12 So with that, I'm now going to turn to  
13 the Workgroup comments. I see there are a few  
14 people. Jennifer, I'm going to start with you.  
15 Lou, I assume you're going to want to join in.

16 MEMBER DIAMOND: Yes, just put me in  
17 line, too. Thank you.

18 CHAIR RAPHAEL: I'll put you on the  
19 list. Okay. Jennifer?

20 MEMBER THOMAS: I want to comment on  
21 the documentation of the medications in the  
22 record, and I want to completely agree with what

1 Andrew said on every single point, and Peter as  
2 well, from the standpoint of this issue seems to  
3 be quite a check-off measure. And there are  
4 pieces within the description that -- I think one  
5 thing that's critical, that's missing here is why  
6 is the medication being used? What's its  
7 indication?

8 And when we talk about across  
9 transitions, this is key. We don't have any  
10 standard way of documenting medication use or  
11 records at all. Everybody does it differently.  
12 From the standpoint of CMS, really the only  
13 standard documentation platform that I'm aware of  
14 is the MTM, the medication therapy management,  
15 that's now required as part of Part D for the  
16 beneficiaries. That's a benefit that's provided  
17 to beneficiaries.

18 It's very labor-intensive to complete  
19 it, so my suggestion is that this would be a  
20 great area that we standardize what we do,  
21 whether it has to look the same, but the elements  
22 should definitely be consistent across all the

1 care settings. So the elements that I think,  
2 again, what's missing is we don't have a --  
3 what's the indication for use? I'd like this to  
4 be more than a check-off-the-box because I'm a  
5 little worried that that has really a lot of  
6 relevance.

7 And then I guess one thing, if you all  
8 could clarify for me, is what makes this a non-  
9 clinical? What does that term mean as non-  
10 clinical within the definition for this  
11 particular measure?

12 MS. GHAZINOUR: We meant more cross-  
13 cutting measurement areas rather than only  
14 measures that evaluate dialysis adequacy.

15 CHAIR RAPHAEL: Right. So it's what  
16 the result of the dialysis process. But this  
17 sort of says what other medications are you on  
18 that may not be derived from dialysis, but may be  
19 because you have diabetes or you may have heart  
20 disease. You might have arthritis. So you are  
21 on 20 medications, many of which are due to the  
22 fact that you have other conditions which



1 intersect.

2 MEMBER THOMAS: Yes, and I think that  
3 actually when I looked at that term as being non-  
4 clinical, and I think Peter's description of what  
5 was happening at Kaiser was definitely clinical.  
6 This whole process and medication reconciliation,  
7 that goes beyond just beyond the record of  
8 medication listing.

9 CHAIR RAPHAEL: Right.

10 MEMBER THOMAS: But the reconciliation  
11 piece is much more in-depth and some, again,  
12 categories or elements that could be included is  
13 what are the problems that have been identified?  
14 Do the lists match? And what discrepancies did  
15 we find? And I don't think there's any of that  
16 being captured here. Or will it be captured  
17 here?

18 CHAIR RAPHAEL: So I think your point  
19 is well-taken. So we probably ought to  
20 substitute for non-clinical, sort of maybe more  
21 cross-cutting and more person-centered  
22 approaches. Allen?

1                   MEMBER NISSENSON: So a few comments.  
2       First, I appreciate Andy and Peter and Tom's  
3       comments, and I'm not going to reiterate  
4       everything that Peter and Andy said, but I agree  
5       with the vast majority of their comments. But  
6       first, Carol, I just wanted to address something  
7       you said a minute ago, which is the deliberation  
8       about the ability of the current program to  
9       absorb more of this stuff.

10                   And I think there's general agreement  
11       these are critically important areas to work in  
12       with these very complex chronically ill patients.  
13       And in fact, when you look at what the whole  
14       industry is doing in the setting of care  
15       coordination, in capitated payment systems, in  
16       commercial ACOs -- we're going to be moving into  
17       ESCOs, the Medicare ACOs for kidney disease,  
18       these things are an integral part of those  
19       programs, and very important in maintaining  
20       patient health, keeping them out of the hospital  
21       and improving survival, as well as their  
22       experience of care.

1           But in the fee-for-service world where  
2           the payment is constrained and in fact, as MedPAC  
3           has pointed out repeatedly in the past several  
4           years, not even equivalent to the cost. So this  
5           is a whole program supported by cost shifting  
6           from commercial payers. That's the entire  
7           support of the ESRD program at the moment. With  
8           that reality it's very hard to just do more and  
9           more and more stuff.

10           So I just wanted to give that context  
11           and a couple of specific things about these four  
12           metrics. And they have a similar theme, and I  
13           think Andy mentioned these. It would be very  
14           important to actually test this cultural  
15           competency implementation measure in the setting  
16           that's being proposed. So whether it was one  
17           unit or seven units in Texas, whatever it  
18           actually was, that's just not adequate to see  
19           whether this is a valid and feasible metric to  
20           use in this population.

21           And I'd add, in contrast to what Tom  
22           said, as you all know two big companies dominate

1 the dialysis industry. In many ways it's harder  
2 for the larger companies to implement programs  
3 like this because there are thousands of  
4 facilities that we have to oversee. So it might  
5 seem like we have more infrastructure and it  
6 would be easier. In fact, it's not necessarily  
7 easier. In fact, it provides all kinds of extra  
8 complexity.

9           So one would be -- so, I'd switch  
10 Joel's request a little bit and I think that  
11 having one and two, these two measures, 1919 and  
12 3716, have the same recommendation I think makes  
13 sense, but I would suggest changing 1919 to  
14 conditional until appropriate testing was done.  
15 And that would be true also of the 3716.

16           On the medication reconciliation one,  
17 there are just two point I'll make: One is first  
18 of all the measure hasn't been tested at all as  
19 far as I can tell, not even in seven dialysis  
20 units. The testing that's been done has been on  
21 a clinician-physician level, and that's totally  
22 different from what goes on in dialysis units.

1       So I think that evaluation needs to be changed  
2       and that these medication metrics need to undergo  
3       appropriate testing in dialysis facilities.

4               And then the second comment relates to  
5       something Peter said, which is patients are on an  
6       average of 8 to 10 different medicines. They are  
7       prescribed by four to six different doctors, none  
8       of whom generally write prescriptions in the  
9       dialysis facility. Some do. Some nephrologists  
10      when they visit will write a few prescriptions.  
11      Most of the prescriptions are actually initiated  
12      outside the dialysis facility.

13             And until we get into ePrescribe and  
14      some more -- which hopefully is going to happen  
15      in the next few years -- get into more systems  
16      that will allow capture of data, whether it's  
17      through HIEs, ePrescribe or whatever the system  
18      is, that will aggregate information from multiple  
19      providers, holding the dialysis facility  
20      accountable will only occur through the method  
21      that Peter outlined.

22             We don't use the brown paper bag. We

1 use the shoe box as the way we tell patients to  
2 bring in their meds, because there are so many.  
3 And having someone sort through that every month  
4 and try to figure this out is just not feasible.  
5 And it's also not necessarily accurate because  
6 that means the patient has actually brought in  
7 all the medicines.

8 And no one's bragging about the state  
9 of medication management in ESRD facilities.  
10 It's not what it needs to be. But I think again  
11 these are metrics that are not ready for prime  
12 time yet.

13 CHAIR RAPHAEL: Thank you, Allen.

14 Joseph?

15 MEMBER AGOSTINI: A comment and a  
16 question around the cultural competency measures.  
17 So I'm very supportive of cultural competency,  
18 and obviously the importance. What I don't fully  
19 understand, and maybe I missed this because it's  
20 my first meeting, was what exactly is the tool or  
21 survey? I mean, how comprehensive? How long?  
22 What domains does it cover? I don't feel fully

1 informed about voting on it when the survey seems  
2 unclear to me. Can someone describe that in more  
3 detail?

4 MR. ANDRESS: So the survey itself was  
5 developed by the RAND Corporation and submitted  
6 to NQF. And the full documentation is available  
7 on NQF's Web site. Actually, that's where we  
8 first identified the measure.

9 MEMBER AGOSTINI: I missed it. Sorry.

10  
11 MR. ANDRESS: All right.

12 MEMBER AGOSTINI: I was looking, but  
13 I couldn't find it.

14 MR. ANDRESS: Sorry. So, yes, but  
15 it's available on the NQF Web site. The survey  
16 itself is fairly lengthy and addresses a number  
17 of domains around communication, sensitivity and  
18 so on.

19 I think there was a question about  
20 burden implementation. I would just say that  
21 it's only done once per year per site. So we  
22 actually presented this internally, and people

1 were jumping on us that we were requiring  
2 patients to fill out extraneous surveys that were  
3 actually burdensome. And the fact of the matter  
4 is that because it's only done once a year, the  
5 burden on the survey itself is relatively low.

6 The survey is designed to be  
7 implemented across multiple setting types. So  
8 the mention was made of the seven Texas  
9 facilities. There were hospitals. And I may  
10 have mis-remembered here, but I believe SNFs,  
11 LTCHs and rehabilitation facilities were also  
12 included within the testing approach, or the  
13 testing of the survey itself when it was first  
14 designed. Does that --

15 MEMBER AGOSTINI: Yes.

16 DR. BURSTIN: I can provide a bit more  
17 detail. So this measure resulted from some work  
18 NQF had done funded by the Robert Wood Johnson  
19 Foundation to come up with a set of preferred  
20 practices of what should always be done to  
21 enhance cultural competency. There were 45  
22 preferred practices endorsed by NQF.



1           We then had additional support from  
2           RWJ to have a group of experts prioritize those  
3           45 practices to pick the ones they thought were  
4           most important. So the survey actually assesses  
5           implementation of the 12 highest prioritized  
6           practices. And we would be happy to share the  
7           tool with you.

8           I believe most of the original  
9           testing, Joel, was actually done at community  
10          health center facility level up front. But  
11          again, happy to clarify that as well. And then  
12          RAND actually did the work to create the tool and  
13          validate it using basically the work of the  
14          cultural competency practices.

15                 MR. AGOSTINI: That's helpful.

16                 MEMBER LEVITT: Mitra, I just emailed  
17          you the PDF for the measure. And the survey is  
18          at the end of the measure, if anyone wants it.

19                 CHAIR RAPHAEL: All right. Lou?

20                 MEMBER DIAMOND: Yes, Carol, thank you  
21          very much. So I concur with many of the comments  
22          that made by Andy, Peter and Tom earlier and by

1 Allen Nissenson.

2 Let me just summarize very briefly.

3 There is a burden that relates to this issue for

4 both sets of measures. The testing it seems to

5 me is incredibly important, especially for --

6 well, for both of them, but from the cultural

7 competency set of measures an important issue.

8 And the testing has to deal with both data

9 collection applicability to the dialysis facility

10 and that patient population, but also on the back

11 side, if you will, on the reporting piece.

12 How are these metrics going to be

13 reported out that would be valuable to the

14 facility so that they can improve their care, and

15 how is it best to be reported out so patients can

16 understand the measure and the metric and

17 participate in the engaged set of activities? So

18 the burden is important. The testing is

19 important.

20 But then I did want to raise another

21 important issue that I think is just absolutely

22 critical. I think it does not do a service to

1       this patient population and to the providers if  
2       we focus the attention on the QRP program, the  
3       ESRD QRP Program, without taking into account all  
4       the other programs that those facilities and the  
5       nephrologists are being, if you will, be  
6       subjected to at the moment.

7               So for the facilities, and Allen  
8       mentioned this, we have a public reporting  
9       program under Dialysis Compare. We've had a good  
10      explanation of what the QRP program is all about,  
11      and these measures are meant to be focused on  
12      that particular program, but we have two other  
13      programs that are part of this entire ESRD  
14      Program. One is about to be rolled out, a Star  
15      Rating Program, with a whole set of other  
16      measures, with a whole set of other reporting  
17      that will be, I think, confusing to consumers and  
18      others.

19              And in addition there is the evolving  
20      -- what is called the ESCO Program, ESRD Seamless  
21      Care Program, which is an ASO program under the  
22      Medicare Program, and we're landing on measures

1 as we speak, some of which are discussed here,  
2 which are the medication, quote-unquote,  
3 recording and reconciliation measures.

4 It does seem to me that it's  
5 critically important before we rush into identify  
6 new measures for these various programs that we  
7 make a more firm commitment to aligning these  
8 measures across these multiple programs within  
9 the same program, in this case the ESRD Program  
10 subjected on folks on the facilities, not to  
11 mention the nephrologists who also are under  
12 programs for reporting programs, PQRS, meaningful  
13 use and maintenance of certification, all of  
14 which are kind of under the umbrella of the  
15 program and all covering these same issues,  
16 especially the medication reconciliation issue.

17 So I'm actually, to be frank with you,  
18 in a good mood, but I would want us not even to  
19 conditionally support these measures because my  
20 concern is I think we will end up rushing in to  
21 deploying them quite rapidly. I think we need to  
22 take a step back, freeze further measure

1 deployment in these programs until we've got a  
2 better understanding of the context of how these  
3 measures are being applied across the various  
4 mandates that are currently in place, not being  
5 planned, but actually in place. Carol and  
6 colleagues, those are my comments. Thank you.

7 CHAIR RAPHAEL: Thank you. Liz?

8 MEMBER PALENA HALL: Thank you. I  
9 just want to bring an awareness again to this  
10 Workgroup about some recent recommendations in  
11 November from the IOM around capturing social and  
12 behavioral domains in electronic health records.  
13 A number of those domains are very similar to the  
14 domains discussed here today, including race,  
15 ethnicity and a number of others. So would  
16 encourage the Workgroup to look at those  
17 recommendations and its alignment to the survey  
18 that's being discussed.

19 CHAIR RAPHAEL: Thank you. Peg, did  
20 you want to say anything?

21 MEMBER TERRY: No, I was just going to  
22 comment on the medication one, and I think it's

1 well taken that in fact it's very hard when you  
2 have multiple physicians, and you do not have the  
3 ability to really change some of these meds for  
4 the patients. This is a problem throughout the  
5 post-acute world, specifically in hospice. So I  
6 just want to say I think it's an issue that needs  
7 to be looked at as we move forward. And I  
8 understand what you're saying, so --

9 CHAIR RAPHAEL: Okay. So I think I'm  
10 going to see -- oops, if either Alan or Joel want  
11 to have any concluding comments here before we go  
12 for a vote.

13 MR. ANDRESS: Okay. So on the issue  
14 of program alignment, I think to clarify, I think  
15 there was some concern raised that the programs  
16 are clashing with one another. So to clarify,  
17 first of all, the Star Rating Program is  
18 essentially an augmentation of DFC, so they're  
19 essentially the same program. We're just  
20 reporting information in a star rating format for  
21 it. So there's that.

22 The CMMI -- the Innovation Center's

1       ESCO project is a payment demonstration. It's  
2       not a competing program. It's one that involves  
3       voluntary participation that certainly uses  
4       measures that are specified differently because  
5       they're applicable to the ESCO as opposed to a  
6       specific dialysis facility. So you would expect  
7       that there are going to be some distinctions in  
8       terms of how measures are specified in that case  
9       with regard to the relationship that the QIP has  
10      with these, right?

11               So the QIP is unusual, is different  
12      from DFC in a number of reasons. For one, the  
13      QIP can require the collection of data of its own  
14      authority, or as far as I'm aware, DFC is not  
15      able to do that on its own. Now what we can do  
16      is, for instance, take data that are being  
17      reported under other authorities and put it up as  
18      a purpose for public reporting, but the purpose  
19      of DFC is to report data to patients so that  
20      patients have access to quality information about  
21      facilities.

22               The QIP, on the other hand, is

1 primarily a value-based purchasing program and  
2 its role is to adjust payment in a fee-for-  
3 service environment in such a way that quality is  
4 also taken into account when facilities are  
5 reimbursed by CMS. So I think I would be  
6 concerned that a measure be eliminated from  
7 consideration simply because there are other  
8 programs related to it.

9 I would also point out that while the  
10 Innovation Center is, as far as I'm aware, still  
11 considering the medication reconciliation  
12 measure, or a version of it, for implementation,  
13 the other programs do not implement measures in  
14 these areas of any type. And so I think when  
15 we're talking about clashing, it's not as if we  
16 have another cultural competency measure that we  
17 can implement, but we're simply choosing to  
18 implement this one.

19 This is a measure that we are seeking  
20 to implement specifically because it addresses  
21 this issue, and we think it's the best measure  
22 available at this time. And I would say that the



1 medication reconciliation measure is also in that  
2 circumstance. And I just want to make clear that  
3 we're not setting these up in competition with  
4 other measures and other programs. These are the  
5 measures that we think are best for these  
6 particular areas.

7 CHAIR RAPHAEL: So we are going to  
8 move to a vote. And let me see if I can get a  
9 motion to move toward approval of the first  
10 cultural competency implementation measure which  
11 we right now have as support. And let me ask,  
12 Laura, is there a way to do support, conditional  
13 support and no support? We've been doing yes and  
14 no, but I wanted to see if I could do three  
15 categories this time.

16 MS. O'ROURKE: Yes, but I actually  
17 have to create that slide.

18 CHAIR RAPHAEL: All right. Well, let  
19 me just see if I can get a motion to bring this  
20 up for a vote now. Anyone want to move approval  
21 of the recommendation as it is?

22 MEMBER SALIBA: So moved.

1                   MEMBER LEVITT: I just had one  
2 clarification. How does the 60 percent rule  
3 apply?

4                   CHAIR RAPHAEL: Oh, you're right.  
5 That's a good point. All right. So let me do  
6 the following: I don't know if this is going to  
7 work. Do we have a precedent here? All right.  
8 Go ahead.

