NATIONAL QUALITY FORUM

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

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MONDAY
DECEMBER 14, 2015

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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 and Debra Saliba, Co-Chairs, presiding.

PRESENT:

CAROL RAPHAEL, MPA, Co-Chair
DEBRA SALIBA, MD, MPH, Co-Chair
JOSEPH AGOSTINI, MD, Aetna
ROBYN GRANT, MSW, The National Consumer Voice for Quality Long-Term Care
E. LIZA GREENBERG, RN, MPH, Visiting Nurses Association of America
ROGER HERR, PT, MPA, American Physical Therapy Association
BRUCE LEFF, MD, Johns Hopkins University School of Medicine
JAMES LETT II, MD, National Transitions of Care Coalition
CARI LEVY, MD, PhD, AMDA -- The Society for Post-Acute and Long-Term Care Medicine
SANDY MARKWOOD, MA, National Association of Area Agencies on Aging
SEAN MULDOON, MD, Kindred Healthcare
PAMELA ROBERTS, PhD, American Occupational Therapy Association

SUZANNE SNYDER KAUSERUD, PT, American Medical Rehabilitation Providers Association
CAROL SPENCE, PhD, National Hospice and Palliative Care Organization*

ARTHUR STONE, MD, National Pressure Ulcer Advisory Panel
JENNIFER THOMAS, PharmD, American Society of Consultant Pharmacists
LISA WINSTEL, Caregiver Action Network

SUBJECT MATTER EXPERTS (Voting):

KIM ELLIOTT, PhD
GERRI LAMB, PhD
PAUL MULHAUSEN, MD
EUGENE NUCCIO, PhD

FEDERAL GOVERNMENT LIAISONS (Non-voting):

ALAN LEVITT, MD, Centers for Medicare and Medicaid Services (CMS)
ELIZABETH PALENA HALL, MBA, RN, Office of the National Coordinator for Health Information Technology (ONC)

MAP DUAL ELIGIBILITIES WORKGROUP LIAISON:

CLARKE ROSS, DPA

NQF STAFF:

CHRISTINE CASSEL, MD, President and CEO
ANN HAMMERSMITH, JD, General Counsel
LAURA IBRAGIMOVA, Project Analyst
ERIN O'ROURKE, Senior Project Manager
KATIE STREETER, Senior Project Manager
MARGARET TERRY, PhD, RN, Senior Director
SARAH SAMPSEL, NQF Consultant

ALSO PRESENT:

JOEL ANDRESS, PhD, Centers for Medicare and Medicaid Services (CMS)
ANDREW BAIRD, HealthSouth
NICOLE FEDELI-TURIANO, University of Pittsburgh Medical Center
DAVID GIFFORD, MD, MPH, American Health Care Association
HOLLY HARMON, American Health Care Association
TROY HILLMAN, Uniform Data System for Medical Rehabilitation
JAMES MULLER, American Health Care Association
ALYSSA KEEFE, California Hospital Association
LANE KOENIG, PhD, National Association of Long-Term Care Hospitals
TERESA LEE, MPH, JD, Alliance for Home Health Quality and Innovation
TARA McMULLEN, MD, PhD, Centers for Medicare and Medicaid Services (CMS)
D.E.B. POTTER, MS, Office of the Assistant Secretary for Planning and Evaluation (ASPE)

*** present by teleconference**

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

(9:08 a.m.)

CO-CHAIR RAPHAEL: Good morning, everyone. Deb and I want to welcome everyone to this meeting of our --- what we belovedly call our MAP PAC Long-Term Care Workgroup and I want to just make sure that I know who is on the phone as we begin here.

So, do we have a roster of who's on the phone? All right. Okay. Great. So, we are going to have a day-and-a-half meeting to accomplish a number of things, to review and provide our input on the measures that are under consideration this round for federal programs that are applicable to our area of post-acute and long-term care.

I believe there are 31 measures. So, we have quite a few. A number of them are tied to the IMPACT Act. A number of them are tied to our QRPs. And there are several tied to the nursing home value-based purchasing that is around the bend here.

And in addition to reviewing and providing input on those measures, we hope to spend some time just stepping back and looking at the high priority gaps that remain in our area.

And then lastly, there are quite a few people on this committee who have been with us from the early stages and we spent a good deal of time trying to come up with a core measure set that was parsimonious and, we thought, consequential, but it's been a number of years. And so, we think that this is a time to just step back and take a look at that core measure set and evaluate what we have done and whether any changes are needed.

So, with that, I want to be sure that we introduce six new members of our workgroup starting with --- and I'm just going to ask each person to introduce himself or herself. Kim Elliott.

MEMBER ELLIOTT: Hi. I'm Kim Elliott. I'm with the Medicaid program in Arizona.

CO-CHAIR RAPHAEL: Okay. Liza

Greenberg.

MEMBER GREENBERG: Good morning. I'm Liza Greenberg representing the Visiting Nurse Associations of America.

CO-CHAIR RAPHAEL: Welcome. Cari Levy.

MEMBER LEVY: Okay. I'm representing AMDA, the Society for Post-Acute and Long-Term Care Medicine.

CO-CHAIR RAPHAEL: Welcome. Sandra Markwood. I don't see --- she will be late. Okay. Thank you. Paul Mulhausen.

MEMBER MULHAUSEN: Good morning. I'm Paul Mulhausen. I am a subject matter expert. And I'm a geriatrician and I work with a quality improvement organization called Telligen.

CO-CHAIR RAPHAEL: Thank you. Eugene Nuccio.

MEMBER NUCCIO: Good morning. I'm Gene Nuccio, University of Colorado, subject matter expert in home health.

CO-CHAIR RAPHAEL: And I also want to

welcome Clarke Ross. Clarke, you are our liaison, I believe, to the Duals Workgroup, but why don't you introduce yourself as well.

MR. ROSS: Thank you. Clarke Ross. I work for the American Association on Health and Disability, but I represent the Consortium for Citizens with Disabilities, which is a 42-year-old national coalition of public policy, 113 national disability organizations and counting. Happy to be here.

CO-CHAIR RAPHAEL: Thank you. And now, it's my pleasure to introduce Chris Cassel, who is the president and CEO of the National Quality Forum. And Chris is someone I know from many, many years now and a real leader in trying to reshape our healthcare system. So, Chris, take it away.

DR. CASSEL: Well, thank you, Carol. And this is an opportunity for me to thank Deb and Carol for their leadership of this important process. And to thank all of you for the contribution that you have made and will make to

our nation and to setting these important quality standards for our most vulnerable patients, really, and on behalf of their families.

So, as a geriatrician, I have a personal interest in the work of this particular part of the MAP process. And I always like to remind people that the decisions that are made here and the quality standards for this aspect of our healthcare system actually affect many, many more people than the acute care system. And people actually don't often understand that just in terms of the numbers.