9                   MS. IBRAGIMOVA: In hospital we  
10 invented a precedent. We did an informal poll to  
11 see where the group was feeling between the  
12 support, conditional support, do not support.  
13 And then we put it on that consent calendar for  
14 the final vote that would need the 60 percent.  
15 So we have precedent of taking just an informal  
16 non-binding vote to see where the pulse of the  
17 group is right now.

18                  CHAIR RAPHAEL: Okay. Great. All  
19 right. That's a good suggestion. So how many  
20 people would vote for support? Just this is  
21 informal. And please raise your hand so we can  
22 get a sense.

1 All right. None. Conditional  
2 support?

3 (A show of hands.)

4 One, two, three, four, five, six,  
5 seven, eight.

6 All right. Do not support?

7 (A show of hands.)

8 CHAIR RAPHAEL: One, two, three, four,  
9 five. And let me get the people on the phone.  
10 Lou?

11 MEMBER DIAMOND: Yes, I'm not  
12 supporting.

13 CHAIR RAPHAEL: Okay. I'm up to six.  
14 Lisa?

15 (No audible response.)

16 CHAIR RAPHAEL: Carol?

17 (No audible response.)

18 CHAIR RAPHAEL: Oh, conditional? So  
19 we have nine condition, six do not support. All  
20 right. So is that now binary? Do we now take  
21 the formal vote on conditional and do not  
22 support?

1 MEMBER LEVITT: I just had a question.

2 CHAIR RAPHAEL: Sure.

3 MEMBER LEVITT: For conditional  
4 support are you going to define the conditions  
5 that the support --

6 CHAIR RAPHAEL: -- would relate to?

7 MS. O'ROURKE: Let me say I would say  
8 it's probably just -- the Workgroup can correct  
9 me if I'm wrong, but pending additional testing  
10 to ensure this measure works in ESRD facilities.

11 MS. IBRAGIMOVA: So to confirm, it's  
12 just Measure No. E1919 without the reporting  
13 measure?

14 CHAIR RAPHAEL: Yes, we're just going  
15 to do this one and then I'll do the reporting  
16 one. Okay? All right. Any other questions?

17 (No audible response)

18 CHAIR RAPHAEL: So now -- yes, Allen?

19 MEMBER NISSENSON: Just to follow up  
20 on Alan's question, I'm concerned by, one, the  
21 lack of public comment. If you know this sector,  
22 the idea that you'd get one comment is

1       inconceivable and to me represents the fact that  
2       there's a window of just a few days to respond  
3       and send comments.

4               And secondly, if the conditions are  
5       based on just this conversation we've been having  
6       the last half hour, to me that's not sufficient  
7       to say we're going to give conditional support  
8       and here are the three things that this group of  
9       people came up with in this conversation. That  
10      doesn't seem like it's really a very rigorous way  
11      of setting the conditions.

12             So is there some other method, or is  
13      there a time frame for people to provide input  
14      that articulate the conditions so that's clear  
15      sort of what the sense of the group is?

16             MS. O'ROURKE: Absolutely. So one of  
17      our improvements for this year is that we've  
18      expanded the public commenting. So we had the  
19      week before this meeting for us to gather  
20      comments for this Workgroup to consider.

21             After this meeting we're going to  
22      summarize your findings and put all of that out

1 for public comment, starting, I believe, December  
2 23rd. That will run until January 13th. So  
3 we'll have about a three-week public comment  
4 period where we'd encourage everyone to submit  
5 their thoughts. If there are inadequate  
6 conditions around the measure, we can certainly  
7 incorporate those into the report.

8 The public comments will be taken to  
9 the MAP Coordinating Committee so that they will  
10 have the benefit of the Workgroup's input and the  
11 public's input when they make their final review  
12 and recommendation of the measures under  
13 consideration for this program.

14 CHAIR RAPHAEL: All right. Debra?

15 MEMBER SALIBA: My understanding,  
16 also, conditional approval meant that they were  
17 giving them guidance, that they would come back  
18 with additional information and it would be re-  
19 discussed and re-reviewed. So it's not saying  
20 that it just gets checked off and then it's  
21 approved. Am I correct with that?

22 CHAIR RAPHAEL: Is that a correct

1 interpretation, Erin?

2 MS. O'ROURKE: I will defer to my CMS  
3 colleagues, but our current interpretation is no,  
4 that they would not be required to bring this  
5 back to us, just to consider our conditions when  
6 they're implementing the measures.

7 MEMBER LEVITT: And again, well, just  
8 to clarify, if a measure is conditionally  
9 supported, if that measure ended up in a rule,  
10 and the rule we would be reviewing MAP  
11 recommendations, we would be also including the  
12 conditions. And then, as Joel would say, our  
13 lawyers -- but, no, again, we would be responding  
14 to those conditions in the rule.

15 MR. ANDRESS: And just to clarify on  
16 that, all facetiousness aside, when we seek to  
17 implement a measure that the MAP has looked at  
18 that has concluded anything other than full  
19 support, we take it on as part of our  
20 responsibility to provide a rationale for why we  
21 are implementing that measure in the face of  
22 something other than full support.

1           Now in the past that's been because  
2       since the MAP has looked at it we've completed  
3       development of the measure, or we've addressed  
4       the issue, or we've done additional analyses that  
5       we think answer remaining questions that the MAP  
6       had. So there are a number of different ways in  
7       which that can be addressed.

8           But the point of it is that once it  
9       becomes a part of the report that ends up going  
10      out from the MAP, it's something that we don't  
11      have -- well, that sounds awful the way I was  
12      about to say that, but we do not and cannot  
13      ignore it simply to implement the measure during  
14      rule writing.

15           CHAIR RAPHAEL: Okay.

16           MEMBER LEVITT: That's why I was  
17      asking the question of what conditions, because I  
18      wanted to know.

19           CHAIR RAPHAEL: Right. I mean, in  
20      terms of conditions, and I'm trying to summarize  
21      this, we had two key issues that were raised.  
22      One was the burden, and the second was the



1 testing. The burden was answered by Joel that  
2 it's a one-time-a-year survey. The testing was  
3 -- I think, Helen, you talked a bit about the  
4 experience at NQF with the Robert Wood Johnson  
5 Foundation grant, and the work that resulted in  
6 these 12 high-priority measures that we think may  
7 have been tested in community health centers, but  
8 still in a limited number of dialysis centers.  
9 So those were the conditions, Alan, that I heard.  
10 Sean, did you want to say anything?

11 (No audible response.)

12 CHAIR RAPHAEL: Okay. Then let's move  
13 to --

14 MEMBER DIAMOND: Lou here.

15 CHAIR RAPHAEL: Yes, Lou?

16 MEMBER DIAMOND: Just put me in line,  
17 please. I can go? So, Carol, with respect, the  
18 burden it seems to me doesn't get answered by  
19 saying it's a one-time-a-year survey. It's a  
20 much more complex question than that. I mean,  
21 every survey is incrementally more -- every  
22 additional amendment is incrementally more of a

1 load on facilities' physicians, and, importantly,  
2 on the patients. And the patients are now being  
3 asked to complete multiple surveys in the  
4 dialysis unit and multiple inputs, etcetera. And  
5 we need to be cautious about that. So that's my  
6 first comment.

7 My second comment, it would be  
8 helpful, Carol, at some other time after this  
9 meeting -- so, I know that the staff puts this  
10 kind of data together, about this history of  
11 measures that were conditionally approved in the  
12 past by the MAP and how they were handled going  
13 forward.

14 Were they in fact subsequently  
15 implemented, and under what conditions were they  
16 subsequently implemented? It would be helpful to  
17 see that in the future. Thank you.

18 CHAIR RAPHAEL: Okay. Thank you.  
19 That's a good question that we will take a look  
20 at. So now we're going to vote. And, Laura, as  
21 I understand it, it's now for conditional  
22 support, it would be one. And if you do not

1 support, it would be two. All right? Should we  
2 now target this toward you?

3 MS. IBRAGIMOVA: Yes.

4 CHAIR RAPHAEL: Okay.

5 MS. IBRAGIMOVA: So consent calendar  
6 End-Stage Renal Disease Quality Incentive  
7 Program, conditional support of cultural  
8 competency implementation measure. Do you agree  
9 with the End-Stage Renal Disease Quality  
10 Incentive Program conditional support calendar?  
11 One yes, two no.

12 (Voting.)

13 MEMBER DIAMOND: And, Carol, my vote,  
14 this is Louie here, is no support.

15 CHAIR RAPHAEL: Okay. And, Carol  
16 Spence, if you could send your vote to Mitra.

17 MS. GHAZINOUR: Did Lisa sign out?

18 CHAIR RAPHAEL: Lisa signed off.

19 MS. GHAZINOUR: Lisa signed off.

20 Okay.

21 CHAIR RAPHAEL: All right. How did it  
22 turn out?

1 MS. IBRAGIMOVA: So the results are 44  
2 percent yes, and 56 percent no.

3 CHAIR RAPHAEL: So it's a no, is that  
4 correct?

5 MS. O'ROURKE: So I think this is one  
6 we'll ask the Coordinating Committee to weigh in  
7 on.

8 CHAIR RAPHAEL: Okay.

9 MS. O'ROURKE: Since we don't have 60  
10 percent in either direction, we'll bring this to  
11 them for guidance.

12 CHAIR RAPHAEL: Okay. Very good. All  
13 right. I'm going to go onto the other one on  
14 cultural competency, sort of the partner to this  
15 one. And can you read that to us, Laura, so we  
16 can vote?

17 (Off microphone remarks.)

18 CHAIR RAPHAEL: Yes, that was  
19 recommended as conditional support. So now it's  
20 going to either be conditional support or do not  
21 support. Do you need to read anything to us?

22 MS. IBRAGIMOVA: Yes.

1 CHAIR RAPHAEL: Okay.

2 MS. IBRAGIMOVA: So consent calendar  
3 End-Stage Renal Disease Quality Incentive  
4 Program, conditional support for cultural  
5 competency reporting measure. Do you agree with  
6 the End-Stage Renal Disease Quality Incentive  
7 Program conditional support calendar? One yes,  
8 two no.

9 (Voting.)

10 MEMBER DIAMOND: Carol, Lou here. I'm  
11 not supporting.

12 CHAIR RAPHAEL: Okay. Thanks, Lou.

13 MS. IBRAGIMOVA: The results are 44  
14 yes --

15 CHAIR RAPHAEL: They're the same.

16 MS. IBRAGIMOVA: -- and 56 percent no.

17  
18 CHAIR RAPHAEL: Okay. At least we're  
19 consistent. All right. Now --

20 MEMBER NISSENSON: And, Carol, could  
21 I --

22 CHAIR RAPHAEL: Sure, Allen.

1                   MEMBER NISSENSON:  -- I just have  
2                   gotten a little bit confused.  So if our new  
3                   system is you need 60 percent to approve  
4                   something and you get 44 percent, then that means  
5                   it's not approved.  So I'm confused by why you  
6                   would need 60 percent to say no?  I mean, to me  
7                   it's odd.  I mean, is that the intent?  Usually  
8                   you vote and you have a threshold and it's  
9                   either you exceed it or you don't.

10                  CHAIR RAPHAEL:  It was 44 and 56.

11                  MEMBER NISSENSON:  Yes, so if you need  
12                  60 percent to approve something --

13                  CHAIR RAPHAEL:  Forty-four was --

14                  MS. GHAZINOUR:  -- and you get 44  
15                  percent --

16                  CHAIR RAPHAEL:  -- conditional.

17                  MS. GHAZINOUR:  -- it's not approved.

18                  CHAIR RAPHAEL:  Fifty-six was no.

19                  MS. O'ROURKE:  So actually we set the  
20                  voting up that we don't have a default position  
21                  of no, so any of the recommendations would need  
22                  to have hit 60 percent to have been finalized.

1       So since we didn't hit 60 on the no, the no  
2       didn't hit that threshold either. So it's just a  
3       split and it will go to the Coordinating  
4       Committee for a decision.

5               DR. BURSTIN: So this is something,  
6       Allen, that we now do across the entire  
7       organization to try to get a better handle on  
8       consensus. So even with our Endorsement  
9       Committees, for example, over 60 percent is the  
10      threshold for yes or no, whatever the case may  
11      be. Forty to sixty is what we consider gray zone  
12      where additional input or discussion is usually  
13      needed. And less than 40 is where we would have  
14      threshold for no. So in this instance it sort of  
15      at least fits into that middle category of just  
16      additional information to be sought from the  
17      Coordinating Committee.

18             CHAIR RAPHAEL: All right. We're  
19      going onto the medication, No. 3.

20             MEMBER ROSS: Carol?

21             CHAIR RAPHAEL: Oh, yes, Clarke?

22             MEMBER ROSS: I'm sorry. I hesitated

1 when we were discussing this. I want to speak in  
2 favor of documenting all current medications. I  
3 serve on a SAMHSA committee, an ONC committee and  
4 two National Quality Forum committees, and every  
5 specialty group says we're all for all of this,  
6 but we only prescribe and manage medication to  
7 treat melanoma, so that's all we should be  
8 accountable for.

9 And I realize this is incremental and  
10 it's burdensome, doesn't answer the big problem,  
11 but the only way we're going to get to this  
12 problem is require every specialty organization  
13 to make a good faith effort at documenting all  
14 medications that people use. And we're doing  
15 this hopefully through meaningful use and  
16 electronic health records.

17 But at some point sitting around  
18 talking about I can't do it, we're going to have  
19 the same problem, and this is a very severe  
20 problem. And this will facilitate and help  
21 consumers in the long run. In the short run  
22 we'll ask more questions and possibly cause



1 confusion.

2 But we're not going to get to the  
3 long-term objective by every specialty practice  
4 saying no, it's beyond our scope of practice.  
5 Documenting medications is not a scope of  
6 practice issue. It's a documentation issue. So  
7 I felt compelled to --

8 (Simultaneous speaking)

9 MEMBER DIAMOND: Carol, this is Lou  
10 here. Can I say something?

11 CHAIR RAPHAEL: Yes, Lou. Go ahead.

12 MEMBER DIAMOND: Yes, so for me the  
13 issue is not that this is not an important issue  
14 and for me it is not the issue that we shouldn't  
15 get started somewhere. For me the issue is  
16 simply stated the alignment question.

17 Nephrologists have medication reconciliation as  
18 part of their measurement set and they are  
19 integrally part of the dialysis facility as they  
20 treat these patients, number one.

21 Number two, the ESCO Program is  
22 putting in place a medication reconciliation

1 measure. And it is true that it is done at the  
2 ESCO level, but the ESCOs are basically  
3 facilities, the aggregation of facilities.  
4 There's nothing else there. That's what they do.  
5 It's facilities and nephrologists.

6 So the fact that these measures are  
7 not reconciled across those various programs is a  
8 very important issue for me. And secondly,  
9 that's not been tested in this particular patient  
10 population. And doing it on a visit basis makes  
11 absolutely no sense given that these patients are  
12 being seen three times a week in the dialysis  
13 facility. So I just wanted to clarify that from  
14 my perspective. Thank you.

15 CHAIR RAPHAEL: Okay. Thank you.

16 So now we are going to vote on No. 3  
17 on the documentation of current meds in the  
18 medication record.

19 MS. IBRAGIMOVA: Consent calendar End-  
20 Stage Renal Disease Quality Incentive Program,  
21 conditional support, documentation of current  
22 medications in the medication record. Do you

1 agree with the  
2 End-Stage Renal Disease Quality Incentive Program  
3 conditional support calendar? One yes, two no.

4 (Voting.)

5 MEMBER DIAMOND: Carol, this is Louie  
6 here. I'm voting no.

7 CHAIR RAPHAEL: Okay. All right. We  
8 got Carol, I'm assuming. All right. Laura?

9 MS. IBRAGIMOVA: And the results are  
10 44 percent yes, and 56 percent no.

11 CHAIR RAPHAEL: Consistent,  
12 consistent. All right. No. 4 on medication  
13 documentation reporting. Laura, please read it  
14 to us.

15 MS. IBRAGIMOVA: So cultural  
16 competency End-Stage Renal Disease Quality  
17 Incentive Program, conditional support,  
18 medications documentation reporting. Do you  
19 agree with the End-Stage Renal Disease Quality  
20 Incentive Program conditional support calendar?  
21 One yes, two no.

22 (Voting.)

1                   MEMBER DIAMOND: Carol, this is Lou  
2 here. I'm voting no.

3                   CHAIR RAPHAEL: Okay, Lou. We got it.

4                   MEMBER DIAMOND: Thank you.

5                   CHAIR RAPHAEL: All right.

6                   MS. IBRAGIMOVA: And the results are  
7 44 percent yes, and 56 percent no.

8                   CHAIR RAPHAEL: All right. Thank you.

9                   MEMBER LEVITT: Carol, can I just make  
10 one comment?

11                  CHAIR RAPHAEL: Yes, Alan, you can.

12                  MEMBER LEVITT: Essentially what just  
13 happened is the MAP has made CMS recommendations  
14 and even submitted measures to us that they felt  
15 were appropriate to our programs, and the MAP has  
16 just not supported what was previously given --

17                  CHAIR RAPHAEL: You mean the Workgroup  
18 has not supported the MAP.

19                  MEMBER LEVITT: The Workgroup. I'm  
20 sorry.

21                  CHAIR RAPHAEL: Right.

22                  MEMBER LEVITT: Okay.

1 CHAIR RAPHAEL: Right.

2 MEMBER LEVITT: Okay.

3 CHAIR RAPHAEL: Yes.

4 MEMBER LEVITT: I just want that  
5 noted.

6 CHAIR RAPHAEL: There's an internal  
7 fissure here, right? Okay. For the record. So  
8 what I would like to do now is break for lunch,  
9 if it's agreeable with everyone. We have three  
10 more ESRD measures that have to do with dosage  
11 levels, and we will take those up immediately  
12 after lunch. Can I just ask if our reactors can  
13 stay with us if we resume at 1:00?

14 MR. NARVA: This is Andy Narva. No,  
15 I'm not going to be able to do that.

16 CHAIR RAPHAEL: Okay.

17 MR. NARVA: But since those measures  
18 are -- I have other commitments, but I don't have  
19 significant comments. They're basically  
20 refinements of previous measures, and I basically  
21 support the intent.

22 CHAIR RAPHAEL: Okay. So you support

1       them.   Peter?

2                   MR. CROOKS:   Yes, I can be back at  
3       1:00 East Coast Time.

4                   CHAIR RAPHAEL:   Thank you.   Tom?

5                   MR. MANLEY:   I'm not going to be able  
6       to be on at 1:00, but I guess I'd just say the  
7       NKF does support the dosing measure with maybe  
8       one concern caveat related to using raw numbers,  
9       versus calculated Kt over V.   And I guess I'll  
10      also note that the KDOQI guidelines on  
11      hemodialysis adequacy are about to be published  
12      and they are consistent with these measures.

13                  CHAIR RAPHAEL:   Okay.   Thank you, Tom.  
14      All right.   So we are going to have a 20-minute  
15      lunch and resume at 1:00.

16                  (Whereupon, the above-entitled matter  
17      went off the record at 12:38 p.m. to resume this  
18      same day at 1:00 p.m.)

19                  CHAIR RAPHAEL:   Okay. Let me introduce  
20      Rob Saunders to you. Why don't you introduce  
21      yourself better than I can probably?

22                  MR. SAUNDERS: Thank you, Carol. So,

1 Carol asked me to provide updates on two issues  
2 specifically related to the last vote and to  
3 what's been going on overall. So, to explain the  
4 MAP process, in order for a recommendation to be  
5 made from a work group to the Coordinating  
6 Committee -- and the Coordinating Committee is  
7 the overarching body that finalizes all  
8 recommendations and makes the official  
9 recommendations to HHS. But in order for a  
10 recommendation to come from this work group there  
11 has to be a 60 percent affirmative vote.

12 So, the fact that there was not a 60  
13 percent vote reached means that there was no  
14 recommendation from this group to the  
15 Coordinating Committee. There's no official  
16 recommendation from this group to the  
17 Coordinating Committee.

18 What the Coordinating Committee will  
19 receive, is they will receive this measure. They  
20 will understand what happened in this group and  
21 the discussions, but they will not get an  
22 official recommendation like that you've made for

1 other measures, where you've said the PCT/LTC  
2 Work Group recommends that you support this  
3 measure, or the PCT/LTC Work Group recommends  
4 that you do not support this measure.

5           Instead there will be an absence of a  
6 recommendation, because this group did not reach  
7 a consensus position. So that's the important  
8 part here. And I wanted to make sure that was  
9 very well specified for this group, that these  
10 measures weren't voted down in some way; rather,  
11 this group just didn't reach a consensus  
12 position, and, therefore, the lack of consensus  
13 position means that issue has to be resolved by  
14 our Coordinating Committee.

15           So, it's a subtle difference but I  
16 think it's kind of an important one in terms of  
17 process, in terms of what that means for these  
18 particular measures, and what the next stage for  
19 these particular measures are.

20           CHAIR RAPHAEL: Okay. Why don't you  
21 go on to the second point you were going to make,  
22 and then I will take questions.



1 MR. SAUNDERS: Yes, ma'am.

2 CHAIR RAPHAEL: Okay.

3 MR. SAUNDERS: So, the second point  
4 that Carol asked me to speak to is what is  
5 conditional support. Apparently, a number of  
6 folks had questions about that. So, support and  
7 do not support decision categories are relatively  
8 self-explanatory. We understand the conditional  
9 support decision category, though, does have some  
10 ambiguity.

11 In essence, what the conditional  
12 support category means is that this group is  
13 generally supportive of this measure, but they  
14 feel before this measure can go into a program it  
15 needs to meet certain conditions. And this group  
16 has the authority and, frankly, it has the  
17 responsibility to provide those conditions.

18 So, if this group conditionally  
19 supported a particular measure they could say it  
20 is conditional, we support this measure but our  
21 support is conditional on the fact that it needs  
22 to go through the NQF endorsement process.

1 That's a common condition. Or it needs to go for  
2 further testing because it's for a new setting.  
3 Perhaps it was for a hospital setting and it's  
4 been extended to a post-acute care setting and we  
5 would like to see additional testing for that  
6 setting.

7 But this group can attach whatever  
8 conditions that it feels are necessary in order  
9 to reach its support. And in practice what that  
10 means is the conditional support category is  
11 oftentimes a consensus category because that  
12 allows you to, if you're generally supportive of  
13 the direction of the measure but you feel certain  
14 conditions are not yet there and they need to be  
15 there in order for you to support this measure,  
16 this group can attach those conditions there.

17 Those conditions then go to CMS and  
18 the CMS interprets those conditions as guidance  
19 interpreting their rules. CMS, of course, has  
20 the final authority of what measures go in the  
21 programs or not, so these don't have the force of  
22 law, but they are the guidance that comes out of

1 the MAP and what the MAP says going forward.

2 Does that help, Carol?

3 CHAIR RAPHAEL: Yeah, that is helpful.

4 All right. Bruce?

5 MEMBER LEFF: That was a helpful  
6 clarification. Just to take it one step further.  
7 So, for instance, if on Measure X we vote  
8 conditional support, more data needed, who and  
9 how is it decided how that happens?

10 MR. SAUNDERS: So, the ultimate  
11 legislative authority still resides with CMS. CMS  
12 will decide, as they're putting together their  
13 rules on what measures go in programs, how to  
14 interpret and to use that guidance. So, it is  
15 only guidance to CMS. In fact, all of MAP's  
16 recommendations are only guidance to CMS. And  
17 the ultimate legislative authority still resides  
18 with CMS, and they have the authority to do with  
19 the measures as they see fit.

20 I do understand from our CMS  
21 colleagues that they take MAP recommendations  
22 very seriously, and that their team of lawyers

1 likes to make sure to see that the program staff  
2 have taken into account MAP's recommendations. I  
3 can't speak for our CMS colleagues, and I'm sure  
4 Alan could do a better job, but the ultimate  
5 authority still resides there.

6 CHAIR RAPHAEL: Okay. Alan, did you  
7 want to say something on this?

8 MEMBER LEVITT: No, the only thing I  
9 would add, I thought it was a great presentation.  
10 Can we just get maybe to the work group,  
11 including myself, just exactly what was presented  
12 so that way we kind of have an overall  
13 understanding of what that meant, particularly in  
14 terms of the voting that went on?

15 MR. SAUNDERS: I'm sorry, sir, can you  
16 repeat your --- can you clarify your ---

17 MEMBER LEVITT: The comments that you  
18 made, is there any way we could just get that  
19 also just in a written fashion or refer us to  
20 where that is in documentation?

21 MR. SAUNDERS: Sure. We'd be happy to  
22 follow up with you with written format. We have

1 some written documents of this already. And the  
2 final results of the vote will go out -- are  
3 being compiled by Mitra and the rest of that  
4 team, and that's what will go out for public  
5 comment.

6 But we're certainly happy to provide  
7 you a written document in terms of what consensus  
8 means, and also in terms of conditional support.  
9 Are those the two areas?

10 MEMBER LEVITT: Right. Right, exactly.

11 MR. SAUNDERS: Okay.

12 MEMBER LEVITT: Thank you.

13 CHAIR RAPHAEL: Okay. Sean.

14 MEMBER MULDOON: Looking for more  
15 clarity on the responsibility of this group on  
16 specifying what the conditions are. If a  
17 conditionally approved metric does not come back  
18 to us, then do we have to get very specific when  
19 we say things like needs further testing? Like,  
20 needs further testing in, you know, to be  
21 extreme, one hospital in Texas versus a sample  
22 across the country, and those results have to

1 show that there's impact? Or can we simply leave  
2 it with, "take it back for further testing, we  
3 like the direction"?

4 MR. SAUNDERS: And that's up to the  
5 discretion of this group. To the extent to which  
6 you feel that this measure needs very specific  
7 conditions because you're concerned that those  
8 conditions may not be carried out, then this  
9 group has the authority and the ability to  
10 provide very specific feedback. If you're  
11 comfortable with and trust that these conditions  
12 are going to be done, then you can give much  
13 broader guidance. And staff are sort of copying,  
14 as well, the discussions that are happening here  
15 and putting those in a rationale that's also  
16 attached to each of these decisions, as well.

17 CHAIR RAPHAEL: Tom?

18 MEMBER VON STERNBERG: I think that  
19 I'll just simply focus on the one measure that I  
20 voted in favor of, conditionally, related to ESRD  
21 was this sense of medication reconciliation?  
22 Critical, boy, have to keep it on the radar for

1 directionally a critique here of the flaws in  
2 that measure, I think are important. So,  
3 conditional support is let's make sure it doesn't  
4 get lost.

5 It seems to me, though, as we've  
6 talked about in other forums, med rec is a  
7 challenge based on the complexity of it. Nobody  
8 really has a great med rec measure. We continue  
9 to have it featured in all conversations about  
10 the critical nature of safe transitions.

11 I don't think this group has the  
12 bandwidth or the time to come up with the  
13 solution to med rec. And so the concern would be  
14 conditional support being directional as opposed  
15 to conditional support resulting in CMS saying,  
16 well, we're going to land on something. And I  
17 would struggle with that.

18 Having said that, we still need to  
19 come up with a solution about med rec for these  
20 high-risk transitions, not just ESRD but long-  
21 term care and IRF. It is critical. I don't have  
22 the answer.

1                   MR. SAUNDERS: And, frankly, just from  
2                   what other MAP work groups have done, that's why  
3                   conditional support is a common recommendation in  
4                   the sense that people support perhaps the  
5                   direction that this measure is going in, but they  
6                   have concerns about that specific measure and  
7                   would like to see various changes made, but don't  
8                   want to vote down the measure and put a do not  
9                   support recommendation, which then carries a  
10                  strong signal that this measure is wrong and  
11                  should be out of the running.

12                 So that's often why the conditional  
13                  support is a popular option because it allows the  
14                  group to signal their support for the direction,  
15                  but then explain what conditions need to be met,  
16                  that these are the concerns with this measure,  
17                  this measure needs to evolve in certain ways, or  
18                  this measure needs to be tested in certain ways,  
19                  this measure needs to be reviewed by the NQF  
20                  endorsement process, which allows for a much more  
21                  in-depth analysis of the numerator, denominator,  
22                  and all the measurement science pieces.



1 CHAIR RAPHAEL: Okay. Any other  
2 questions? Yes, Jennifer?

3 MEMBER THOMAS: I guess I have a couple  
4 of comments about, again, that medication  
5 documentation and we are using that terminology  
6 as a surrogate, apparently, for medication  
7 reconciliation, which I don't think that's what  
8 that measure specifies. If we want to say it's  
9 medication reconciliation we need to be very  
10 specific about what medication reconciliation is,  
11 and a list of meds is not medication  
12 reconciliation.

13 Two, the other point is that non-  
14 clinical, the wording in there, to me -- again,  
15 you can obtain a list of medications with non-  
16 clinical personnel. A patient can provide that, a  
17 pharmacy technician can provide that, a medical  
18 assistant in a nursing home or otherwise. So  
19 multiple folks can capture that information. How  
20 valuable it is, how accurate it is, if it's been  
21 reconciled, and so there's been some clinical  
22 connection with that, so I think that's my

1 concerns with the measures as they're stated.

2 CHAIR RAPHAEL: Okay, thank you.

3 MEMBER DIAMOND: Carol?

4 CHAIR RAPHAEL: Yes?

5 MEMBER DIAMOND: This is Lou.

6 CHAIR RAPHAEL: Yes. Go ahead, Lou.

7 MEMBER DIAMOND: Yeah, thank you. I'm  
8 sorry to come back again, and I appreciate the  
9 clarification. But just, again, to explain my  
10 previous vote. I have a deep concern, and have  
11 for an extended period of time, about the  
12 alignment question. And it does seem to me that  
13 if we continue to roll out measures and even  
14 conditionally approve them without some firm  
15 commitments on the alignment issue, that creates  
16 a big concern for me.

17 The second issue, which I didn't  
18 mention in my earlier comments, which related to  
19 some extent on the medication measures -- and  
20 although I'm going to vote for the dose measures  
21 that are coming up now -- is the discussion we  
22 had in 2012 on this committee, which was to send

1 CMS a strong message, as I recall, about the lack  
2 of progress to develop health information  
3 infrastructure within the ESRD program with a  
4 clear roadmap to creating e-measures at some time  
5 in the foreseeable future.

6 And to be frank with you, we've made  
7 no progress since that recommendation we made  
8 back in 2012. So, I'm at the kind of a threshold  
9 of being concerned about those kinds of issues;  
10 hence, my vote earlier on. So, thank you, Carol.

11 CHAIR RAPHAEL: Okay, thank you, Lou.  
12 Thank you, Rob.

13 So, we're going to go on to the three  
14 measures having to do with delivered dose. And  
15 while it is categorized as encouraging further  
16 development as the staff's recommendation, I  
17 understand that we need to get clarification here  
18 in terms of the developmental stage actually that  
19 this measure is in. So, I don't know, Alan or --  
20 -

21 MEMBER LEVITT: Yeah, I'm going to  
22 turn it right over to Joel on this.

1 CHAIR RAPHAEL: Okay.

2 MR. ANDRESS: Hi again. So, we  
3 realized last night -- and I want to thank you,  
4 Mitra, for working with us on this -- that there  
5 had been an error in the information that was  
6 submitted to you for the measures in defining the  
7 stage of development the measures were in which  
8 implied that they were just beginning  
9 development.

10 So, to clarify what these measures  
11 are, and this is what Andy Narva was talking  
12 about when he commented earlier. These are not  
13 new measures per se, but they are modifications  
14 of existing dialysis adequacy measures that have  
15 already been reviewed by the MAP and are NQF-  
16 endorsed -- or I should say three of the four are  
17 NQF-endorsed.

18 The issue at play here --- well, I'll  
19 just get to the point of it. These measures are  
20 intended to replace the existing dialysis  
21 adequacy measures in our programs. They are  
22 addressing a particular issue that's been raised

1 at this MAP and has been raised in public comment  
2 and the rules and at measurement development and  
3 in discussion for measure development.

4 Essentially, the way that four  
5 measures are designed, they partition the  
6 dialysis population for the assessment of  
7 dialysis adequacy along two axes, and those are  
8 modality and age. So you have pediatric measures  
9 and adults measures for hemodialysis and  
10 peritoneal dialysis.

11 And the purpose of this, of course, is  
12 to get at, with some granularity, the success at  
13 which facilities were providing dialysis care for  
14 these different groups, and to recognize that  
15 they were in some cases different standards, you  
16 know, in terms of appropriate levels of clearance  
17 by age and modality.

18 The consequence of this, however, is  
19 that CMS has to make a decision when it's  
20 implementing its measures about the minimum  
21 number of cases that a facility can have before  
22 it is willing to report data on that measure. In

1 short, if you have below that threshold, we're  
2 not going to assess you on the measure for a  
3 couple of reasons. One, there's the risk of  
4 patient identification. And, two, there's the  
5 fact that the measure may not be sufficiently  
6 reliable for the purposes of a quality program.

7 And what we found is that because of  
8 the way the measures are partitioned and the fact  
9 that the vast majority of dialysis patients are  
10 adult hemodialysis patients -- many facilities  
11 may have a handful of peritoneal dialysis  
12 patients, or a handful of pediatric patients, but  
13 because there weren't 11 or more, they were being  
14 systematically excluded from the QIP's assessment  
15 of dialysis adequacy. And we tried a couple of  
16 different ways to solve that without adjusting  
17 the measures through policy tools we had, and  
18 essentially hit a dead end with that.

19 So, at essentially the same time we  
20 were putting together the measures under  
21 consideration list that you were sent, we also  
22 began our three-year measure maintenance cycle

1 with NQF. And what we did was we used that  
2 period to modify the existing dialysis adequacy  
3 measures to do two things.

4 First, we took the two adult measures  
5 of peritoneal dialysis and hemodialysis and we  
6 simply removed the age exclusion from them. So,  
7 we included adult and pediatric patients in the  
8 same two measures. And that's what you see up  
9 here with the --- I should say actually the two  
10 bottom measures. So, delivered dose of  
11 hemodialysis above minimum, and then delivered  
12 dose of peritoneal dialysis above minimum.

13 And what we've done is we've  
14 essentially said with these measures, okay, it's  
15 possible that there's a difference in the dose  
16 that is to be provided in a particular group of  
17 people, but the fundamental question of the  
18 measure is, for how many of your patients are you  
19 providing dialysis adequacy, however that is  
20 defined by that patient's characteristics? And  
21 in this case primarily meaning age and modality.

22 So, we took those two measures and we

1 essentially combined both pediatric and adult  
2 patients in those measures. And then with  
3 consideration to wanting to try to include as  
4 many patients as we possibly could within the  
5 assessment of the QIP, because we didn't want to  
6 systematically exclude patients where we could  
7 avoid it, we created an overall composite measure  
8 that looks at all patients in those four original  
9 categories. And the purpose of that was to  
10 maximize both the facilities that receive a  
11 rating on dialysis adequacy, but also to maximize  
12 the number and type of patients that are  
13 contained within the QIP's assessment.