So, this is important work. It has increasing attention because of the IMPACT Act, because of the increasing acceleration that the Secretary announced last January about moving more quickly in every aspect of Medicare and of federally-funded healthcare in general and the direction of value-based purchasing. And, therefore, we have to know how to define value if we're going to purchase according to value.

And as all of you know, the quality

measures that are part of --- and safety measures that are a part of these various systems are key to that. So, I also want to, just in terms of this process, thank our staff, all of whom have worked tirelessly on this.

Some people refer to this time of year as the holiday season. At NQF, we refer to it as MAP season, because inevitably the measures under consideration list comes the day before Thanksgiving, happened again this year, and our staff work within this holiday period with the deadlines that are very important, legislatively mandated and rulemaking deadlines so that this process can happen over this holiday period.

So, particularly to all of you, thank you for the professionalism that's involved in sometimes long hours.

That said, we've gotten much better at making that process more efficient. So the hours aren't quite as long as they used to be and particularly with some of our new staff on board and the leadership of Marcia and Elisa and their

teams looking at how we can get the materials that go to you to be more meaningful, more easily accessible and more positive in terms of how efficiently your work for the MAP can go.

So, we've seen tremendous progress over the last two years in that area. We got lots of really good feedback last year and I think we're even in better shape this year, but we can always do --- just like healthcare and everything else, we can always get better. So, do give us your feedback, and we will be asking you for that about how the materials worked for you, what we might do differently, et cetera.

Just do remember in terms of the timeliness of the process, that we don't have complete control over all of that. So, thank you for that.

I wanted to mention two other things that are going on at NQF and that are related to, in some ways, the goals of the IMPACT Act to both standardize and strengthen the accountability framework in post-acute and long-term care. And

that has to do with this, with two areas of innovation at NQF. One is measurement science.

As you know, Helen Burstin is our chief science officer. And under her leadership, we have really developed a lot of CMS-funded and foundation-funded work asking the questions about how could measurement be better.

I was on a political panel last week where Joanne Kenen asked --- the first question she threw my way was, well, Dr. Cassel, is measurement an art or a science? So, you know, that was an interesting question.

And my answer is it's definitely a science, but like any science, it's evolving and it doesn't have all the answers. It's an imperfect science, if you want to think of it that way, and it can get better.

So, NQF is working on trying to improve methodology as we live in a world of very changing data sources and approaches to measurement.

So, you're all familiar with one of

the first of the reports in this area, which was our report last year on risk adjustment for socioeconomic and demographic factors, which now is in a trial period for CMS and I suspect will continue to be influential in a lot of important work, including yours, but we just recently got contracts to do a similar study on attribution in healthcare measurement. Another really vexing and complex issue. I see a lot of heads nodding around the table. So, you'll be hearing more about that.

We also just had public comment on report on intended use. Can you classify measures according to what they're actually going to be used for, public reporting versus payment, for example, a really interesting question that I think will only become more important, and then another project on variation.

In this time when everybody is trying to standardize measures and yet at the state level and institutional levels people use slightly different versions of the same thing to

measure the same thing, instead of having this idea that every specification has to be exactly the same in order for the information to be comparable, we're asking the question how close is close enough and is there, as there is with everything else in life, a bell-shaped curve where you can actually say, well, these are close enough and could be used, saving a lot of expense for people having to retool their IT systems, et cetera.

I won't prejudge what the answer to that will be, but I think it is, at this point in time, a really important question to ask.

The last thing is this issue of the gaps in measures. And as you know, those of you who have worked with us before, NQF has done a lot of really authoritative work with committees like this on what are the important gaps in measurement that are out there.

And then we issue these reports. And then we sit back and wait for somebody to send us the measures. And you know what? It often

doesn't happen because there is kind of a market failure in the measure development world where the organizations that have the resources and motivation to actually develop measures are fine, but in a lot of these areas such as the area we're here talking about today, mental and behavioral health, care coordination, a whole range of things, we just are not seeing a robust pipeline of measure development.

So, we decided to get into trying to help people develop measures more rapidly and more efficiently and hopefully lower cost, too, by creating a measure incubator.

So, first thing to say is NQF will not become a measure developer, because that is not our --- part of this world as the standard setter, we are very careful to keep a firewall between the endorsement process and anything that goes on in the development world.

On the other hand, we have learned that it can be very helpful for us to give upstream advice to measure developers about what

works and what doesn't work and our experience, and we will continue to do that.

So, this is taking that next step in being kind of a matchmaker to bring together the people with the idea, the technical expertise, the resources, both financial and human, and probably most important of all, the datasets for testing. That's the thing that very often bedevils this whole process.

So, living in the world of big data as we do, we've developed agreements with a number of big data sources. The first one that Carol is familiar with is Optum Labs in Cambridge, Massachusetts. A spinoff of Optum.

They have not only a huge database of claims data, but also because of other relationships, millions of clinical data sources as well.

And they have data partners that include Mayo Clinic, Johns Hopkins, Yale and AARP and AMGA and a number of other people. So, there's lots of richness of data there. And so,

we're working with them on a proof of concept about could this relationship be used to develop measures.

AARP, thank you, Carol, has been very supportive of this effort and we are working on ideas about measures for dementia and Alzheimer's disease. We're actually bringing in the international registry consortium, ICHOM, involved in that. So, lots of interesting exploratory work there.

We also, as you know, patient-reported outcomes are kind of the really bright star that we all keep looking at, and yet getting that data is often thought to be so expensive.

So, we just got a grant from Robert Wood Johnson Foundation to work with Patients Like Me, the cloud-based crowdsourcing organization that brings patients with specific conditions together and to see if that kind of approach could get more quickly to patient-reported outcomes, at least for those kinds of conditions that Patients Like Me represents, and

maybe present a model for other things.

We're also in discussions with PCORnet, with a number of large delivery systems who could also be clinical test beds as well. So, if you're interested more about that information, just let me know.

And there's also a letter that I sent out to our members this month that sort of describes the incubator and we'll be happy to make --- and if any of you are members, just go on the member website and you'll find it there.

So, I will --- Carol and Deb, I'll stop there, but I'm happy to take questions, if people have any questions.

CO-CHAIR RAPHAEL: Are there any questions from any workgroup members? Okay. Gerri.

MEMBER LAMB: Good morning. Gerri Lamb. I co-chair the Standing Committee on Care Coordination, and it's relevant to this group as well just to comment that I am absolutely delighted to hear that, because that has been a

real issue in the area of care coordination, and I'm the sitting expert in this committee on that, is that we have not gotten new measures. So, that's very, very promising and it's something that our committee has really talked to Helen a lot.

DR. CASSEL: Well, you'll probably be hearing more from Helen about this. And any ideas you have about ways that we could bring the right people together to get this done would be great.

CO-CHAIR RAPHAEL: Any other questions? Bruce, did you have a question?

MEMBER LEFF: No, not a question, but just a comment to pile on what Chris said about the Optum Lab/NQF partnership. We were at one of those meetings. They got interested in our work. They've been tremendous partners.