14 There's been a fairly consistent  
15 concern among the dialysis community that  
16 pediatric patients, and the facilities that  
17 predominantly serve them, as well as peritoneal  
18 dialysis patients, are not able to participate  
19 fully within the QIP program, and that they  
20 aren't covered within its measures. And so these  
21 measures are a direct response to that.

22 And, as I say, the first measure is



1       itself a composite of the two measures below.  
2       Now, when you received the documentation for this  
3       it indicated that the measure is still under  
4       development, but where we are with these measures  
5       is that we've completed development of the  
6       measure specifications -- or I should  
7       modification of the measure specifications -- as  
8       of September of this past year. We are at a  
9       stage where we are prepared to submit the  
10      documentation to NQF for the renal project that  
11      comes to an end in February along with a number  
12      of other measures that are also undergoing  
13      maintenance.

14               Our intention, ultimately, once we  
15      have feedback both from you and from NQF about  
16      these measures, is to retire the other four  
17      existing measures and replace them with these in  
18      our various quality programs.

19               CHAIR RAPHAEL: Okay, thank you. So,  
20      are there any other comments, Mitra, that you  
21      want to make on these three measures? Okay. Then  
22      let me just turn to Peter, who I think was still

1 going to be on the phone and see if he wants to  
2 make a comments as a reactor.

3 MR. CROOKS: Thank you. Basically, I  
4 understand that --- well, having sat on the  
5 Steering Committee for NQF for three rounds of  
6 previous renal metrics, I appreciate the changes  
7 that are being made to include pediatrics, and  
8 also understand the rationale for combining those  
9 first two to make it so that perhaps more units  
10 reach the patient threshold. And maybe also it's  
11 easier for public reporting, public understanding  
12 of the metric.

13 A comment I want to make for those on  
14 the panel who are not nephrologists, is that this  
15 emphasis on removing urea as being adequate  
16 dialysis is a longstanding issue and debate in  
17 nephrology. We have come a long ways, I think,  
18 in the last eight years or so. I'm trying to  
19 remember if the first round was hemo study which  
20 was an adequacy study looking at patients  
21 receiving longer dialysis, more urea removal to  
22 see if that helped outcomes.

1           But we appreciate, I think, more than  
2     in the past that adequate dialysis is not only  
3     removing urea as measured by Kt over V, but it's  
4     also getting to adequate volume control. It needs  
5     to take into account residual kidney function. It  
6     needs to be individualized for patients.

7           But, nevertheless, the idea that we  
8     still continue to need a floor for urea removal  
9     is pretty well-accepted and I think  
10    scientifically supported. So, I am in favor of  
11    seeing these measures continued, and it makes  
12    perfect sense to make sure the pediatric  
13    population, which has been relatively ignored  
14    because of small numbers, get included. So, my  
15    reaction is very positive to these metrics.

16           When it comes to what you'd include in  
17    a QIP, I don't know that you would want all three  
18    of these in a future QIP. Maybe the combined  
19    metric would be the one selected, but that's  
20    future work. But as they stand, I would  
21    recommend supporting all three of these.

22           CHAIR RAPHAEL: Okay. And just to

1 remind the work group that Andy indicated his  
2 support, and Tom did as well. So, let me see if  
3 there's any questions from our work group at this  
4 point. Allen?

5 MEMBER NISSENSON: Actually, it's a  
6 question for Joel about the testing of the  
7 composite metric. And there's a generic part to  
8 this question, which is -- because I'm sure this  
9 isn't the first time this has come up where there  
10 are approved measures that then get combined into  
11 a new measure. So, it is general and then  
12 specific about this particular one.

13 It seems to me that the fact that we  
14 have two measures that have been endorsed doesn't  
15 mean that combining them eliminates the need to  
16 do testing, because the combined metric is not  
17 necessarily the same as the two separate ones  
18 just added up. So, I'm just wondering how that's  
19 approached both by MAP, but also what your  
20 thoughts were, Joel, and how you've gone about  
21 that?

22 MR. ANDRESS: Sure. So, as part of

1 the measure maintenance process we also undertake  
2 to engage in the validity and reliability testing  
3 that's part of our standard measure development.  
4 In this case, because these measures are claims-  
5 based, we had access to the data and were able to  
6 conduct the testing.

7 We paralleled it with the testing that  
8 was done for the existing dialysis adequacy  
9 measures. Actually, I have a quick rundown of  
10 these. In terms of reliability, all three  
11 measures have inter-unit reliability of 95  
12 percent, roughly. I think one of them is .947.  
13 But, essentially, if you're not aware, that means  
14 that 95 percent of the variability is due to  
15 between facility variation, which means the  
16 variability that you're looking at is a  
17 consequence of differences in the achievement  
18 level between facilities, and not within them, or  
19 in comparison to each other.

20 All the measures have very similar  
21 relationships to outcome measures that we've  
22 developed for the population, including mortality

1 and hospitalization, to the existing and  
2 underlying dialysis adequacy measures; that  
3 is, that greater achievement of these measures is  
4 negatively associated with higher mortality and  
5 hospitalization rates.

6 So, I mean, that's much of the meat of  
7 the testing. Of course, the underlying evidence  
8 for the dialysis adequacy measures is very much  
9 the same. If you look in the screens here,  
10 you'll see that we've been very careful that, for  
11 instance, with the peritoneal dialysis measure,  
12 there is a different threshold to be met for a  
13 pediatric or an adult patient. So, depending on  
14 your age, you have a different threshold to meet.  
15 But assuming you meet that threshold, you fit  
16 within the numerator.

17 So, in terms of what we wanted to  
18 accomplish, which was to increase the number of  
19 patients that we're assessing, in the existing  
20 measures we were capturing --- and keep in mind  
21 this is limited to Medicare patients because  
22 we're using claims data. Of the 430 pediatric PD

1 patients, we were capturing 95 with the old  
2 measure. We're capturing 430 with the combined  
3 measure. With the pediatric HD measure we were  
4 capturing 150 out of 483 patients. We are now  
5 capturing, I think, 482. So, the proportion of  
6 pediatric patients that we're capturing with the  
7 measure is much higher.

8 We've also slightly increased the  
9 number of facilities that receive ratings. Most  
10 facilities received an adult hemodialysis rating  
11 already because most facilities have enough, but  
12 there were specialty facilities that focus on  
13 peritoneal dialysis patients, or pediatric  
14 patients, who didn't receive ratings.

15 At this point, I believe, we were  
16 capturing, as with the data we were using for  
17 testing, out of just over 6,000 facilities, we  
18 could provide a rating for 5,965 for the overall  
19 composite measure. The numbers are a little bit  
20 smaller for the two individualized measures. One  
21 of the reasons that we've come forward with those  
22 is because they offer the opportunity of

1 reporting a greater deal of granularity,  
2 particularly for something like public reporting  
3 purposes where it may make sense for a patient to  
4 know if a facility is better or worse at  
5 providing peritoneal dialysis, for instance. That  
6 kind of information may be helpful for them.

7 We wanted to get your feedback as to  
8 whether --- you know, essentially, it's a  
9 tradeoff. You capture a little bit more patients  
10 with the overall measure. You get a little more  
11 granularity in terms of quality performance for  
12 the different types of modality with the two  
13 measures. And that was one of the things that we  
14 wanted feedback from NQF and from the MAP as  
15 we're looking toward implementing these.

16 CHAIR RAPHAEL: Thank you, Joel. That  
17 was helpful. Sean?

18 MEMBER MULDOON: So, on the question of  
19 the lumpers versus the splitters, I would think  
20 that a consumer --- well, check me on this -- a  
21 consumer knows whether they're getting PD or HD.  
22 And unless performance within a given facility



1 has those things basically indistinguishable  
2 because they're either good or bad, I would think  
3 there would be a value of separating them so that  
4 someone could say, "I'm a PD patient, I prefer  
5 this place. Or, "I'm a HD patient, and I prefer  
6 that place."

7 And although none of this stuff helps  
8 for quality improvement because of the time lag,  
9 it will still force the people to solve those two  
10 different problems in presumably two different  
11 ways.

12 CHAIR RAPHAEL: Okay. Do I have a  
13 motion now to move for a vote? But I want to  
14 clarify something, because the way this was  
15 originally provided was to encourage continued  
16 development. Are we now changing it to  
17 conditional support? Is that correct?

18 MS. O'ROURKE: Yes. Could I provide  
19 some procedural clarification?

20 CHAIR RAPHAEL: Yes, okay.

21 MS. O'ROURKE: We had built this  
22 recommendation based on some old information.

1 But based on what Joel said, since the measures  
2 have completed testing and will be submitted to  
3 NQF in the coming month or so, it would be more  
4 appropriate to evaluate them for the fully  
5 developed measure pathway. So we would propose a  
6 conditional support pending NQF endorsement, if  
7 there's a work group member who would support  
8 that motion.

9 CHAIR RAPHAEL: Okay. Do I have someone  
10 who wants to move that motion of conditional  
11 support?

12 MEMBER LEIB: So moved.

13 CHAIR RAPHAEL: Okay. Second?

14 MEMBER STONE: Second.

15 CHAIR RAPHAEL: All right. Can you,  
16 Laura, we're going to do all three together, all  
17 right?

18 MS. IBRAGIMOVA: So, consent calendar,  
19 End Stage Renal Disease Quality Incentive  
20 Program, conditional support for delivered dose  
21 of dialysis above minimum composite score,  
22 delivered dose of hemodialysis above minimum, and

1 delivered dose of peritoneal dialysis above  
2 minimum.

3 So, do you agree with the End Stage  
4 Renal Disease Quality Incentive Program  
5 conditional support calendar? One, yes; two, no.

6 MEMBER DIAMOND: Carol, this is Lou  
7 here. I'm voting for conditional support, which I  
8 think is the one option.

9 CHAIR RAPHAEL: Okay. Thank you, Lou.  
10 And I'm assuming Carol is still on and we'll get  
11 her vote.

12 MS. IBRAGIMOVA: So, the results are 94  
13 percent yes and 6 percent no.

14 CHAIR RAPHAEL: Okay, thank you.

15 All right. So, we are going to go on  
16 now to Medicare Shared Savings Program. And I  
17 believe Rabia Khan from CMS is joining us to  
18 describe this program.

19 MEMBER DIAMOND: So, Carol, this is  
20 Lou here. I've got to check out at around 2  
21 o'clock.

22 CHAIR RAPHAEL: Okay. Thanks, Lou, for

1       letting us know.

2               MEMBER DIAMOND: Yeah.

3               CHAIR RAPHAEL: Rabia, are you on the  
4       line?

5               MS. KHAN: Yes, can you hear me?

6               CHAIR RAPHAEL: Yes, we can hear you.  
7       And we're looking to you to provide a brief  
8       overview of the program and the measures that we  
9       need to be considering.

10              MS. KHAN: Sure, thank you. So, the  
11       Medicare Shared Savings Program was established  
12       under the Affordable Care Act. And essentially  
13       it incentivizes accountable care organizations,  
14       or ACOs, to generate savings and provide high-  
15       quality care for beneficiaries.

16              So, under the Shared Savings Program,  
17       ACOs enter agreements with CMS, voluntarily, and  
18       then they're responsible for coordinating care  
19       and improving quality for their patient  
20       population.

21              We here at CMS assess the ACO  
22       performance annually on quality performance, and

1 then also against financial benchmarks which are  
2 used to determine shared savings.

3 ACOs contain a variety of providers  
4 and a key aspect of our program is that we look  
5 at the broad spectrum of care provided to  
6 beneficiaries. And we encourage ACOs to  
7 coordinate care across the different providers  
8 within their ACO, and also outside of their ACO.

9 Our program currently has 33 measures  
10 across four domains. And measures really range  
11 from being used as pay-for-reporting and then  
12 pay-for-performance depending on how we finalized  
13 each measure in our physician fee schedule  
14 regulation or when an ACO joined the Shared  
15 Savings Program.

16 So, for any ACO in their first year  
17 participating in a Shared Savings Program, all  
18 measures are pay-for-reporting. And as I  
19 mentioned before, that the 33 measures across the  
20 four domains --- the four domains include the  
21 patient caregiver experience, which is largely  
22 made up of CG-CAHPS measures. Care coordination

1 and patient safety. Our third domain is  
2 preventive health, and then at-risk population,  
3 which also focuses on some important clinical  
4 conditions.

5 So, we've recently, just an update,  
6 we've recently completed our first performance  
7 year in the program, and we had participation  
8 from 220 ACOs. And just briefly, I'm not sure if  
9 you have the list in front of you of measures  
10 that we have under consideration, but, as you can  
11 see, and I believe you're only reviewing four --  
12 some of the measures are being reviewed at the  
13 clinician work group and hospital work group  
14 meetings -- but we're largely looking at measures  
15 that are focused on care coordination of patient  
16 care across the different providers.

17 We've received a lot of feedback from  
18 stakeholders, and in particular from MedPAC, that  
19 strongly encourage that we consider more outcome  
20 measures, measures that address a potentially  
21 avoidable admission or readmission. And we agree  
22 with the feedback that we've been receiving thus

1 far, so we feel, in addition to considering  
2 measures to meet these gaps, we also feel it's  
3 important that when we are considering measures  
4 that we're aligning with other existing CMS  
5 quality reporting programs.

6 So, for the measures under  
7 consideration for today's meeting, you'll see  
8 that we have four measures. There's the acute  
9 care hospitalization measure, which looks at the  
10 percentage of home health stays and which  
11 patients were admitted to an acute care hospital  
12 during the 60 days following the start of their  
13 home health stay.

14 Now, we put this measure on this list  
15 primarily because it fills a gap in care  
16 coordination outcome measures that we have.  
17 Although a large proportion of our measures in  
18 our current measure set are focused on  
19 physicians, whether in a group practice or  
20 individual that are participating within an ACO,  
21 and also hospital measures, we are looking to  
22 include more post-acute care measures, and

1 specifically moreso around care coordination  
2 outcomes.

3 We also have on the list, we have the  
4 antipsychotic use and persons with dementia,  
5 which is also a measure we felt addresses a gap  
6 in appropriate use of medications and patient  
7 safety.

8 Now, the other two measures that are  
9 on this list we've actually recently finalized in  
10 the 2015 Physician Fee Schedule rule. So we have  
11 the SNF all-cause 30-day post-discharge  
12 readmission measure, and the documentation of  
13 current medications in the medical record that  
14 were just finalized and wouldn't start being used  
15 until the 2015 reporting period.

16 So, again, I think this just  
17 emphasizes that, you know, we're looking for  
18 measures that address gaps in care coordination.  
19 And I guess what I would like to highlight is  
20 that we like to emphasize to ACOs that, although  
21 they are responsible for coordinating care within  
22 the ACO, we also encourage them to be working



1 with providers outside of their ACO for more  
2 streamlined coordinated care for their patients.  
3 So, I think that's what you would see with the  
4 measures that are on this list and what we're  
5 trying to address by considering them. I'm not  
6 sure who to turn this over to to continue the  
7 discussion, but thank you.

8 CHAIR RAPHAEL: Okay. Erin?

9 MS. O'ROURKE: Thanks, Carol. So, I  
10 wanted to just provide some details about what  
11 our preliminary analysis of these measures were.  
12 We supported all four of these through our  
13 preliminary analysis.

14 The first measure, you'll see, is the  
15 acute care hospitalization measure. As Rabia  
16 mentioned, this is a measure that's currently in  
17 the Home Health Quality Reporting Program, so it  
18 would help promote alignment with that program.  
19 We did not receive any public comments on this  
20 measure, but our staff analysis felt that this  
21 measure meets a critical program objective by  
22 encouraging coordination and shared

1 accountability and by promoting alignment across  
2 programs.

3 This would also address a current gap  
4 in the program of post-acute care outcomes and  
5 would address a PAC/LTC core concept of avoidable  
6 admissions. This measure is in the Affordability,  
7 Care Coordination and Hospice MAP families of  
8 measures.

9 The second measure is documentation of  
10 current medications in the medical record. This  
11 is one of the measures currently finalized in the  
12 MSSP program. We did not receive public comments  
13 on this measure. The preliminary analysis would  
14 be that this measure addresses a critical program  
15 objective. It would encourage coordination and  
16 shared accountability across settings. It would  
17 address the NQF's priority of safety, and this  
18 measure is included in the Dual-Eligible  
19 Beneficiaries family of measures.

20 The next measure is antipsychotic use  
21 in persons with dementia. We did not receive  
22 public comments on this measure. The preliminary

1 analysis was that this measure would address a  
2 PAC/LTC core concept and a critical program  
3 objective. This would also help promote  
4 alignment as this is another measure in the MAP  
5 Dual-Eligible family.

6 Finally, we have the skilled nursing  
7 facility all-cause 30-day post-discharge  
8 readmission measure. We received one public  
9 comment on this measure supporting the measure  
10 pending NQF endorsement. This measure would  
11 address a PAC/LTC core concept and it's a  
12 required measure for the SNF Value-Based  
13 Purchasing Program under the Protecting Access to  
14 Medicare Act of 2014. Use in the MSSP program  
15 would help promote alignment and shared  
16 responsibility across settings. MAP had reviewed  
17 and supported the direction of this measure  
18 concept in its 2012 pre-rulemaking. This is  
19 currently under review for endorsement and was  
20 recently finalized for use in the MSSP program.

21 CHAIR RAPHAEL: Erin, in regard to the  
22 documentation of current meds and antipsychotic

1 use in people with dementia, do these apply to  
2 all post-acute and long-term care sites and  
3 settings?

4 MS. GHAZINOUR: The documentation of  
5 current medication is the same measure that we  
6 just reviewed for the ESRD program and it only  
7 applies to the clinicians.