So, I would encourage people to try and push that forward. It's just been great.

CO-CHAIR RAPHAEL: Thank you so much. All right. So, after that update, we're going to

go to some of our administrative work and I'm going to introduce Ann Hammersmith who is the NQF general counsel, so that we can review our disclosure of interests. Ann.

And can I just ask everyone who's sitting around the table to turn your name plates so that we can be sure to see them? Thanks a lot. Okay. Ann, take it away.

MS. HAMMERSMITH: Thank you, Carol. Many of you are veterans of the Committee and of NQF committees. So, you're familiar with this process.

We do this every year. If you recall, you received disclosure of interest forms from us. And what we do is at the meeting, the first meeting of the group for the year, we have you disclose anything that you think is relevant, that you do that's relevant to the Committee's work.

If you recall, MAP committees are different from standing committees in terms of the disclosures. MAP committees have subject

matter experts, we have organizational representatives, and then they have federal representatives who are nonvoting.

The disclosures are different for the organizational representatives and the subject matter representatives. This group is mostly organizational representatives. So, that disclosure is easiest. So, we'll do that first.

If you are an organizational representative, you've got a very simple form from us where the only thing that you were asked to disclose is if you have an interest of $10,000 or more that is relevant to the Committee's work.

The reason that we ask you for such a brief disclosure is because you are organizational representatives. You do represent a particular group. We expect you to come to the table with that viewpoint. So, we only ask you a very limited disclosure of interest question.

So, let's start with the organizational representatives. As a reminder, I will read the subject matter experts' names.

It's your chairs, Carol Raphael, Debra Saliba, Kim Elliott, Gerri Lamb, Paul Mulhausen, Eugene Nuccio and Thomas von Sternberg.

If I called your name, please do not disclose in this round. We'll get to you in a moment. So, if I could start with Dr. Agostini?

MEMBER AGOSTINI: Hi. Joe Agostini, National Medical Director at Medicare and full-time Aetna employee.

MS. HAMMERSMITH: Do you have anything to disclose?

MEMBER AGOSTINI: No further disclosures.

MS. HAMMERSMITH: Thank you.

MEMBER GRANT: Okay. Robyn Grant, Director of Public Policy and Advocacy, National Consumer Voice for Quality Long-Term Care and nothing to disclose.

MEMBER STONE: Art Stone. National Pressure Ulcer Advisory Panel, Advisory Board Member. Nothing to disclose.

MEMBER GREENBERG: Liza Greenberg,

Interim Vice President of Quality and Performance Improvement with Visiting Nurse Associations of American, and I have nothing to disclose.

MEMBER LEVITT: Alan Levitt, Medical Officer for the Division of Chronic and Post-Acute Care at CMS. Nothing to disclose.

DR. McMULLEN: Tara McMullen, Measure and Analytic Lead for the Division of Chronic and Post-Acute Care. I have nothing to disclose. I'm with the Centers for Medicare and Medicaid Services.

MEMBER LETT: Jim Lett representing the National Transitions of Care Coalition. Nothing to disclose.

MEMBER LEFF: Bruce Leff, Johns Hopkins University. I'm on an advisory board to a company called Landmark Health, which deals in home-based primary care.

MEMBER KAUSERUD: Suzanne Kauserud, representative of the American Medical Rehabilitation Providers Association. I have an agreement. It's new work for me to be an advisor

to RAND on some of the IMPACT Act measure work.

MEMBER PALENA HALL: Hi. I'm Liz Palena Hall. I'm a long-term post-acute care coordinator within HHS, the Office of the National Coordinator for Health IT. And I have nothing to disclose.

MEMBER THOMAS: I'm Jennifer Thomas. I'm a member of the American Society of Consultant Pharmacists. I have nothing to disclose.

MEMBER LEVY: Cari Levy representing AMDA, the Society for Post-Acute and Long-Term Care Medicine, and I have nothing to disclose.

MEMBER HERR: Roger Herr, American Physical Therapy Association. Nothing to disclose.

MEMBER ROBERTS: Pam Roberts representing American Occupational Therapy Association. Nothing to disclose.

MEMBER ELLIOTT: Kim Elliott, the Medicaid program in Arizona. I have nothing to disclose.

MEMBER WINSTEL: Lisa Winstel, Caregiver Action Network. Nothing to disclose.

MS. HAMMERSMITH: Okay. Thank you. Is Carol Spence on the phone?

MEMBER SPENCE: Yes, I am. This is Carol Spence. I am representing the National Hospice and Palliative Care Organization, and I have nothing to disclose.

MS. HAMMERSMITH: Thank you. Are there any other organizational members on the phone? Organizational members only.

(No response.)

MS. HAMMERSMITH: Okay. We'll move to the subject matter experts. Subject matter experts sit as individuals. They are on the Committee because they are experts. They do not represent the views of their employer, any organization with which they're associated, or anyone who may have nominated them to sit on this committee.

Because the subject matter experts sit as individuals, they got the long form. And the

long form asks a great deal of information about professional activities.

We don't expect you in this disclosure to review your CV, but only to disclose things that you believe are relevant to this committee's work.

We're especially interested in consulting, grants, research, speaking engagements, but only if it's relevant to the work before the Committee. So, I will start with your chairs.

CO-CHAIR RAPHAEL: Okay. So, I'll disclose that I'm a Senior Advisor at Manatt Health Solutions. I'm the Chair of the Board of the Long-Term Quality Alliance.

I have been the Chair of the Board and still sit on the Board of the New York eHealth Collaborative, which does a lot of work with ONC. And I am the Chair of the Board of AARP.

CO-CHAIR SALIBA: I'm Deb Saliba, and I'm Secretary of the Board of Directors for the American Geriatric Society. As a researcher, I

have funding from several different organizations, including the Centers for Medicare and Medicaid Services, AHRQ, NIH, and the State of California, which I have disclosed on my form.

I also am on the Board of Directors for the California Association of Long-Term Care and Medicine.

MEMBER MULHAUSEN: Paul Mulhausen. I am a Committee Chair at the American Geriatric Society. I am employed by an organization called Telligen, which is a federal contractor with the Centers for Medicare and Medicaid Services, including operational support for the IMPACT Act.

I'm a consultant for RAND Corporation. I think that came out since my initial disclosure. So, that would be the only addition.

MS. HAMMERSMITH: Okay. I think Eugene Nuccio is the next SME.

MEMBER NUCCIO: Yes. Eugene Nuccio from the University of Colorado. We have funding from CMS on --- to develop many of the home health measures, some of which you'll be seeing

today, and also with the IMPACT Act with the home health area.

MEMBER LAMB: Gerri Lamb, Arizona State University. I am on the advisory groups for measure development for AHRQ and NCQA. I do a lot of public presentations for professional organizations across multiple disciplines on care coordination. And I'm the editor of a book on care coordination.

MS. HAMMERSMITH: Kim Elliott, would you like to disclose?