8 CHAIR RAPHAEL: Only applies ---

9 MS. GHAZINOUR: To the clinician  
10 setting. So, your question --

11 CHAIR RAPHAEL: No, I meant is this  
12 something we're expecting in home health care, in  
13 skilled nursing facilities, in long-term care  
14 hospitals, and inpatient rehab facilities?  
15 That's what I'm trying to ascertain.

16 MS. O'ROURKE: I think, as Mitra said,  
17 it's currently endorsed for the clinician level.  
18 And, Rabia, please correct me, but I believe this  
19 would be primarily addressing clinicians for the  
20 MSSP program? Could you clarify that?

21 MS. KHAN: Yes, so the measure would be  
22 used at the physician encounter.

1 CHAIR RAPHAEL: I don't really  
2 understand how that would be translated. So, can  
3 you explain how that would work in a home care  
4 setting and how that would work in a skilled  
5 nursing facility setting?

6 MS. KHAN: So, the way that we are  
7 using it, this measure actually is used in the  
8 Physician Quality Reporting System, and we're  
9 using it in the same manner as they are for their  
10 program. So it's at each physician encounter.  
11 And I don't think this is applying to home health  
12 or SNF, is it?

13 CHAIR RAPHAEL: Sorry. So, I'm trying  
14 to understand why this work group is considering  
15 these measures, because in a home care setting,  
16 and Peg can jump in here, we're going to  
17 generally have a nurse who is the care manager  
18 who's going to be doing the assessment, the care  
19 planning, the monitoring, doing the medication  
20 reconciliation. And I'm not sure, you know, and  
21 it probably varies by skilled nursing facility in  
22 terms of who would be doing the assessment, and

1 care planning, and medication review. It might  
2 be someone else in an inpatient rehab facility.  
3 So I don't really understand why this work group  
4 is considering these measures. Alan?

5 MEMBER LEVITT: Rabia, was this your  
6 decision or did the NQF divide it this way?

7 MS. KHAN: So, I believe the decision  
8 was to divide some of the measures across the  
9 different work groups that they felt were  
10 applicable. This was a measure considered for  
11 PQRS and as our alignment with that program we  
12 finalized it. I can't speak to why this was  
13 included for this work group to review. I know at  
14 the hospital work group we came across the same  
15 issue as some of the measures are also being  
16 considered for PQRS in alignment with that  
17 program that we moved for clinician work group  
18 review. I'm not sure if --- I mean, I leave it to  
19 NQF and the MAP to decide whether you feel this  
20 measure needs to be reviewed here or at the  
21 clinician work group on Monday.

22 CHAIR RAPHAEL: Helen, what are your

1 thoughts?

2 DR. BURSTIN: Just briefly, we actually  
3 had centralized review of the entire MSSP program  
4 done; actually, I did a good portion of it. It  
5 then got ferreted out to the work groups we  
6 thought might want to add additional input. It'll  
7 still go to the Coordinating Committee, who's  
8 actually the ultimate group for these measures  
9 because it does cross settings. So, some of these  
10 logically because they're about home care and  
11 dementia seemed like they would fit here, was  
12 really the logic of just getting your input  
13 before it goes to the Coordinating Committee.  
14 But, again, it still a measure at the level of an  
15 ACO, not a clinician, not home care, et cetera.

16 MEMBER LEVITT: Yes, if I can make a  
17 comment. I mean, I think the impact, once again  
18 this standardization across settings, we may, you  
19 know, for patients with multiple chronic  
20 conditions, the frail, elderly patient, there  
21 needs to be a place to start really looking at  
22 these types of patients. And perhaps, you know,

1       that's something to think about, is that a  
2       mission that a committee such as our's wants to  
3       take on.

4               CHAIR RAPHAEL: I think that for the  
5       population that we generally take care of, in  
6       either post-acute or long-term care, these are  
7       important areas. You know, the rate of  
8       rehospitalizations, the ability to improve  
9       medication compliance, and the validity of the  
10      medication regimen. The people with dementia are  
11      going to be a very key group in our population,  
12      so this really applies. But what I'm trying to  
13      understand is this is reported at the ACO level,  
14      and then it's up to the ACO to determine how its  
15      component partners kind of capture and report  
16      this data, I assume.

17              MS. KHAN: Yes, we report all the  
18      results at an ACO level to the ACOs.

19              CHAIR RAPHAEL: Okay. Are there other  
20      questions or comments on this? Peg?

21              MEMBER TERRY: It's an interesting  
22      point whether home care really today cares for a



1 lot of dementia patients. In fact, they don't.  
2 It's very interesting. I think it's changing.  
3 It's a different population from what I --- from  
4 the data I've looked at, where it's more in SNFs  
5 and other post-acute settings, but I think it's a  
6 big question in my mind whether home care would  
7 have at this point because of what happens  
8 quickly, their short stays, whatever, in home  
9 care to really address or be able to manage these  
10 kinds of issues with the multiple physician  
11 population they deal with. So, I just --- it's an  
12 interesting way to look at it. I've never thought  
13 about it before, but I think it's certainly a  
14 concern.

15 CHAIR RAPHAEL: Thank you. Sean?

16 MEMBER MULDOON: So, some  
17 clarification. You're an ACO that has two SNFs in  
18 your network, one has everyone on antipsychotics,  
19 another one has none. So, your ACO then receives  
20 a piece of data that says on average your ACO  
21 patients have, you know, that simple example, 50  
22 percent. So, how does that help the --- what

1 additional --- I guess that provides --- is the  
2 idea that the subscriber might want to know that,  
3 but the ACO already does.

4 MS. KHAN: So, this is Rabia. What ---  
5 and I just want to be clear we're still sticking  
6 to documentation of current medications in the  
7 medical record. Correct?

8 MEMBER MULDOON: Fine.

9 MS. KHAN: So, the way this measure is  
10 going to be reported, we provide --- I mean, ACOs  
11 will be submitting data to CMS through our web  
12 interface, and we would identify for them the  
13 encounters in which they would report to us,  
14 whether it's been documented at that visit or at  
15 that encounter, what the current medications are  
16 in the medical record.

17 MEMBER MULDOON: But an ACO does not do  
18 the encounter; the ACO has a network of providers  
19 who do the encounter.

20 MS. KHAN: Right.

21 CHAIR RAPHAEL: Right.

22 MS. KHAN: Yes.

1 CHAIR RAPHAEL: Right. So, it's  
2 incumbent upon the ACO to figure out how it will  
3 collect and aggregate this information and report  
4 on it.

5 MS. KHAN: So, they report it to CMS  
6 via our G-Pro web interface, and they have to go  
7 through consecutive beneficiaries, so we provide  
8 them with a list of --- based on our assignment  
9 sampling approach identifying beneficiaries and  
10 providers that are assigned to the ACO who would  
11 be --- who they would report on over the course  
12 of an eight-week period. So, that's how we would  
13 be collecting the data in the future on that  
14 measure.

15 CHAIR RAPHAEL: Okay. Dianna?

16 MEMBER REELY: I'm curious why the  
17 acute care hospitalization measure would be  
18 different than the acute care hospitalization  
19 measure for Medicare that's currently being  
20 reported, which is a rehospitalization within 30  
21 days of the hospital discharge.

22 The concern from Providence on the

1 West Coast are our home health length of stay is  
2 much shorter than the first 60-day episode. And I  
3 didn't see that the exclusion would be a patient  
4 who was discharged from home health services in  
5 the ACO model before their 60-day episode was up,  
6 so you could have a 21-day length of stay, and  
7 then have the remainder of the time where, you  
8 know, there could be a home health or an ACO  
9 penalty if the patient was rehospitalized.

10 MEMBER LEVITT: Rabia, this is the old  
11 measure. Right, the existing measure?

12 MS. KHAN: This is the existing measure  
13 that's being used.

14 MEMBER LEVITT: Right. Right. So, the  
15 advantage of this measure ---

16 MEMBER REELY: Not the existing  
17 measure.

18 MEMBER LEVITT: The measure that is  
19 still under NQF endorsement is not this measure;  
20 this measure is the existing measure that's on  
21 Home Health Compare already. It's 60-day for the  
22 episode; it's not a readmission measure, it's a

1 hospitalization measure because it includes all  
2 home health patients whether or not they have  
3 recently been discharged from the hospital. They  
4 could have been referred by a physician or a  
5 nurse practitioner into home health care.

6 CHAIR RAPHAEL: Okay. Peg?

7 MEMBER TERRY: So, I have a question  
8 about that. I know this is the old measure that  
9 exists today, and we'll have a new measure in  
10 January for 30 days, but my question is okay, so  
11 these patients --- it's a 60-day measure. You  
12 discharge a patient in 30 days, they're not with  
13 you. Everybody knows about this measure and how  
14 it works, but these are not patients coming from  
15 the hospital. These are not readmissions. It  
16 doesn't totally make sense to me if you're  
17 holding the ACO Shared Savings Account  
18 responsible and you're saying it aligns with the  
19 home care measure, that doesn't quite align with  
20 the home care measure.

21 The 30-day one is patients who are  
22 discharged from the hospital, and that's how they

1 capture that. That is a different measure, the  
2 one that --- the new one in January. The 60-day  
3 is all patients, you're right, and it's through  
4 the whole 60 days, but many of these patients  
5 don't come from the hospital, probably the  
6 majority. So, I'm not sure how the thinking is. I  
7 just don't understand it, and so maybe you could  
8 help me.

9 MS. KHAN: So, with the Shared Saving  
10 Program, we're focused on trying to address more  
11 avoidable admissions, or potentially avoidable  
12 admissions, or even readmissions. I know there's  
13 the other readmission measure that's going  
14 through the endorsement process, but in this  
15 instance we're really focused on preventing a  
16 patient from being hospitalized.

17 I understand that, you know, the  
18 patient is not being discharged from the hospital  
19 and then being readmitted, but in terms of  
20 coordinating care, if we can prevent the patient  
21 from being admitted into the hospital in the  
22 first place, that is sort of our goal with

1 introducing more potentially avoidable admission  
2 measures into our measure set.

3 But as far as the different types of  
4 providers that make up ACOs, it's not solely just  
5 hospitals or individual physicians or group  
6 practices. We also do have post-acute care  
7 facilities, and we are noticing even with the  
8 first performance year -- and this is why we've  
9 introduced the SNF readmission measure -- is that  
10 there is significant savings being generated  
11 around coordination with post-acute care  
12 facilities. So, we want to be sure that, you  
13 know, we're also looking at the quality of care  
14 being provided.

15 So, with this measure, and I cannot  
16 say off the top of my head how many ACOs have a  
17 home health provider as among their participants,  
18 participating providers, but I can say that like  
19 from our analysis with the SNF readmission  
20 measure, we have seen that for 2014 out of the  
21 338 ACOs that we have, we have about 189 SNFs  
22 that are participating within an ACO. So, we are

1       trying to identify measures that we think will  
2       help promote primary care and coordination  
3       amongst the different providers, so that's why  
4       we're considering the existing hospitalization  
5       measure here.

6               CHAIR RAPHAEL: I think that we should  
7       all be aware that in ACOs they're finding that a  
8       certain percentage, a significant percentage, of  
9       course, are attributable to post-acute care, so  
10      this is a very important part of the continuum  
11      for ACOs.

12              Now, I think the issue becomes if you  
13      admit someone from the community who has  
14      congestive heart failure, and then, you know, the  
15      question is if it's pneumonia or UTI, could you  
16      have prevented a hospitalization? But then if  
17      it's a stroke, you know, it's a different  
18      situation, so I think it just really --- there  
19      are some things that are preventable. I'd feel  
20      better if this sort of had a sensitivity kind of  
21      part of it that, you know, preventable  
22      hospitalizations rather than hospitalizations per



1 se. But anyway, Tom?

2 MEMBER VON STERNBERG: I cannot speak  
3 for the 186 ACOs, but I happen to actually  
4 represent two very excited integrated care  
5 systems that are involved in the ACO world. I  
6 will tell you these group of measures are  
7 absolutely in line with what the ACOs expect to  
8 be measured on. They are also absolutely in line  
9 with the expectation of signaling, too, either  
10 with existing in-system partners or contracted  
11 partners around simply paying attention to the  
12 aspect heightening the awareness to home care  
13 nurses about their role in identifying potential  
14 risks of hospitalization period. That language  
15 and that conversation at the home care level,  
16 which I have with my teams now, again, is not  
17 that that home care agency says boy, this  
18 pneumonia couldn't be prevented, and this stroke  
19 could have been. It isn't down to that parsing.

20 The dementia measure of antipsychotics  
21 is an overuse measure, and it's a global overuse  
22 measure. Similar to readmission, the rate should

1 not be zero. Readmission from home care or from  
2 hospitals should not be zero. Antipsychotic use  
3 for patients with dementia does happen, not at  
4 the rate of 25 percent, is not what we expect to  
5 have as normal.

6 So, I think each of this I think  
7 resonates well. I struggle with the 60 versus 30  
8 because I think that's a bit confusing. I'm not  
9 necessarily committed to saying can't go forward  
10 on either, or one versus the other, but they are  
11 all very consistent with what the ACOs signed up  
12 for. And that their learning curve of --- they  
13 didn't know they had to have relationships with  
14 SNFs. Their readmission rates are higher. These  
15 people bought SNFs. Their readmission rates are  
16 lower. So, I don't feel much heartburn about  
17 this.

18 CHAIR RAPHAEL: Okay, that's very good  
19 to hear, Tom. All right. Marc?

20 MEMBER VON STERNBERG: I'm from  
21 Minnesota.

22 MEMBER LEIB: I'm glad that these

1       resonate with you and that may be tempering some  
2       of my comments. The only one I have an issue with  
3       and it's only a minor quibble is the first one,  
4       the admitted to an acute care facility during the  
5       60 days following the start. I'm wondering if  
6       that measure might discourage attempted use of  
7       home health prior to an admission -- this is not  
8       a readmission, so you want to keep someone out of  
9       the hospital, but a certain percentage of those  
10      people are going to get worse no matter what you  
11      do in the home health setting and will end up  
12      hospitalized. But this measure of how many of  
13      them get hospitalized may, in fact, discourage  
14      the use of home health prior to hospitalization  
15      to try to keep someone out. And I'm not sure how  
16      to word it in a way that would temper that.

17               MEMBER VON STERNBERG: I guess I would  
18      only quickly comment that going from the level of  
19      ACO measurement and system design to the point of  
20      care of Dr. X in the office, I will absolutely  
21      tell you that my experience being the doctor in  
22      the office across the room from someone who needs

1 home care or not, I do not think physicians at  
2 the individual patient level are at all capable  
3 of that kind of calculation from their supervisor  
4 doc saying don't order home care, or put them in,  
5 or what have you.

6 I just don't think that point of care  
7 physicians are at that level of ability to  
8 distinguish. In fact, they don't want to be. In  
9 fact, many of these docs are seeing an ACO  
10 patient, and then at 2:30 they're seeing an Aetna  
11 Medicare patient, and then at 4:00 they're seeing  
12 a Medicare Advantage patient from Cigna. So, I  
13 think that's just another part of the process to  
14 be aware of.

15 CHAIR RAPHAEL: Okay. Clarke?

16 MEMBER ROSS: So, I wanted to speak in  
17 favor of the two medication measures, and the  
18 first one. Just to emphasize, the duals work  
19 group is predominantly focused on the consumer  
20 and beneficiary, what is best for them. And the  
21 clinician group is predominantly focused on  
22 physicians and how you practice medicine. And

1       they both conclude that in order to practice  
2       medicine in the best standard, when you prescribe  
3       a medication or change the dose, you should know  
4       what the other medications are. And this is just  
5       one of those little vehicles to get to that basic  
6       point where physicians, and consumers, and  
7       beneficiaries agree, so I would hope the group  
8       could be comfortable with that.

9               And then I wanted to reinforce Tom's  
10       point. It's a lot more complicated point, but we  
11       have an OIG report and a GAO report on the misuse  
12       of antipsychotics particularly in skilled nursing  
13       facilities, and what are we going to do about it?  
14       And this is an effort to try to address a very  
15       glaring and documented problem throughout the  
16       country. So, those two observations from the  
17       duals group.

18              CHAIR RAPHAEL: All right. Sean?

19              MEMBER MULDOON: I'm talking about the  
20       admission rate from home care and the readmission  
21       from SNFs. Check me on this, if you are in an  
22       ACO, you're in the ACO metric denominator. You

1 are not in the fee-for-service denominator.

2 Right?

3 CHAIR RAPHAEL: Let me ask CMS on that.

4 Rabia?

5 MS. KHAN: Yes, you would be a part of  
6 the ACO denominator.

7 MEMBER MULDOON: And not part of the  
8 fee-for-service denominator. That has ---

9 MS. KHAN: No.

10 MEMBER LEVITT: Sean, I'll get back to  
11 you, but I think it's just they're not included,  
12 nor is like Medicare Advantage. I think it's fee-  
13 for-service, but I'll get back to you separately  
14 on it.

15 MEMBER MULDOON: Well, make sure it is,  
16 because that keeps Marc's problem from being a  
17 big problem. Because if you're in an ACO, you're  
18 going to use a home care visit as a way to stave  
19 off a short-term visit, knowing that it's risky  
20 for them. And you don't want to penalize that  
21 home care agency or that SNF from trying to  
22 prevent a short-term admission. So, if they're

1 separate, we're okay on that. If they're  
2 together, then you're going to have a conflict of  
3 interest between what the ACO wants the SNF to  
4 do, and the SNF putting themselves out at risk  
5 because they're taking someone that has a high  
6 probability of being admitted.

7 CHAIR RAPHAEL: Okay. And I know there  
8 are always attribution issues that underlie this  
9 as well, but we won't go there. Dianna?

10 MEMBER REELY: My comment is you can  
11 be, I believe, a home care organization, let's  
12 say, that is in an ACO, and also seeing fee-for-  
13 service or Medicare patients. Right? You've got a  
14 business that you're running, it doesn't matter.  
15 So, my question is with --- going back to the  
16 acute care hospitalization measure here -- I just  
17 want to make sure I understand this. Why would it  
18 not be the same measure that we'll be going  
19 forward with in 2015 for the 30-day readmissions  
20 because, again, we get back to the burden on  
21 organizations to collect and report data two  
22 different ways. We've got 30 days for non-ACO

1 patients, and 60 days for ACO patients, if I'm  
2 interpreting this correctly. So, the question is,  
3 am I?

4 CHAIR RAPHAEL: All right. Alan or  
5 Rabia?

6 MEMBER LEVITT: I just wanted to point  
7 out again the readmission measures are claims-  
8 based measures, so they would not add increased  
9 burden to providers.

10 MEMBER REELY: I don't think that's  
11 true because we said earlier from the provider  
12 standpoint, like with the annual reporting that  
13 we talked about earlier with ESRD I believe it  
14 was, there's still a lot of work that the  
15 providers go through. I can speak for Providence  
16 as an organization because we're collecting the  
17 same data concurrently, not to wait for the  
18 public reporting or the claims-based reporting.  
19 So, the concept that there isn't increased work I  
20 don't think is necessarily --- isn't true from  
21 our perspective as a provider, just to state  
22 that.



1 DR. HITTLE: Excuse me. This is David  
2 Hittle, one of the measure developers for home  
3 health.

4 CHAIR RAPHAEL: Yes?

5 DR. HITTLE: And the claims-based  
6 measure that's described here is the one that's  
7 currently being reported, not the one that's  
8 coming up for --- to be implemented in 2015. This  
9 is a hospitalization measure as opposed to a  
10 rehospitalization measure, and it is based  
11 strictly on the Medicare claims that are  
12 submitted by the home health provider in order to  
13 identify a home health care episode, and then  
14 they match those to hospital claims in order to  
15 determine whether or not there's been a  
16 subsequent ---

17 CHAIR RAPHAEL: All right. Peg?

18 MEMBER TERRY: So, I understand it's a  
19 60-day. I have to bring back another issue that I  
20 discussed before. The claims-based admission or  
21 readmission data in my opinion does not take into  
22 account, and I'm saying this for the record

1 because we had a long conversation about this at  
2 the last meeting. Some of the factors that really  
3 account for patients in home care going back into  
4 the hospital, lives alone, does not have a care  
5 provider, and some of these factors are very  
6 important. And I think particularly for some of  
7 the dually eligible patients they are increased  
8 factors, so I just want to get that on the table  
9 again. I know it hasn't --- I don't believe it's  
10 changed, but I think it's an important thought  
11 when you're looking at ACOs because now it's  
12 taking on a different look, in my opinion, now  
13 that it's going to be part of an ACO concern, or  
14 interest, or measure.

15 CHAIR RAPHAEL: Okay. With that, let me  
16 see, are there any other comments on this? Yes,  
17 Robyn?

18 MEMBER GRANT: First, just real briefly  
19 kind of for the record, as well, I just wanted to  
20 express my continued concern about the SNF  
21 readmission measure being a disincentive to  
22 hospitalization. But I just wanted to speak very

1 strongly in support of the antipsychotic use in  
2 patients with dementia.

3 CHAIR RAPHAEL: Talk a little louder.

4 MEMBER GRANT: Oh, I'm sorry. I just  
5 wanted to speak very strongly in support of the  
6 measure for antipsychotic use in persons with  
7 dementia. As we know, it is a terrible problem in  
8 nursing homes, it's about one in about 20 percent  
9 I think of residents now are still on these  
10 medications, but we can't get at this if we just  
11 look at one setting. It really does need to ---  
12 we need to look at it across settings. And this  
13 is a step, I think, toward doing that so that we  
14 could look at this problem holistically and solve  
15 it that way.

16 CHAIR RAPHAEL: I'd like to ask the  
17 group if anyone wants to pull out any of these  
18 four that are now all having a recommendation of  
19 support? All right. If not, do I have a motion to  
20 support these four recommendations as part of the  
21 Medicare Shared Savings Program? Okay, a second?  
22 All right, Roger.

1                   So now, Laura, we are ready.

2                   MS. IBRAGIMOVA: So, consent calendar  
3 Medicare Shared Savings Program for PCT/LTC  
4 setting support acute care hospitalization risk-  
5 adjusted measure, documentation of current  
6 medications in the medical record measure,  
7 antipsychotic use in persons with dementia  
8 measure, and skilled nursing facility all-cause  
9 30-day post discharge readmission measure. Do you  
10 agree with the Medicare Shared Savings Program  
11 support calendar? One, yes; two, no.

12                  CHAIR RAPHAEL: Lou dropped out so did  
13 we remove him from the base? Okay.

14                  MS. IBRAGIMOVA: So, we have --- the  
15 results are 100 percent yes, and zero percent no.

16                  CHAIR RAPHAEL: Okay, very good. Thank  
17 you. All right. Thank you, Rabia.

18                  So, we are going to go on to our pre-  
19 rulemaking measure on the consideration for home  
20 health quality reporting. And, Erin, are you  
21 going to provide a brief overview of this, the  
22 staff's preliminary analysis? Oh, long-term care

1 hospital, hang on. Oh, all right, hold on. I must  
2 have missed that. Thank you. I did. All right.  
3 Going on to long-term care hospital. And I think,  
4 let's see, Erin, you are going to start. All  
5 right.

6 MS. O'ROURKE: Yes. So, we have one  
7 measure under consideration for the long-term  
8 care hospital quality reporting program. This is  
9 a paper reporting and public reporting program.  
10 For Fiscal Year 2014 and for each year after  
11 LTCHs must submit data on quality measures to CMS  
12 to receive the full payment update. Failure to  
13 report this data will result in a 2 percent  
14 reduction in their annual payment update.

15 The data must be made publicly  
16 available with LTCH providers having an  
17 opportunity to review it prior to its release.  
18 And there's been no date specified to begin  
19 public reporting of this data.

20 The goal of the program is furnishing  
21 extended medical care to individuals with  
22 clinically complex problems such as multiple

1 acute or chronic conditions needing hospital-  
2 level care for relatively extended periods of  
3 greater than 25 days.

4           So, again, we have the one measure  
5 under consideration for this program as VTE  
6 prophylaxis. This is the same measure we  
7 considered earlier for IRFs. The staff had a  
8 preliminary analysis that we conditionally  
9 support this measure pending appropriate  
10 expansion and testing of the measure to address  
11 the LTCH setting. This measure addresses the  
12 NQF's priority of safer care and is relevant to  
13 the priority of LTCHs. Venous thromboembolism has  
14 an annual incidence of approximately 900,000  
15 cases of which 300,000 are fatal. AHRQ has noted  
16 the appropriate use of preventative measures has  
17 a potential for reducing the incidence of VTE and  
18 improving patient safety. Use of this measure  
19 would promote alignment across programs because  
20 it is used in other acute care program settings  
21 such as the IQR program. This measure is not  
22 ready for implementation as it needs further

1 testing for this setting before it could be used  
2 in the program.

3 CHAIR RAPHAEL: So, is the major  
4 condition having to do with testing it in LTCHs?  
5 It's been used in other sites, but it has not  
6 been tested in the long-term care hospitals.

7 MS. O'ROURKE: Yes, this is currently  
8 used in acute care hospitals, so the  
9 recommendation would be to just ensure it could  
10 also be used accurately in LTCHs.

11 CHAIR RAPHAEL: All right. Okay. CMS?

12 MEMBER LEVITT: I just wanted to say  
13 once again --- well, first of all, Charles  
14 Padgett who's lead in LTCHs has also come up to  
15 the table. But we would be looking at this  
16 measure similarly to the IRF measure and see, you  
17 know, if it needed to be respecified, so to  
18 speak, in terms of special population of the LTCH  
19 patients.

20 CHAIR RAPHAEL: Okay. Are there any  
21 questions? Sean?

22 MEMBER MULDOON: Just remind me about

1 the ICU exclusion, is that the ICU at the  
2 referring hospital, or the ICU in the long-term  
3 care hospital?

4 MEMBER LEVITT: Charles can answer.

5 MR. PADGETT: Charles, can you speak a  
6 little louder, please?

7 MR. PADGETT: I believe it's the ICU in  
8 the referring hospital.

9 MEMBER LEVITT: This is the acute  
10 hospital. This is the same measure that we were  
11 talking about earlier. We're taking the hospital  
12 measure and we're going to be, you know, looking  
13 at it and moving it into the LTCH setting. So,  
14 once again, Sean, we'll work to look at the LTCH  
15 setting and see, you know, what the VTE  
16 prophylaxis guidelines and recommendations are,  
17 and adjust specifications, you know, as such.

18 MEMBER MULDOON: Well, I mean,  
19 conceptually this is perfectly fine. The glitch  
20 will be that there will probably be more people  
21 for whom prophylaxis was considered but not  
22 chosen, and that's a chart extract. So, to some



1 degree, you know, we'll be grading our own paper  
2 on that one.

3 CHAIR RAPHAEL: All right. Jennifer?

4 MEMBER THOMAS: Just clarification from  
5 a standpoint of settings. A long-term care  
6 hospital does not infer nursing home. Correct?

7 CHAIR RAPHAEL: Right.

8 MEMBER THOMAS: And since the duration  
9 is longer here, I just want to throw out the idea  
10 of unintended consequences here if we start using  
11 some of the newer oral anticoagulants because of  
12 the issues of persons that miss doses; hospital  
13 stays are about three, four, five days, you're  
14 not going to capture a lot of this, but in this  
15 setting will have a longer stay likely. And  
16 stopping those medications even for a day can  
17 actually cause an embolic event because of pro --  
18 become a pro-coagulant type state, so just throw  
19 that out there for --

20 CHAIR RAPHAEL: Okay. Debra?

21 MEMBER THOMAS: Consideration for  
22 testing.

1                   MEMBER SALIBA: My comment is also  
2                   related to the length of stay and the fact that  
3                   anticoagulation may not be appropriate for every  
4                   person in LTCHs. And it's not clearly defined in  
5                   any guidelines right now what to do with people  
6                   that are sort of between the acute care hospital  
7                   and the long stay, the people that are in that  
8                   little post-acute care window. How much you  
9                   anticoagulate and for how long is very unclear.  
10                  And it's sort of a patient by patient decision to  
11                  look at risk factors, prognosis. It's a much more  
12                  complex decision than it is in the hospital where  
13                  it's pro forma for most people.

14                 CHAIR RAPHAEL: Okay. Pam?

15                 MEMBER ROBERTS: Just two  
16                 clarifications. One, this measure is just that  
17                 you document that you looked at it. It doesn't  
18                 say you have to have given it. Correct?

19                 MR. PADGETT: Yes, that's correct.

20                 MEMBER ROBERTS: And then my other  
21                 question, this would be anybody that's admitted  
22                 to the LTCH regardless if they're in the ICU in

1 the LTCH or wherever. Is that correct?

2 MR. PADGETT: Correct.

3 CHAIR RAPHAEL: Okay.

4 MR. PADGETT: I mean, the measure that  
5 we're looking at, I mean, right here that's being  
6 considered today, is the acute care hospital  
7 measure. And what we're saying is that, you know,  
8 while it's under review today for LTCHs, that CMS  
9 would consider all of these --- take all of these  
10 considerations under advisement and if we need to  
11 respecify the measure to some degree to make it  
12 more appropriate for the LTCH setting, we would  
13 certainly do that.

14 CHAIR RAPHAEL: All right. Any other  
15 comments or questions? If not, I'm going to move  
16 this to accept the recommendation for conditional  
17 support. Do I have a motion to move that? Second?  
18 Okay. Laura?

19 MS. IBRAGIMOVA: Consent calendar long-  
20 term care hospital quality reporting program for  
21 conditional support venous thromboembolism  
22 prophylaxis. Do you agree with the long-term care

1 hospital quality reporting program conditional  
2 support calendar? One, yes; two, no. We're going  
3 to have to vote again.

4 CHAIR RAPHAEL: Okay. All right. We are  
5 going to vote again. Should we do it right now?

6 MS. IBRAGIMOVA: Yes, you can vote.  
7 So, the results are 94 percent yes, and 6 percent  
8 no.

9 CHAIR RAPHAEL: Okay. All right, thank  
10 you. Then we've met the 60 percent requirement.  
11 And now we're going to go on to home health  
12 quality. Erin?

13 MS. O'ROURKE: I apologize, I misspoke  
14 on the LTCH program.

15 CHAIR RAPHAEL: Oh, we do.

16 MS. O'ROURKE: And we've got two  
17 measures under development that we need to do  
18 discuss. Apologies, I was trying to let you all  
19 go a little early.

20 CHAIR RAPHAEL: All right.

21 MS. O'ROURKE: So, we have two measures  
22 under consideration for this program, or these

1 measures are still under development. We gave  
2 them a preliminary analysis that we would  
3 encourage continued development.

4 The first measure is compliance with  
5 ventilator process elements during the LTCH stay.  
6 This measure addresses an important safety  
7 priority for LTCHs. It's estimated that 25  
8 percent of ventilated patients in LTCH acquire  
9 ventilator-associated pneumonia, and there's  
10 evidence for interventions developed to decrease  
11 incidence of ventilator-associated pneumonia and  
12 improve ventilator care. VAP and BAE are  
13 associated with substantial morbidity, mortality,  
14 and excess health care costs, so we would  
15 encourage further development of this measure.

16 We did receive one public comment on  
17 this measure. The commentor was supportive of the  
18 measure pending NQF endorsement. The commentor  
19 noted that currently available modes of invasive  
20 mechanical ventilation encourage patient  
21 spontaneous breathing and promote liberation from  
22 mechanical ventilation contributing to successful

1 spontaneous breathing trials.

2 The next measure is ventilation  
3 weaning liberation rate. This measure addresses  
4 an important safety priority for LTCHs. MedPAC  
5 estimates that 16 percent of LTCH patients use  
6 ventilator services. Weaning is the process of  
7 decreasing the amount of support a patient  
8 receives from the ventilator, and successful  
9 weaning is associated with decreased morbidity,  
10 mortality, and resource use.

11 We received three public comments on  
12 this measure. The comments were mixed on this  
13 measure. Commentors noted that measuring the rate  
14 of weans in a health care facility is good  
15 conceptually; however, this particular measure is  
16 not useful for differentiating among LTCHs  
17 because it is not risk-adjusted. However, the  
18 definition of weaning is fairly strong because it  
19 does not include partial weans. The commentor  
20 noted their concern that this is a self-reported  
21 measure for which the reporting tool has not been  
22 defined.

1 CHAIR RAPHAEL: Okay. Are there  
2 questions or comments on these two measures?  
3 Sean?

4 MEMBER MULDOON: I was on the subgroup  
5 that did all this, so I have fairly intimate  
6 knowledge of it. We went round and round on the  
7 wean rate, which we would generally support with  
8 the recognition that, you know, you're either  
9 going to be precise or accurate. You can't be  
10 both on one of these things, and that's why we  
11 did not choose to do a partial wean. And we did  
12 not allow the hospital to determine, with very  
13 few exceptions, what category of patient was  
14 unweanable. So, you're just going to have to live  
15 with that and we'll either have that discussion  
16 again here, or you'll just have to kind of  
17 believe that we vetted it as well as we could,  
18 and had to call it one way or another, and called  
19 in both of those ways.

20 It will penalize the hospitals who  
21 take the riskiest patients. And it will favorably  
22 impact those who take COPD exacerbations.

1 CHAIR RAPHAEL: All right. Any comments  
2 from CMS on this?

3 MEMBER LEVITT: Charles, did you want  
4 to say anything?

5 MR. PADGETT: Yes, sure. So, as Sean  
6 said, we --- you know, the TEP when we met with  
7 them did go round and round on these measures. I  
8 just wanted to make a few comments regarding the  
9 public comments that were made regarding this.  
10 And one, about the lack of risk adjustment. You  
11 know, this was certainly discussed by the TEP and  
12 it was certainly advisable that we risk-adjust  
13 this measure, but there's very little data out  
14 there right now to inform this particular risk-  
15 adjustment. And the cities that are available are  
16 very small in scope, or look at one or two  
17 hospitals and the data is just simply not  
18 generalizable to the larger LTCH population. So,  
19 that's something we still are struggling with and  
20 looking at, but we understand that it is very  
21 important to this measure, and we will work  
22 towards getting there.



1                   And then, secondly, I believe there  
2                   was a comment regarding how this measure was to  
3                   be reported. And I just wanted to make it known  
4                   that this measure would be collected using the  
5                   LTCH care data set that's currently in existence  
6                   for use in the LTCH setting. And it's currently  
7                   how LTCHs report their quality data, their  
8                   assessment data to CMS.

9                   CHAIR RAPHAEL: All right. Any other  
10                  comments here? If not, this was recommended for  
11                  encourage continued development. Do I have a  
12                  motion to move toward a vote on that? Second? All  
13                  right, Laura?

14                 MS. IBRAGIMOVA: So, consent calendar  
15                 long-term care hospital quality reporting  
16                 program, encourage continued development,  
17                 compliance with ventilator process elements  
18                 during LTCH stay measure, and ventilator weaning  
19                 rate measure. Do you agree with the long-term  
20                 care hospital quality reporting program encourage  
21                 further development calendar? One, yes; two, no.  
22                 And the results are 94 percent yes, and 6 percent

1 no.