MEMBER ELLIOTT: Kim Elliott, the Medicaid program in Arizona. I have nothing to disclose.

MS. HAMMERSMITH: Thank you. Is Thomas von Sternberg on the phone?

(No response.)

MS. HAMMERSMITH: Thomas von Sternberg on the phone?

(No response.)

MS. HAMMERSMITH: Okay. Thank you for those disclosures. Based on what was disclosed,

do you have any questions of each other or of me? Anything you would like to discuss?

(No response.)

MS. HAMMERSMITH: Okay. Before I leave you today, I just want to remind you that we rely on all of you to make the conflict of interest process really work. So, if you're in the meeting and you think that you have a conflict, or you think someone else has a conflict, please do speak up.

We don't want you to sit there and feel uncomfortable and kind of wonder, and then tell us a few months later that you had a conflict or you think somebody else did.

So, if you do believe that there is a conflict or someone is behaving in a very biased manner, you're always welcome to bring that up openly in a meeting. If you prefer not to do that, you can go to your chairs, who will go to NQF staff, or you can go directly to NQF staff. Thank you.

CO-CHAIR RAPHAEL: Thank you, Ann.

(Pause.)

CO-CHAIR SALIBA: Thank you, Ann. So, we're going to move on to the next agenda item, which is introducing Alan Levitt and Tara McMullen to talk with us about the post-acute care quality reporting programs and statutory guidelines.

MEMBER LEVITT: Okay. Well, thank you. This is Alan Levitt. I first wanted to thank you for allowing me to lead off the meeting here. And from myself, from Doc McMullen, from all my colleagues in the Division of Chronic and Post-Acute Care at CMS, both here and in Baltimore, our contractors who are both here and on the phone, I wanted to thank the workgroup for your continued collaboration and support of our programs.

This is my third year here. And one of the more consistent requests or themes that I've heard here is kind of to understand more when measures may be statutory. And if those measures are statutory, what the timelines are

for those measures.

And so, I thought I'd quickly review the guidelines on those and hopefully bring us back a little bit more towards the schedule that we're supposed to be on.

So, if we go to the next slide, this is kind of the history of our program from earliest to the newest. The Home Health Quality Reporting Program, as my wife who's a pediatrician would say, it's in the middle childhood, and the skilled nursing facility at the other end is in the infancy. It just finalized its first rule. And so, we'll be going from beginning to end.

If you go to the next slide, the Home Health Quality Reporting Program was established in the Deficit Reduction Act of 2005. And this will be a consistent theme that you will see here.

And for any home health agency that was not submitting data, they would be subject to a two percentage point decrease in their market

basket increase.

And for this year now, there's going to be a 70 percent threshold in the submission of quality assessment. And it will be 80 percent next year, 90 percent the following year.

CAHPS surveys have been added to the Quality Reporting Program in 2012. This is our most mature quality reporting program. It has a well-established, publicly-reported website. We've added star ratings in the past year.

We have a lot of measures. Probably too many, as Peg would say. And we're looking at always what we should be doing in terms of retiring those measures, adding new measures.

It is a quality reporting program. There is also, as you know, there is a value-based purchasing program at CMS that was finalized in this past year's rule. And that's a demonstration, it's a model that's being done through the Innovation Center in nine states. It's using some of our measures, but as of now this is a quality reporting program.

Going to the next slide, the Patient Protection of the Affordable Care Act was a game changer, not just from a financial standpoint in terms of marketplace, but also from a quality standpoint.

It's probably the reason why we're here, it's certainly the reason why I'm here today, as it expanded the responsibilities of the National Quality Forum.

It also established these three quality reporting programs for long-term care hospitals, inpatient rehabilitation hospitals/facilities, and hospice program.

And once again these programs needed to submit data. And if they did not submit data, they would be subject to the two percentage point decrease in their market basket.

Public reporting was also part of the Affordable Care Act. And in this past year's rule, we've finalized that in the fall of 2016 for the long-term care hospitals, the inpatient rehab facilities, we will be public reporting

those programs. Hospice we'll be announcing in future rules.

Let's go to the next slide. Now, measures come in different shapes and sizes. This is just to show you where measures may show up for us statutorily. This was on Page 40 of the 40-page Bipartisan Budget Act.

There was a small, little section added that we needed to establish a functional status quality measure in long-term care hospitals for patients on ventilator support.

This was a measure that came up here a couple years ago, as the older committee members may remember. And so, again, Congress told us we need to establish this measure by this certain time.

Next slide. PAMA, or the Protecting Access to Medicare Act, in 2014 again had a section that established the skilled nursing facility value-based purchasing program. And within that section there were two measures that needed to be specified.

Both measures were to be publicly reported. And one, then the other, would then be used in the value-based purchasing program and again the program had an established date as well.

Let's go to the next slide. The IMPACT Act, which probably is now mentioned, I guess, probably the sixth or seventh time today, we can count how many times it will be mentioned today, once again is a game-changer.

It's requiring post-acute care providers to report on standardized patient assessment data, to use post-acute care assessment instruments, to report on data and quality measures and measures in those five domains that I have listed on the slide. And then also to report data on resource use and other measures. And those three measures we are going to be discussing later this morning.

Let's go to the next slide. We've known that we need standardized patient assessment data in post-acute care for a long,

long time. For the sake of today, I'll start with MEDPAC's recommendation that they've recommended that we have a core set of assessment information back in 1999. They have repeated that in their updates up until the present.

Congress in 2000, through BIPA, required that CMS report on developing standardized assessment instruments. In 2005, in the Deficient Reduction Act, an impatient Congress once again told now CMS to test a concept of a common standardized assessment tool and that was in the form of the PAC-PRD. CMS developed, as part of that PAC-PRD, the continuity assessment record and evaluation or care item set.

In 2011 CMS came back to Congress, reported on the PAC-PRD. They reported on the successful, consensus-based development of this item set, the successful reliability testing of the item set, positive feedback that they got, and also the idea that patient information could actually be used to look at the differences in

resource use in post-acute care.

In 2013, Congress held a hearing on post-acute care reform. Some of you were there for that hearing. They also sent out a letter to stakeholders requesting feedback on how to best do post-acute care reform.

And as I have written on the slide here, this is a direct quote from Congress, the resounding theme across more than the 70 letters was the need for standardized post-acute care assessment data across Medicare post-acute care provider settings.

So, we go to the next slide and so came the IMPACT Act of 2014 and standardized patient assessment data by these dates. And it's within these six different categories which I have listed here.

And I'm proud to say that it's really been my division which has done a lot of work in this, particularly Dr. McMullen next door and Stella or Stacy Mandl back there. They've done an incredible amount of work bringing Congress'

vision to reality. So, we should definitely thank them.

As a former post-acute care provider, this is something that really is essential and really is game-changing. So, thank you.

We're here today for the next slide, which is actually the measures that are associated with that standardized, interoperable assessment data. These measures are within five domains.