2 CHAIR RAPHAEL: Okay. All right. Now,  
3 we're going to go on to home health quality  
4 reporting. And, Erin, you're going to give us  
5 again a brief overview of the program and your  
6 analysis and recommendation.

7 MS. O'ROURKE: Yes. So, the home health  
8 quality reporting program is a pay-for-reporting  
9 program with a public reporting element. Medicare  
10 certified home health agencies are required to  
11 collect and submit the OASIS data set. The OASIS  
12 is a group of data elements that represent core  
13 items of comprehensive assessment for an adult  
14 home care patient and form the basis for  
15 measuring patient outcomes for purpose of  
16 outcome-based quality improvement.

17 Home health agencies meet their  
18 quality data reporting requirements through the  
19 submission of OASIS assessments and home health  
20 CAHPS. Home health agencies that do not submit  
21 data will receive a 2 percentage point reduction  
22 in their annual home health market basket

1 percentage increase. Subsets of the quality  
2 measures generated from OASIS are reported on the  
3 Home Health Compare website which provides  
4 information about the quality of care provided by  
5 home health agencies across the country.

6 The goal of the program is to --- the  
7 CMS had adopted the mission of the Institute of  
8 Medicine, which has defined quality as having the  
9 following properties or domains: effectiveness,  
10 efficiency, equity, patient-centeredness, safety,  
11 and timeliness.

12 So, we have one measure under  
13 consideration for the home health quality  
14 reporting program. A percent of patients with  
15 pressure ulcers that are new or worsened. This  
16 measure had a preliminary analysis of conditional  
17 support, was conditional support pending further  
18 development and NQF endorsement of the measure.  
19 This measure addresses a PCT/LTC core concept,  
20 and will be a required measurement domain under  
21 the IMPACT Act. This measure promotes alignment  
22 as it is harmonized with NQF Number 678, percent

1 of residents or patients with pressure ulcers  
2 that are new or worsened, which is included in  
3 the SNF, LTCH, and IRF settings.

4 We received one public comment on this  
5 measure. The public commentor supported this  
6 measure pending NQF endorsement, and noted that  
7 currently available remote patient monitoring  
8 technologies are equipped with sensors that  
9 detect patient position and movement, and notify  
10 caregivers of the need to reposition the patient  
11 in order to reduce pressure which may contribute  
12 to the development of pressure ulcers.

13 CHAIR RAPHAEL: Does anyone from CMS  
14 want to speak to this? Alan?

15 MEMBER LEVITT: I'll just make a couple  
16 of comments. First of all, the data element that  
17 we are looking for for this measure will start to  
18 be collected. OASIS-C1 begins January 2015, and  
19 so the data elements for this will start then.

20 Second thing interesting about this  
21 measure is including the --- we've included  
22 actually in this measure slough and eschar, which

1 have not previously been included in our other  
2 pressure ulcer measures, so just to note that.

3 CHAIR RAPHAEL: Are there comments or  
4 questions on this? Peg?

5 MEMBER THOMAS: So, I have a comment on  
6 the exclusion criteria for this measure. And I've  
7 spent a lot of my time looking at patients who do  
8 not --- their wounds do not improve, a lot of  
9 data. And we have found one of the reasons that  
10 patients don't get better is that they're dying,  
11 so the patient is transferred to a hospice. That,  
12 to me, would be a very helpful exclusion measure  
13 to put in there; not just death, but that they  
14 are being --- they are moving, they are going to  
15 a hospice, so I think that those patients,  
16 obviously, don't get better.

17 My second question, of course, gets  
18 back to risk adjustment. And this is the kind of  
19 patient that really relies on the support of a  
20 family. Home care and helping wounds get better  
21 or improving wounds, it's critical to have  
22 adequate risk adjustment because it's critical to

1 have family members available, or a caregiver  
2 available. It's not like an institutional  
3 setting, so I just wanted to make that point.

4 I don't know what the criteria are  
5 included in the risk adjustment calculations, but  
6 I think we've really got to include something  
7 along the lines of caregiver availability as a  
8 factor. That's my only other comment.

9 CHAIR RAPHAEL: Okay, thank you. Art?

10 MEMBER STONE: I'm sorry. I just  
11 wanted to mirror what was just said on the risk  
12 assessment, what factors were brought into that?  
13 And there are many things that are coming out of  
14 particularly the acute hospitals that are never-  
15 events on their side, but are major events on the  
16 home health side, and they're not accounted for.  
17 And it could present a huge problem over the  
18 period of time as this begins to develop a little  
19 further.

20 MEMBER LEVITT: Would anyone like to  
21 comment on the phone?

22 DR. NUCCIO: This is Gene Nuccio

1 calling from the University of Colorado. We are  
2 the contractor that developed the measure and do  
3 the risk adjustment on all of the OASIS-based  
4 measures. This measure, as Alan pointed out, is  
5 not yet being collected because the data set is  
6 not available, and it won't be available until  
7 January 1st. However, I can tell you that  
8 historically we have about five percent of our  
9 home health population has pressure ulcers at  
10 stage two or higher, only five percent of our  
11 patients. And approximately two percent of the  
12 patients have stage one pressure ulcers. So this  
13 is not a very large population or group that we  
14 do this measure for. However, I can tell you  
15 that for the other approximately 40 home health  
16 outcomes that are OASIS-based, virtually all of  
17 them make use of patient ---excuse me, caregiver  
18 variables as part of the prediction model used  
19 for risk adjustment.

20 We have several items on the OASIS  
21 data set that get to both if a caregiver is  
22 available and if a caregiver is knowledgeable and

1 willing to participate in the care of the  
2 patient. So, we do quite clearly recognize those  
3 for the other prediction models and would  
4 anticipate that this model, when built, will also  
5 include that variable. It will certainly be  
6 tested as part of about 400 potential risk  
7 factors that are used in the testing and the  
8 development of prediction models.

9 CHAIR RAPHAEL: Okay.

10 MEMBER WINSTEL: This is Lisa Winstel  
11 with the Caregiver Action Network. I'd like to  
12 have a comment.

13 CHAIR RAPHAEL: Sure, go ahead.

14 MEMBER WINSTEL: In that last comment  
15 when you were talking about caregiver variables,  
16 were you referring to the paid home health  
17 caregiver, or were you talking about the family  
18 caregiver being available, knowledgeable, and  
19 willing?

20 DR. NUCCIO: We're talking --- hi, this  
21 is Gene Nuccio, again. We're talking about the  
22 family member primarily, although it could be a



1       paid member. But, in fact, the item, data item  
2       2102 in the OASIS data set specifically excludes  
3       the agency, the home health agency staff from  
4       that.

5               So, for example, we have the types of  
6       assistance broken out into ADL assistance, IADL  
7       assistance, medication administration, medical  
8       procedures and treatment, management of  
9       equipment, supervision and safety, and advocacy  
10      and facilitation. So there are seven dimensions.  
11      And across each of those dimensions, the  
12      caregiver could provide assistance. Currently,  
13      the caregiver could be judged to provide  
14      assistance if training was provided. We do have a  
15      column for the caregiver, not likely or unclear,  
16      and as well as assistance is needed but no  
17      caregiver is available.

18              So, it's a very large grid of 35  
19      particular elements that discriminates what sorts  
20      of care that the patient could be receiving.

21              CHAIR RAPHAEL: Just one --- go ahead,  
22      Lisa.

1                   MEMBER WINSTEL: It sounds like a very  
2 comprehensive grid, and I'm very sorry I'm not  
3 there. I know it's awkward to comment on the  
4 phone, and I apologize. But I maybe missed this,  
5 who is doing the assessment of the caregiver?

6                   DR. NUCCIO: The nurse or the physical  
7 therapist who is completing the OASIS at the time  
8 of admission or, that is, start of care or  
9 resumption of care.

10                  CHAIR RAPHAEL: Is that required that  
11 there be an assessment of the caregiver's  
12 preparedness and capacity to perform the tasks  
13 that are needed?

14                  DR. NUCCIO: That is a data item within  
15 the OASIS instrument, and so it would be  
16 required.

17                  CHAIR RAPHAEL: Go ahead, Lisa, back to  
18 you.

19                  MEMBER WINSTEL: Sorry. But so I  
20 understand correctly, that is not --- at this  
21 moment that is not required. Correct? Caregiver  
22 assessments?

1 DR. NUCCIO: The caregiver item is  
2 currently used on the OASIS-C instrument, and  
3 it's just numbered slightly different because  
4 we've collapsed two categories. We used to have  
5 six functional categories of the caregiver and we  
6 collapsed it to five based on our data analysis  
7 of the current data. So, under the current  
8 instrument, it's Item M2100.

9 CHAIR RAPHAEL: Okay. Sean, you ---oh,  
10 Lisa, do you want to say anything more?

11 MEMBER WINSTEL: I might but I'm okay  
12 right now. Thank you.

13 CHAIR RAPHAEL: Okay. Sean?

14 MEMBER MULDOON: Yeah, I want to do a  
15 concise summary of why I don't like this  
16 measurement at all. It's basically two basic  
17 reasons. It's the first measurement for whom the  
18 behavior we're trying to modify is not that of an  
19 employee. And second of all, it's the first  
20 measurement for whom it does not apply to 19 out  
21 of 20 recipients. And put together, I would  
22 propose that there's a better place to put

1 effort.

2 DR. HITTLE: I actually need to clarify  
3 that. This is David Hittle from the University  
4 of Colorado. The measure itself, the denominator  
5 for the development of a new or worsened pressure  
6 ulcer is not the people who come in with a  
7 pressure ulcer, it is everybody who may or may  
8 not --- who comes into the home care --- who is  
9 treated by the home care agency. And, so, what  
10 we're looking at is whether at the end of the  
11 home health care episode of care, when they're  
12 discharged from home health care back to the  
13 community, whether or not they have developed a  
14 pressure ulcer during that episode of care.

15 MEMBER MULDOON: Okay. So, the 19 out  
16 of 20 doesn't count, but the vast majority of  
17 home health recipients, I would think, are not  
18 bed- or chair-bound. Well, whatever the --- I  
19 think the direction of the comment stands. And  
20 then the one about employee is just the way it  
21 is. I would think we go someplace else.

22 CHAIR RAPHAEL: All right. I'm going to

1 go to Clarke.

2 MEMBER ROSS: I wanted to react to  
3 Sean's comments. Christopher Reeve, you probably  
4 all know from Superman, died of an infected  
5 pressure ulcer. He had a personalized attendant,  
6 he had a loving wife, and in the best of  
7 circumstances, people with paralysis get ulcers  
8 and die. And people live in the community who  
9 are paralyzed, but one of the biggest fears for  
10 my engagement with United Spinal, and the  
11 Christopher & Dana Reeve Foundation, and the  
12 folks who are paralyzed is the fear that this  
13 ulcer, any little red spot on their body, they  
14 instantly fear because it could become an ulcer,  
15 and it could be infected, and they could die like  
16 Christopher Reeve. So this numbers game, I think  
17 we have to look at the consequence of not  
18 detecting an ulcer, not the numbers of who might  
19 have an ulcer. Thank you.

20 CHAIR RAPHAEL: Okay. Alan?

21 MEMBER LEVITT: Sean, I appreciate  
22 your comments. The IMPACT Act, one of the

1 measures in the IMPACT Act is skin integrity and  
2 changes in skin integrity. And this will need to  
3 be looked at within the home health setting by,  
4 if I look at my timeline, January 1st, 2017. So,  
5 statutorily we are asked to do this as well,  
6 irrespective of any other reason.

7 CHAIR RAPHAEL: Okay, Liz?

8 MEMBER PALENA HALL: I just want to  
9 point out there are some health IT standards  
10 around pressure ulcers, and I encourage the  
11 Workgroup to look at those in relation to  
12 whatever transpires out of this.

13 CHAIR RAPHAEL: Robyn?

14 MEMBER GRANT: First of all, I wanted  
15 to support what Clarke said. I think it  
16 shouldn't just be a numbers game, because each  
17 and every one of those pressure ulcers is really  
18 critical when you think about who it's effecting.

19 But I have a question. Under the  
20 exclusions, I'm not sure I'm understanding  
21 correctly. It says, "episodes of care ending with  
22 a transfer to an inpatient setting." So, would

1       that mean that if somebody were at home and  
2       getting home health services, they developed a  
3       severe pressure ulcer, stage four, it was so bad  
4       they had to go to the hospital, that that  
5       wouldn't be counted? I'm concerned I'm missing  
6       something here, because if that ----

7               DR. HITTLE: This is David from the  
8       University of Colorado again. That is actually an  
9       artifact of the data collection method  
10      because when they leave the care of the home  
11      health care agency, with an ordinary discharge,  
12      the clinician comes out and does a discharge  
13      assessment on them. If somebody is unexpectedly  
14      transferred to an inpatient facility --- well, if  
15      they end up going to an inpatient facility, the  
16      home healthcare clinician does not have the  
17      opportunity to go out there to assess their  
18      clinical status. And, therefore, we simply don't  
19      have the data because they weren't able to make a  
20      visit out there for the assessment and collect  
21      the OASIS assessment data.

22               And that's a shortcoming with just

1 about all of the OASIS-based outcomes, but  
2 unfortunately it's just a part of the nature of  
3 the data collection process.

4 CHAIR RAPHAEL: Okay. Art?

5 MEMBER STONE: Again, I just want to  
6 make sure that in the assessment -- and I realize  
7 we're using the OASIS assessment process -- but  
8 that varies in somewhat -- and I'm not sure we're  
9 collecting the same thing of apples to apples and  
10 oranges to oranges to make sure that we are  
11 collecting the appropriate data. And I strongly  
12 recommend there is something added to that for  
13 palliative care and people in their end stages of  
14 living, because that can skew the whole thing  
15 completely in where we are and what we're trying  
16 to prove, because those ulcers are not going to  
17 heal.

18 DR. HITTLE: We are able to --- there  
19 is an item, at the time of discharge, there is a  
20 question as to their discharge destination, and  
21 admission to hospice is one of those criteria,  
22 because they can't really be getting the home



1 health benefit and the hospice benefit at the  
2 same time. So, they end up being discharged from  
3 the home healthcare, sometimes to the same  
4 provider because a lot of home care agencies are  
5 also hospices. But it's a different provider  
6 number because it's a hospice.

7 So, at any rate, when they're  
8 discharged we do have the information that  
9 they've been discharged to hospice, and it would  
10 be possible, therefore, to have the exclusion  
11 that I believe Dr. Terry mentioned.

12 CHAIR RAPHAEL: Bruce?

13 MEMBER LEFF: Yeah, I just want to  
14 pick up Art's banner. You know, there are a  
15 number of folks who are in home-based primary  
16 care types of programs who never make it to  
17 hospice because they don't want to change  
18 providers, who are quite disabled and you're in a  
19 situation where you're choosing between treating  
20 or relieving pressure and actually causing pain  
21 and discomfort by doing so. So sometimes those  
22 are in conflict, and patient preferences need to

1 guide. So, you know, the notion of trying to  
2 find some sort of exclusion for people who are at  
3 that stage, I think is important.

4 CHAIR RAPHAEL: All right. Peg?

5 MEMBER THOMAS: So, it would be great  
6 to be able to capture that data, truly. Just two  
7 points. Of course, diabetes is an issue for  
8 these patients, and I'm sure it'll be part of the  
9 risk adjustment. But the other thing I just want  
10 to mention to the person on the call, Lisa, that  
11 the new proposed COP does have a lot of  
12 requirements that the home health agency work and  
13 train, and that there's evidence that you're  
14 training caregivers to care for patients;  
15 although, it is not there today in that explicit  
16 state. And that's still under review; just  
17 wanted to mention that.

18 CHAIR RAPHAEL: Okay.

19 MEMBER WINSTEL: Thank you. That's  
20 actually I think what I was getting to. And while  
21 I'm speaking, I do have a question. I want to  
22 pose a scenario to make sure I'm understanding

1 this proposed rule correctly.

2 If we have a family caregiver caring  
3 for a loved one and then home health comes into  
4 the home, the family caregiver is there 24/7, the  
5 home health aide is not. Pressure ulcers develop  
6 and worsen. Does this that we are considering  
7 then in some perverse way encourage home health  
8 to, for want of a better word, blame the family  
9 caregiver for that pressure ulcer, since the  
10 family caregiver is the one who is there around  
11 the clock? And how would we capture that? I'm  
12 just worried about an unintended consequence.

13 CHAIR RAPHAEL: Does anyone on the  
14 phone want to respond to that?

15 DR. HITTLE: This is David Hittle from  
16 the University of Colorado again. I'm not sure  
17 that the measure --- I mean, the measure simply  
18 says whether or not --- you know, simply  
19 indicates whether or not a new or worsened  
20 pressure ulcer had developed. There isn't any  
21 assignment of responsibility or way that we could  
22 --- in terms of whether that came from the

1 caregiver's limitations or from the home health  
2 agency's limitations.

3           There is, certainly, the fact that we  
4 do collect the information on the caregiver's  
5 involvement in care and what their availability  
6 is. But I don't think that really is an  
7 assignment of responsibility for the outcome one  
8 way or the other. Obviously, if they have less  
9 caregiver availability that's probably an  
10 indicator that they're more at risk of having  
11 some decline in their health status, but there  
12 really isn't any assignment of blame or  
13 responsibility there.