Last year we discussed functional status, skin integrity and incidence of major falls. This year we'll be talking about medication reconciliation domain. And those are the application dates. Application date, earliest one would be January 1st of 2017 for that domain.

Let's go to the next slide. There were also specified application dates for the resource use measures. And that the post-acute care settings need to report data on these three measures starting in the three facility settings

by October 1st of next year, and home health by January 1st of 2017. And we'll be discussing those three measures later today.

Go to the next slide. Finally, the IMPACT Act also established the skilled nursing facility Quality Reporting Program. Again, this is a quality reporting program, not a value-based purchasing program like previous slides I mentioned in PAMA.

And so, once again, by fiscal year 2018, skilled nursing facilities need to submit data, or be subject once again to the two percentage point decrease.

Next slide, I guess questions or questions throughout the day we can go to, but thank you. Thank you for the time.

CO-CHAIR SALIBA: Thank you, Alan. Did anyone have any questions for Alan? That was a very nice overview. Thank you.

(No response.)

CO-CHAIR RAPHAEL: Before we turn it over to Erin, I was just thinking, Alan, as you

were talking, I guess, from my MEDPAC experience that it's important to keep in mind that post-acute care expenditures continue to rise faster than other sectors of healthcare.

I think given the demographics, the changing nature of illness with more chronic illness, I think we can expect that there will be continued increase in need for post-acute care services and pressure on payers, primarily in the public sector.

And the other thing that always struck me at MEDPAC, and I don't know, Alan and Tara, if this has changed, but I don't think it has from the latest data that I looked at, there is tremendous variation in the post-acute care sector, in terms of utilization and the little that we know about outcomes at this juncture.

So, any other comments that anyone wants to make before we end our little context setting and turn it over to you, Erin, to go through the process with us?

(No response.)

MS. O'ROURKE: Thanks, Carol. So, we're excited to let you know about some updates that we've made to the pre-rulemaking process this year. We're always working to improve our processes and we've made these changes based on what we've heard from you, the MAP members, as well as members of the public.

So, we've reviewed the majority of this during our all-MAP web meeting, but I did want to give you a brief refresher before we get into the nuts and bolts of making our recommendations.

First, we use a three-step process for the analysis and selection of measures. We first develop a framework to organize the measures that are currently in the program measure set.

This is an attempt to help you see what is currently addressed by those measures, and we include information about what PAC/LTC core concept the measure might address, what IMPACT Act domain might address, as well as what National Quality Strategy priority it relates to.

Next, we review each measure under consideration to see what that might add to the program measure set. And finally, we identify and prioritize the gaps for each program and setting.

So, a change for this year is that we are asking the workgroups to reach a decision about every measure under consideration and to not leave any, quote/unquote, split decisions.

The decisions are standardized for consistency. I'll review those with you in the next few slides. We also developed rationale for each decision that helps explain how that decision was reached and allows us to capture the workgroup's deliberations. So, just to let you know it is not just the decision that goes on to CMS. It is also the workgroup's rationale.

So, we have two pathways this year that we're using to review measures under consideration. For a fully developed measure, MAP can make a recommendation to support, conditionally support, or not support the

measure. And on this side, you'll also see a few examples of a rationale that we might use to explain why the workgroup made that decision.

The next slide shows the pathway for measures that are still under development. As you know, we've been reviewing measures that are earlier in development, increasingly, over the past few years.

For these measures, you can make a recommendation to encourage continued development, not encourage further consideration, or that there is insufficient information for the group to come to a decision.

And this last category would be discouraged, but we do want to recognize that the group may feel there is not enough information, but again this is something we would try to push you to come to a full recommendation.

So, the MAP measure selection criteria were developed to help review the characteristics of a program measure set and help the workgroup to think about what might be an ideal set of

measures for a program.

They're intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs.

They're not absolute rules. Rather, they are meant to give general guidance on measure selection decisions and to complement program-specific statutory and regulatory requirements such as the ones that Alan just reviewed.

The central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps and increase alignment across the programs and settings.

Although competing priorities are often weighed against one another, the measure selection criteria can be used as a reference when you're evaluating the relative strengths and weaknesses of a program measure set and how the addition of an individual measure might

contribute to that set.

Measure selection criteria are constantly evolving and they have changed to reflect the input of a wide variety of stakeholders since we implemented these back in the first year of MAP.

And to determine whether a measure should be considered for a specified program, the MAP evaluates the measures under consideration against these measure selection criteria. And we'd ask you to take a few minutes and familiarize yourselves with the criteria and to use these to support your decisions when you're reviewing the measures under consideration.

A change that we made to the process last year and that we've refined for this year is the addition of a preliminary analysis of each measure under consideration.

The preliminary analysis is really staff's attempt to operationalize the measure selection criteria. We answer a series of questions about each measure under consideration

to give the workgroup a summary of that measure. And from staff's perspective, what it might add to the program measure set.

We ask if the measure addresses the program goals and objectives, if it addresses an important quality issue for that setting, if it fills a gap in the program measure set and if it's tested for the setting and level of analysis of the program.

We also pull in any information we can find about how that measure is currently being used and if we can find any results from the field on that measure. We ask if the measure promotes alignment.

For the PAC/LTC group, you'll see information if it addresses one of your core concepts or if it addresses a high-priority issue for dual-eligible beneficiaries. And finally, if the measure has been reviewed for NQF endorsement, you'll know we pull in a summary of the results of that review.

So, I think I can pause and take any

process questions. If not, we can jump into the voting instructions.

CO-CHAIR RAPHAEL: Okay. Are there any questions for Erin? Erin, I was just going to ask you if you could talk a little bit more about for the measures under development you can support continued development, you cannot support continued development, and the third was insufficient information.

Would you talk a little bit more about the third?

MS. O'ROURKE: Of course. So, the third is really a category we are trying to sunset. So ---

CO-CHAIR RAPHAEL: That's why you gave a short ---

MS. O'ROURKE: That's why it was glossed over. And this is something we've been working with our colleagues at CMS so that they provide as much information as they can about the measures under consideration. And definitely kudos to them because it's changed quite a bit

form the early years of MAP, where all we might have received is a title of a measure, and the groups felt they really could not make a good decision, when all that they had to go on was a title.

So, now you'll notice there are at least preliminary specifications about each measure. So, we do ask that if you can avoid that insufficient information decision, to do so. But when you really do not feel like you have the right information to make a solid recommendation, that is why that is there.

CO-CHAIR RAPHAEL: Thank you. Any other questions for Erin?

(No response.)

CO-CHAIR RAPHAEL: All right. So, why don't we go on to voting instructions.

MS. O'ROURKE: Okay. So, before we get started on the instructions, does everyone who is a voting member of the workgroup have a little blue clicker?

If you're a federal liaison or the

liaison from the dual eligible groups, you are not a voting member. Sean, you need a clicker?

MS. IBRAGIMOVA: So, whoever doesn't have a clicker, can you just put up your tent so I'll walk around and assign you one?

MS. O'ROURKE: And while Laura is taking care of that, Sean, if you wouldn't mind introducing yourself and reviewing any disclosures that you have?

MEMBER MULDOON: My name is Sean Muldoon. I'm with Kindred Healthcare and I, by disclosure, is that I'm a full-time employee of a provider of post-acute care services.

MS. O'ROURKE: Thank you. Was there anyone else who joined us after introductions and needs to introduce themselves?

(No response.)

MS. O'ROURKE: Okay. So, moving on to some key principles about voting, every measure under consideration is subject to a vote. We'll either vote on that individually, or as part of a consent calendar.

As I mentioned, the workgroups will be expected to reach a decision about every measure under consideration this year. This is a request from the Coordinating Committee that we no longer pass things up to them as a split decision.

They stress that it's difficult for them to make a solid recommendation when they don't have the benefit of at least a preliminary recommendation on that measure from the experts in post-acute long-term care that are around this table.

There's a more diverse group of expertise at the Coordinating Committee. So, they greatly value what the preliminary recommendations from the workgroups are.

That being said, the workgroup recommendations are still subject to continued discussion at the Coordinating Committee level, particularly if it addresses an important program policy issue or strategy in the context of a measure for the program.

So, after introductory presentations from the staff and the Chair, to give you a little bit of context about the program, we'll start the discussion and voting using the electronic discussion guide.

So, I would ask if you have a computer, to please pull up the discussion guide that we sent around. This will be the main document that we'll be going through.

We've also assigned a lead discussant to each group of measures. They'll be people that our co-chairs will be turning to when we start conversation about an individual measure. If you have remarks, Carol and Deb will be looking to you to make them to help kick off the workgroup's conversation.

You'll notice on the discussion guide the content is organized as follows. The measures under consideration are divided into a series of related groups for the purposes of discussion and voting.

Each measure under consideration has

a preliminary staff analysis that I just described, and this discussion guide notes the results of that preliminary analysis. For example, if staff would recommend support, do not support or conditional support based on the results of the analysis. And it provides rationale for how that conclusion was reached.

So, how we will actually go about this voting. So, the step one is we'll review the preliminary analysis consent calendar. So, we'll present each group of measures as a consent calendar that reflect the results of the preliminary analysis that we came to using the selection criteria and the objectives of the program.

For the next step, the co-chairs will ask the workgroup to identify any measures under consideration that you'd like to discuss individually, and not have them be voted on as part of a consent calendar.

Any workgroup member can ask for one or more MUCs to be removed from the consent

calendar and turned into an individual agenda item.

Once we have gone through that and all of the items that you'd like to discuss have been identified, the co-chairs will ask if there's any objections to accepting the preliminary analysis and recommendation for the measures under consideration that remain on the consent calendar.

And if no objections are made, what's left on the consent calendar will pass. There will not be a formal vote on accepting the consent calendar. This is something we heard from last year that voting on what you've already agreed to was getting a little bit redundant. So, we removed this vote to try to make it a little smoother for you.

Once we're through with the consent calendar, we'll move on to the individual measures that you've pulled for discussion. The person who identified that measure for discussion is asked to be the first to go and to explain why

you pulled the measure and what your concerns are with the preliminary analysis.

We will then turn to the lead discussants to see if there's something they would like to add to the conversation. They can state their own point of view, either whether they agree with the person who pulled the measure, if they agree with the preliminary analysis, or if they have a completely different opinion. And then we'll open that measure up for discussion by the workgroup.

And then once conversation is starting to come to a conclusion, Carol and Deb will move us for a vote. And here is another change that I wanted to draw your attention to for this year. We'll only be taking one vote per measure.

Last year, we took it through a series of votes and we received some feedback that was an awful lot of clicking. So, this time we'll take one vote per measure.

We do need to get to a 60 percent threshold for consensus. So, you'll be taking

one vote per measure. You'll notice you'll have the choice of all three categories for --- if it's either a fully developed measure or a measure under consideration.

A change we did want to draw your attention to is if we don't --- we can sum the scores for support and conditional support to get to a recommendation of conditional support. And we'll be clarifying announcing the conditions at the conclusion of the vote.

So, basically for this year if anything gets to a 60 percent threshold on its first vote, that stands. So, no further actions are needed.

If we don't get the 60 percent for any one decision, we'll sum the votes for support and conditional support to see if that gets the 60 percent. If that doesn't get the 60 percent together, the recommendation is a do not support. And then finally, abstentions are discouraged. But if there are, they will not count in the

denominator.

And this is also something -- we've built a few more breaks into the agenda this year. So, we'd ask that you if at all possible, not step away from the voting until a formal break.

Another change that we've made for this year are some increased opportunities for public comment. We'll be taking public comment before each consent calendar.

We do ask that commenters limit their comments to only the measures under consideration for that consent calendar and that you limit the comments to two minutes to allow everyone a chance to speak.

We will have two global public comment periods at the end of each day where commenters can address any topic that the workgroup discussed. We'll also have public comment on the workgroup recommendations that will run from December 23rd through January 12th.

This will be the formal written public

comment period on the draft recommendations. And those comments will be considered by the Coordinating Committee and submitted to CMS.

I also wanted to note if you're looking at your Discussion Guide, you'll see the comments that were generated from the early public comment period, we've been calling it.

This is the comment period on the measures under consideration. So, we did want to draw your attention to those comments and to please consider them in your deliberations.

So, I think with that we can do a quick -- first I'll take questions, and then we'll do a quick test run of the voting.

CO-CHAIR RAPHAEL: Okay. Are there any questions? I think we're going to have to go through this and then we'll see if we really understand what you have shared with us, Erin.

Okay. Any preliminary questions? I would say that one of the things that I think is a real improvement is getting public comments before we do our deliberation.

We used to do our deliberations and then turn for the public comment. And, you know, I spent a good deal of time yesterday reading the public comments that have come in, as I'm sure many of you did, from many organizations. And they were very thorough and very thoughtful. And there were certain themes that kind of came through to me and we probably will hear them again.

One is the compressed time frame that people experienced and wished they had had more time, but I think we all, including the NQF staff, have dealt with that.

I think the second question was the degree to which these measures are well correlated with outcomes was raised several times.

A third, and this to me is reflective of the fact that, as you said, this is early stage when people asked a lot about testing and validity and reliability.

A fourth, and this is a perennial

theme that we have heard, and I think it's going to be raised again, and it's an important area for us to think about, which is how do you deal with the areas that are beyond your control.

And, you know, we've heard that before and I read that in the home healthcare comments, as well as in some of the nursing home comments where you cannot necessarily control all the variables, nor can you control the behavior of the patient.

You make a recommendation, but they may not comply with the recommendation. So, that was another, you know, recurring theme that I heard.

Another one which we are grappling with at NQF has to do with risk adjustment and socioeconomic status. That's an important area that a lot of attention is being given to at NQF.