14           CHAIR RAPHAEL: All right. Any other  
15 questions or comments?

16           MEMBER LEVITT: Gene, are you talking  
17 about Item M2110 in the new OASIS?

18           DR. NUCCIO: Yes.

19           MEMBER LEVITT: Okay.

20           DR. NUCCIO: And that was ---

21           MEMBER LEVITT: Mitra, I did send the  
22 OASIS to you, if anyone wanted to see it. Oh,

1       you sent it out, so it's on page 22. If everyone  
2       looks at page 22 on the top, they can see the  
3       item that is being referred to.

4               CHAIR RAPHAEL: All right. Are there  
5       any other comments or questions on this? All  
6       right. What is recommended is conditional  
7       support, so do I have a motion to move to a vote  
8       on that? All right. Second?

9               Okay. Any more discussion? All right.  
10       If not, Laura?

11               MS. IBRAGIMOVA: Consent calendar, Home  
12       Health Quality Reporting Program for conditional  
13       support, percent of patients with pressure ulcers  
14       that are new or worsened. Do you agree with the  
15       Home Health Quality Reporting Program conditional  
16       support calendar? One, yes; two, no.

17               We're going to have to vote again.  
18       Sorry.

19               CHAIR RAPHAEL: Okay. And do we have  
20       Lisa's vote?

21               MS. IBRAGIMOVA: Yes.

22               CHAIR RAPHAEL: Okay. And is Carol

1 still on? Okay, good.

2 MS. IBRAGIMOVA: And the results are 72  
3 percent yes, and 28 percent no.

4 CHAIR RAPHAEL: All right, thank you.

5 All right. So, now the last thing  
6 we're going to consider today is the Hospice  
7 Quality Reporting Program, where I believe we do  
8 not have any measures that are under  
9 consideration. I think what we wanted to hear  
10 from the Workgroup are, based on where we are  
11 today, what additional priority measurement areas  
12 do we recommend and what could we import from  
13 PAC/long-term care programs into the hospice QRP  
14 and vice versa?

15 But is there a way of kind of giving  
16 us a rundown of where we are in hospice, so that  
17 we all have a common understanding?

18 MS. O'ROURKE: Sure. So, Alan, please  
19 jump in if I get anything wrong. So, right now  
20 the Hospice QRP, which is used to collect data to  
21 calculate six NQF-endorsed measures, and one  
22 modified NQF measure. They're Number 1617,

1 patients treated with an opioid who are given a  
2 bowel regimen. NQF Number 1634, pain screening;  
3 NQF Number 1637, pain assessment; NQF 1638,  
4 dyspnea treatment; NQF 1639, dyspnea screening;  
5 and NQF 1641, treatment preferences. And a  
6 modified version of NQF 1647, beliefs or values  
7 addressed if desired by the patient.

8 MAP has made some previous  
9 recommendations around this program, including  
10 that the program should include measures  
11 addressing concepts such as goal attainment,  
12 patient engagement, care coordination,  
13 depression, the role of the caregiver, and a  
14 timely referral to hospice.

15 Some future directions of the program  
16 that MAP had noted that we would like to see were  
17 to develop an outcome measure addressing pain and  
18 selecting measures that address care  
19 coordination, communication,  
20 timeliness/responsiveness of care, and access to  
21 the healthcare team on a 24-hour basis.

22 CHAIR RAPHAEL: Okay. Carol, do you

1 want to say anything on this?

2 MEMBER SPENCE: Yeah. Are we limited  
3 just to the Hospice Quality Reporting Program?  
4 Because the fact that there is going to be,  
5 starting in January, a experience of care measure  
6 survey -- and I think there's eight measures that  
7 are going to be calculated from the results of  
8 that survey -- round out the picture a good deal.

9 But if our focus is just on the  
10 reporting program, which right now is the hospice  
11 item set, we can do that, too. I just think  
12 people need to know that information from that  
13 survey is also going to be part of what hospices  
14 are required to do related to quality  
15 measurement.

16 CHAIR RAPHAEL: Carol, could you just  
17 clarify that survey?

18 MEMBER SPENCE: Well, it's going to be  
19 part of the CAHPS family of surveys, so it's  
20 going to go --- but what makes it unique, because  
21 it's hospice, it's going to be sent out to family  
22 caregivers. So it's not a patient survey, it's a



1 bereaved family caregiver survey.

2 And for those --- anybody --- I don't  
3 know who's around the table -- is at all familiar  
4 --- Peg, you might be -- with the family  
5 evaluation of care survey that NHPCO has had out  
6 there for over 10 years, there's a lot of  
7 similarities. But it goes to the caregiver and  
8 it asks questions both about the care that the  
9 patient received and some of the care that the  
10 family caregiver received. Keep in mind that the  
11 unit of care for hospice is the patient and the  
12 family, so it does address some of the family  
13 care, as well as patient care.

14 CHAIR RAPHAEL: Okay. All right. So,  
15 let me see if there are other comments. Alan?

16 MEMBER LEVITT: Yeah. Originally, this  
17 actually was not on the agenda because there was  
18 no measure, and I had actually asked to put this  
19 on because we actually do very much value your  
20 opinion. There's a new lead in our program,  
21 Michelle Brazil, who's sitting back there who's  
22 very engaged and really wants to hear from the

1 post-acute care community and the hospice  
2 community as to what we can do with this program.  
3 So that's why we're here.

4 CHAIR RAPHAEL: So, just sort of  
5 stepping back and recalling our conversations, I  
6 mean, we were very much focused on pain  
7 management and the outcomes since managing pain  
8 is such a critical element in high-quality  
9 hospice care and just continued focus on  
10 alleviating suffering.

11 And then we also were very focused on  
12 what we called access and responsiveness, and  
13 just sort of the continued issues around how late  
14 people often come to hospice, and whether or not  
15 there's anything we can do to give people the  
16 choice and the opportunity at an earlier point to  
17 participate in hospice no matter what decision  
18 they make. Because I think all of us who work in  
19 this field know that we still haven't moved the  
20 needle on when people tend to come into the  
21 hospice program, if you look at the mean and the  
22 medians.

1                   And then the last thing was just this  
2 really important element of service of having  
3 members of the team be available around the  
4 clock, because I think we all know that, you  
5 know, the terrors and the problems tend to come  
6 in the middle of the night and that this is one  
7 service where having access to the team quickly  
8 in the middle of the night or on the weekends is  
9 so terribly important.

10                   So, those just come from our practice  
11 experience in terms of directions that we thought  
12 we needed to move. But I am very open to kind of  
13 new members of our Workgroup or others who want  
14 to add anything to the kind of areas that we  
15 really felt were remaining gaps.

16                   MEMBER WINSTEL: This is Lisa Winstel  
17 at Caregiver Action Network, and I applaud your  
18 prioritization, especially around access and  
19 responsiveness. I think that having lack of  
20 access, or lack of response, is one of the  
21 greatest causes of stress to family caregivers at  
22 those times. And I would also like to add maybe

1 access and responsiveness not just during the  
2 course of hospice, but at intake, as well.

3 CHAIR RAPHAEL: Okay. And we now have  
4 up on the board -- I don't know how many of you  
5 can see it easily -- but sort of looking at our  
6 core concepts and looking at nursing homes, home  
7 health, long-term care hospitals, the inpatient  
8 rehab facilities, ESRD, and hospice, how are we  
9 doing in regard to our core concepts?

10 And interestingly enough, home health  
11 has the highest number. I think nursing homes  
12 are probably second. And the smallest number is  
13 in the hospice column. So, there is experience  
14 of care, and there is establishment of patient  
15 family caregiver goals. There isn't anything on  
16 mental health, interestingly enough, nor shared  
17 decisionmaking, which is hard to understand.

18 So, I think we still, even in terms of  
19 our core concepts, have some room to strengthen  
20 the hospice QRP.

21 All right. Any other comments?

22 Anything that you would like to say as

1       our CMS new lead here?

2                   MS. BRAZIL: Can everybody hear me?

3       We did take into consideration all of the  
4       stakeholder priorities, particularly with our  
5       technical evaluation panel that we had in the  
6       summer right before I came on board, but also the  
7       NQF and MAP high priority consideration areas.  
8       Even the media we're taking into consideration.  
9       As many of you know, the Washington Post articles  
10      and the IOM report on "Dying in America."

11                   So, our top priorities right now that  
12      we're currently researching is the pain outcome  
13      measure as our number one, but also those areas  
14      on the access, responsiveness, and timeliness of  
15      care specifically measures the timeliness and  
16      responsiveness to care and access to a health  
17      care team on a 24-hour basis with a goal of  
18      providing timely and appropriate intervention.  
19      Because as you just mentioned, after-hours care  
20      is very critical.

21                   We're also looking at possibly a  
22      composite measure, and we're not quite sure just

1 yet, but on communication, access to care and  
2 care coordination, and looking at the access and  
3 availability of services, communication as it  
4 relates to caregiver, patient education and  
5 support, even avoiding unwanted treatments,  
6 unnecessary hospital and ED admissions, and  
7 implementing patient, family, and caregiver  
8 goals.

9           The care coordination piece might be  
10 a little bit more difficult because you're  
11 talking about a measure that would cross multiple  
12 settings, but we are currently doing our research  
13 on that, as well, to see what would be feasible  
14 for the program.

15           CHAIR RAPHAEL: You know, I think the  
16 ED one is particularly challenging, and others  
17 can certainly weigh in. But, you know, you work  
18 very, very closely with the family to tell them  
19 do not panic, if anything happens, call someone  
20 from the hospice team. And then you still find  
21 that when something happens, you know, bleeding,  
22 the family panics, calls 911, the ambulance

1 comes, the person ends up in the ED, the ED  
2 doesn't know that the person is in hospice or has  
3 really had an advanced directive with certain  
4 instructions and starts the aggressive sort of  
5 therapies all over again. So, I find that a  
6 particularly challenging area of practice.

7 That being said, you are focusing on  
8 the areas that matter to us. Michelle, would it  
9 be possible to get out to our work group the IOM  
10 report? I think they would find that very  
11 helpful and informative. I don't think we have  
12 seen that as a work group.

13 MS. BRAZIL: Okay. I'd be happy to  
14 send it to everybody.

15 CHAIR RAPHAEL: Okay, great. All right.  
16 Any other thoughts on this area? If not, I'm  
17 going to ---

18 MEMBER SPENCE: Carol, this is Carol.  
19 I'm just going to just beat the very same drum  
20 that I continually do I think at each meeting.  
21 And, you know, CMS is making a huge step by  
22 including that --- having that survey, that post-

1 death survey. But that survey, you know, you're  
2 still dependent on a response rate for a survey.  
3 And while I think it is a great measure, or data  
4 source for measures, and certainly, you know,  
5 we've supported exactly that thing for many, many  
6 years, I think family needs to be included in  
7 some of the process and chart-based measures  
8 also.

9           So, I'm not saying it's --- it's not  
10 really an addition to the things that Michelle  
11 has said and the priorities that this group has  
12 talked about. It's just that that family piece  
13 needs to be included as we're talking about  
14 measure development in the specific measures,  
15 just to keep in mind patient and family are the  
16 unit of care for hospice.

17           It's a tough concept because we're the  
18 only ones that have it stated. It should be,  
19 they should be included, of course, across other  
20 providers, but it is a stated unit of care for  
21 hospice, and so that we're held responsible,  
22 should be held responsible for inclusion of



1 family. And I think sometimes the specific focus  
2 on family, while it's always in the background,  
3 it can be something that slips aside, so I really  
4 would like to see it highlighted with quality  
5 measures.

6 CHAIR RAPHAEL: Thank you, Carol. I'm  
7 going to now turn to public comment and see,  
8 Cathy, our operator, if we have anyone from the  
9 public that wants to make a comment?

10 OPERATOR: Okay. At this time to make  
11 a public comment, please press \*1.

12 There are no public comments at this  
13 time.

14 CHAIR RAPHAEL: Okay. Then we are going  
15 to have a summary of the day, of what we have  
16 accomplished today. Mitra, do you want to run  
17 that down for us?

18 MS. GHAZINOUR: Sure. So, we have put  
19 up this table that should be familiar to most of  
20 you. This is called PAC/LTC Core Concepts By  
21 Programs. And so it demonstrates the core  
22 concepts that have been addressed in the PAC/LTC

1 programs. So far as of to-date, today we added  
2 the avoidable admissions core concept that the  
3 measure for the skilled nursing facility value-  
4 based purchasing to this table. However, there  
5 are still gaps, other core concepts that have not  
6 currently being addressed across programs, such  
7 as advanced care planning and treatment, adverse  
8 drug events, establishment of patient, family,  
9 caregiver goals, experience of care,  
10 inappropriate medicine use, shared decisionmaking  
11 and transition planning, they remain as gaps.

12 These are high priority measurement  
13 areas across all PAC/LTC programs. Currently we  
14 don't have any measures to address these core  
15 concepts.

16 I just wanted to show that this is our  
17 progress, and we still have a way to go. Just  
18 wanted to get your thoughts.

19 CHAIR RAPHAEL: Okay. And in terms of  
20 what we did today, can you just give us a  
21 rundown? We know that on ESRD we're coming in  
22 with no recommendation. In all the other cases

1 we are coming in with a recommendation from MAP.  
2 Is that correct?

3 MS. GHAZINOUR: Yes. For ESRD, I  
4 think we supported conditionally the three  
5 measures that we initially thought that they were  
6 under development. So, we have a recommendation  
7 for those measures. However, we don't have a  
8 recommendation for the first four measures that  
9 we are asking the Coordinating Committee to  
10 review. For the other programs, we have  
11 recommendations.

12 CHAIR RAPHAEL: Okay. So, before we  
13 all depart, which should be fairly soon, Erin, I  
14 don't know if you wanted to just give us a couple  
15 of minutes on something that is really, really  
16 important. There was a big program, I think, on  
17 all the news channels this morning about a study  
18 in the UK actually on antibiotic overuse. And I  
19 think we have an action team. So, if you could  
20 just give us a couple of minutes before we  
21 conclude?

22 MS. O'ROURKE: Thank you very much,

1 Carol. So, I wanted to bring up an issue, as  
2 Carol mentioned, that's been in the news lately  
3 and was a focus area at the recent MAP Hospital  
4 Workgroup meeting, that as we're putting  
5 increased attention on infection rates, there's a  
6 potential unintended consequence of a lack of  
7 antibiotic stewardship, if you will, and a  
8 continuing problem that we could see more sewer  
9 bugs developing. So we wanted to highlight the  
10 work of the NQF Antibiotic Stewardship Action  
11 Team that's working to promote the stewardship in  
12 this area, sorry. And we're fortunate enough to  
13 be joined by Wendy Prins, who is leading this  
14 work.

15 MS. PRINS: Well, I've also been here  
16 all day because I immensely enjoy the topic of  
17 long-term care and post-acute care. But thank  
18 you, Erin and Carol, for bringing this up.

19 I just wanted to raise this as we've  
20 been doing a lot of work and thinking about the  
21 hospital setting and ambulatory care around the  
22 issue of antibiotic stewardship. And we had a

1 meeting in November to bring together a small  
2 group of stakeholders, NQF members to start to  
3 focus on this area.

4 And I think we'd be interested in  
5 maybe if you have any comments or want to talk  
6 with me separately afterwards if you have any  
7 thoughts about how this might be addressed in the  
8 post-acute or long-term care setting  
9 particularly. As we know, a lot of people get  
10 discharged from the hospital on antibiotics and  
11 are there processes in place or programs, or  
12 stewardship programs in the post-acute setting  
13 that we should know about, learn about, and try  
14 to integrate into this work? Because we recognize  
15 that it's certainly something that is not just  
16 isolated in the hospital setting or with  
17 physicians. There are a lot of others who could  
18 play a role, so --- oh, Bruce. Yes?

19 MEMBER LEFF: Thanks, Wendy. So, I  
20 could tell you I have colleagues at Hopkins who  
21 have developed antibiotic stewardship programs  
22 both for hospital and for nursing home settings.

1 So if you'd like me to help you make contact,  
2 feel free to drop me an email. I'd be happy to do  
3 that.

4 MS. PRINS: Yeah. I would love to,  
5 thank you.

6 CHAIR RAPHAEL: Tom?

7 MEMBER VON STERNBERG: The Medicare  
8 QIO in Minnesota, Stratis Health, is right now in  
9 the early phases of a statewide collaborative  
10 with nursing homes to reduce antibiotic use. I  
11 mean, if you need contacts, I can get them to  
12 you, but it's been about a year so far they've  
13 been working on it.

14 MS. PRINS: Okay. And I know this is  
15 something that's sort of in some of the scope,  
16 the new scope of work for the QIOs. Right?

17 CHAIR RAPHAEL: Yeah. Okay. Bruce, go  
18 ahead.

19 MEMBER LEFF: Yeah, I would just say,  
20 you know, another thing to think about with  
21 something like that is, you know, we tend to  
22 think about our traditional approaches, but for

1 something of that sort, I think thinking about  
2 large supply chain types of situations; so, for  
3 instance, the Premier Hospitals, which there are  
4 about 2,000 Premier Hospitals, they --- it's  
5 quality improvement, and they have the supply  
6 chain. So those kinds of organizations are in a  
7 position to really influence how things like  
8 antibiotics get moved out into the world.

9 CHAIR RAPHAEL: Good point. Good point.  
10 All right. Thank you, Wendy.

11 MS. PRINS: Thank you.

12 CHAIR RAPHAEL: And my thanks to all  
13 of you, I mean, for really a very productive  
14 session. And I just think that we have a group  
15 that brings a lot of complementary skills and  
16 experience to our deliberations. So, thank you  
17 so much. And safe travels to everyone, and a  
18 good holiday.

19 (Whereupon, the above-entitled matter  
20 went off the record at 3:10 p.m.)  
21  
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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/Long-Term Care

Before: NQF

Date: 12-12-14

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.

  
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