And the last one had to do with this whole issue about improvement versus stabilization, because there are some patients where you cannot achieve improvement, where the

best that you can get is stabilization and how we are mindful of that as we really deliberate and move these measures along.

So, we may hear some of the same things again and we may hear others, but I thought that was a very valuable change that we have made to the process.

Okay. Any other comments or questions before we launch here?

(No comments.)

CO-CHAIR RAPHAEL: Okay. So, we are going to start with the first -- and please interrupt Deb and me if we are not -- yes, go ahead, Sarah.

MS. SAMPSEL: If we could do staff introductions?

CO-CHAIR RAPHAEL: Oh, thank you. That is really important. So, let us do staff introductions. Thank you, Sarah.

MS. IBRAGIMOVA: I'll start. My name is Laura Ibragimova. I'm a project analyst here at NQF. I've been here for about two years and

this is the second time I am supporting the MAP PAC/LTC Workgroup.

DR. TERRY: Hi. My name is Peg Terry and I know many people here, because I was on this workgroup for many years. And I'm from the Visiting Nurse Association of America. And I'm really delighted to be here.

I've been here about five months at NQF and I look forward to this meeting.

MS. STREETER: Hi. Good morning. I'm Katie Streeter, Senior Project Manager. I have been with NQF for about five years and this is the first time I'm working with the PAC/LTC workgroup.

I've supported MAP in the past, but this is my first time with PAC/LTC.

CO-CHAIR RAPHAEL: You'll tell us later how we stack up compared --

MS. STREETER: Of course.

CO-CHAIR RAPHAEL: -- to the other workgroups. Okay.

MS. O'ROURKE: Hello. I'm Erin

O'Rourke. I'm also a Senior Project Manager here at NQF. And I've actually been supporting the PAC/LTC Workgroup since the beginning.

So, this is my fifth year with you all. So, thank you again for all of your hard work and looking forward to another exciting pre-rulemaking.

MS. SAMPSEL: Well, good morning. And I'll introduce myself before I get started with the next -- for the first consent agenda, but I'm Sarah Sampsel. I'm a consultant to NQF. Have been working with NQF actually for a long time since I am a former measure developer from NCQA and also out of the health plan world.

And more recently have been working more on endorsement projects, including person and family-centered care, many of those measures we'll be discussing over the next couple of days, or a similar adaptation of some of those measures. And I also work in renal, behavior health and do some musculoskeletal work.

But with that, and, again, I do want

to recognize all the work that staff do to prepare for this meeting and make sure that if any of you have any logistics questions, that you let us know or if you have any concerns or issues.

We do know there was at least one problem with the hotel. So, if you do have issues with the hotel, if you could let one of us know so we could get that solved for you during the day before you go back.

But with that, our first -- and, actually, I'm going to turn it back to Carol first to do the public comment.

CO-CHAIR RAPHAEL: Okay. All right. So, the first thing, we are going to ask the operator to actually open the lines for public comment. And these are for the group of measures having to do with the IMPACT Act and medication reconciliation.

So, let me ask the operator to open the lines for public comment.

THE OPERATOR: Okay. If you would

like to make a comment, please press * and the number one.

CO-CHAIR RAPHAEL: Is there anyone on line?

THE OPERATOR: There are no public comments at this time.

CO-CHAIR RAPHAEL: Okay. Then I'm going to turn to anyone -- part of the audience in the room who wishes to make public comments.

MS. HARMON: Good morning. I'm Holly Harmon. I serve as the Senior Director of Clinical Services at the American Healthcare Association. We do represent 10,000 nursing homes across the country and have been a strong supporter of the IMPACT Act.

We also recognize the importance of medication reconciliation upon reducing rehospitalizations and reducing unintended healthcare outcomes, which is a very important part of our National Quality Initiative.

For those reasons, it's very important to us that the drug regimen review and/or

medication reconciliation measure is an effective and appropriate measure.

We do have concerns for this measure which I will briefly outline, and our recommendation is that this measure is not ready for rulemaking. And we recommend encourage continued development for these five reasons:

There is no NQF application or endorsements or reliability and validity is unknown. Second, the data elements for this measure do not currently exist in all PAC assessments.

Third, the definition of "drug regimen review" is not consistent with other PAC settings. And, in particular, is inadequate in capturing the scope of drug -- medication regimen review and does not address the involvement of interdisciplinary team members.

Third, the measure -- or fourth, the measure description does not define what constitutes a potentially significant medication issue, which is a critical part of the measure.

And fifth, the measure has not been tested, nor has an examination of feasibility for implementing this measure across PAC settings been completed, nor a pilot has begun yet.

So, for all of these reasons, this drug regimen review measure is not ready for rulemaking and should receive a vote of encourage continued development. Thank you for the opportunity to comment.

CO-CHAIR RAPHAEL: Are there any other comments from the audience?

(No comments.)

CO-CHAIR RAPHAEL: Okay. Laura, is there anything that's come in on the chat box?

MS. IBRAGIMOVA: No, there are no chats via chat box.

CO-CHAIR RAPHAEL: Okay. Thank you. So, I'm going to turn it over to you, Sarah, to provide a brief overview of the IMPACT/med reconciliation measures and also share with us the preliminary analysis from the staff.

MS. SAMPSEL: Sure. First, though,

Jim, did you have comments before we got started with that part?

MEMBER LETT: Just a procedural thing. If those who make a public comment would tell us which specific measure under consideration they're addressing or whether it's for the whole packet. Thanks.

MS. SAMPSEL: Okay. So, with that, what we did, and you'll notice on the agenda for the first part of this morning, as well as when we start up tomorrow morning, is for any of those measures that have been identified as IMPACT Act measures and meeting those domains or being put forward as measures under consideration for the IMPACT Act domains, we have pulled those onto their own consent calendars.

We really felt that speaking about all of the similar concept measures at once would again help with the rest of the flow of the meeting. And so, we wouldn't have to repeat the conversations through each of the programs. We just pulled them all together.

So, the first set of such measures is four measures, and it is -- they are the medication reconciliation measures which are looking for drug regimen review being conducted.

The timing of that review is dependent on the setting. So, it could be upon admission, it could be on resumption of care if it's home health, but would be specific to each PAC setting. And you'll find those in the details of the measures that were provided to us.

And then the measures also looking for follow-up with a physician on an ongoing basis and any time a clinically important or clinically significant medical issue is identified, these measures are in early development, as reported to us from CMS. So, all of the overall staff recommendations were to encourage continued development.

And the preliminary analysis, we felt, supported that encourage continued development due to the fact that these are patient safety issues.

As we just heard from public comment, this is an important issue. Falls under the National Quality Strategy not only for patient safety, but also for preventing some downstream events that could happen with improper or not performed medical reconciliation.

The other comments that we would make staff-wise is obviously this measure is -- these MUCs, there are four of them, are being presented to you for consideration, because they are promoting that alignment across the program settings, which is one of the goals of the IMPACT Act. And medication reconciliation is one of the IMPACT Act domains.

So, with that, I will go ahead and turn it back over to Carol.

CO-CHAIR RAPHAEL: Thank you. So, now let me ask Alan and Tara if you want to comment on these.

MEMBER LEVITT: Okay. Well, first of all, thank you. Thank you for going through the measure. And also thank you for the public

comment as well.

The concerns just in terms of public comment are also things that we've really, you know, thought about in the development of the measure itself that these three items in the measure are actually items that are part of the OASIS and have been defined as such. And have been given guidance as such in the home health manual without being totally prescriptive in terms of what it means.

Well, certainly after I'm done, I guess, be interested in how the workgroup feels about how prescriptive we really need to be in defining what "clinically significant" means and what "one day" means.

I mean, my hope was allowing the settings to define it best for, you know, the way that the settings saw it to be, but have the idea that the drug regimen review is a very serious act and needed to be done and needed to be done well under review by each one of these post-acute care settings, but we are interested in terms of

the feedback on that and certainly can further discuss that without changing the specification to the measure itself, just in terms of the guidance that would be given for that measure.

In terms of testing and feasibility of the measure, as I said, this is a measure that the components of the measure have been used in the home health setting for several years now and have been used successfully.

Testing has begun in the other settings and already getting in terms of preliminarily that this is something that can be done.

In those settings, I think if you look at the items themselves and see whether or not you think that they would be items that would be feasible to be done within your own setting, you can make up your own mind as well.

I'm trying to think in terms of other comments itself. Certainly validation will be important. It's important in all of the measures that we are presenting here today and are

measures in our program. When you're dealing with anything that's particularly on an assessment instrument, validation is going to be important.

And we will continue to work with the other components in CMS. And we will work through our rulemaking in terms of trying to best ensure that we are getting the best information that's possible on these measures.

As things come up in the workgroup, Carol, if you wish, I can continue to come back and comment on other items that are going on.

CO-CHAIR RAPHAEL: I just had one question that came up in some of the comments I read. Is there -- the difference between drug regimen review and medication reconciliation.

MEMBER LEVITT: I consider drug regimen review/medication reconciliation on steroids that essentially medication reconciliation is the process of identifying an accurate list of medications that an individual is on.

Drug regimen review is more than that. It's really looking at the adverse effects, drug reactions that potentially are there. It's a review that's done initially when somebody is first admitted to your setting and continues, when appropriate, throughout the rest of the setting.

And when circumstances come up within that review that's conducted, it's felt that contact needs to be done with the prescriber of interest that that get done in a timely fashion that is appropriate for the patient that you're taking care of.

CO-CHAIR RAPHAEL: Right. So, now let me ask the workgroup if you would like to pull any of these four measures from the consent calendar that we're going to be reviewing and discussing and propose a different disposition. Jennifer.

MEMBER THOMAS: Can you clarify what you mean by that by pulling that from the consent calendars that you've -- expand on that, please.

CO-CHAIR RAPHAEL: Okay. So, Erin, why don't you --

MS. O'ROURKE: Of course. So, the consent calendar is based on the result of the staff preliminary analysis, which you can find in your discussion guide. I'm trying to pull that up for these.

So, Sarah, correct me if I'm wrong, but I believe all have a preliminary analysis result of encourage continued development. So, if you disagree with that result, please at this time pull the measure for the whole workgroup to discuss.

CO-CHAIR RAPHAEL: Okay. Robyn.

MEMBER GRANT: So, what if you have a concern about an element within that measure, but you don't disagree with the recommendation?

MS. O'ROURKE: You can still pull that and we can have some conversation to work through those concerns, or if there's something you'd like to have captured in the report, that's certainly on the table. We don't want to stop

any conversation about any elements.

MEMBER GRANT: But if it --

CO-CHAIR SALIBA: I think --

MEMBER GRANT: Go ahead.

CO-CHAIR SALIBA: I think Robyn's question is can she raise a point to -- I think Robyn's question is -- I was starting to yell -- can she raise points or issues without pulling something from the consent calendar?

Does it have to be pulled from the consent calendar for her to raise some points or discuss it?

CO-CHAIR RAPHAEL: I mean, I think that's the part that's not clear. If we leave all of this in the consent calendar, how extensive a discussion can we have?

MS. SAMPSEL: So, what I would recommend here is -- and this is almost a function of how this workgroup is different from some of the other workgroups which might have five measures that are all very different where how we group these measures is making them all

together.

So, what I would encourage is you wouldn't necessarily pull these measures from the consent calendar. You need to indicate to us that you want to discuss these measures further, that -- but what we would ask that you do is as we discuss these, to also if you have specific concerns about a particular setting of care since these are all grouped as predominantly the same measure, but for different settings of care, that you also indicate to us which setting of care or which program you would have the most concerns about.

So, I mean, I think if anybody has slight issues about any issue of any one of these, it kind of applies to all of them, which is how we did it in the first place. So, it's going to be a little bit difficult to say pull a measure from the consent calendar, if that makes more sense.

CO-CHAIR RAPHAEL: Okay. Bruce.

MEMBER LETT: Just another process

question. Is there -- so, for instance, let's say as an example we agreed with the public comments. Is there added value to members of the workgroup piling on with similar comments, or is that adequate for discussion? Do we need to repeat? Is there a value in repetition?

MS. SAMPSEL: That's a great question. So, while we want to prevent, you know, speaking about the same measure for hours on end if you feel there was something particularly relevant that you feel should be, you know, kind of a I just want to agree with what the public commenter said, that is perfectly acceptable and would be encouraged.

At the same time we don't -- or we would appreciate not having the same conversation over and over and over.

CO-CHAIR SALIBA: So, Bruce, I would use the word "amplify" as opposed to "pile on."

CO-CHAIR RAPHAEL: I think it's part of the role of the chairs to make sure that we don't hear the same thing over and over and over

again. So, we can handle that.

All right. Jim.

MEMBER LETT: Thank you. I just didn't feel we could allow these to go to the consent calendar without emphasizing how important medication reconciliation is. And it seems to not discuss it a little bit would lessen its importance, number one.

Number two, I will amplify what I've heard. And I think the real problem for me as a practicing physician and as a medical director and as the other roles I've had, is defining the word "significant."

I mean, my world is frail elders and transitions of them. And polypharmacy in this day and age is a very perverse, but new normal in this population. We end up adding on medications many times, because there are multiple guidelines that really aren't validated for this age group. But we feel to meet quality indicators, we should add medications even when we think maybe it's not the best of ideas.

So, we need some help out there in, number one, determining what is significant in drug reactions. Because sadly when we're seeing patients in various sites who are on 20, 25, sometimes more medications, their everyday normal is an adverse drug event.

I mean, a hundred percent of those people have them. So, what is significant? What will allow us to withdraw medications appropriately? Otherwise, I would say absolutely I'm in favor of measures for medication reconciliation.

I don't want perfect to be the enemy of good. They can't be perfect to start with, but we need some help with significance. Thank you.

CO-CHAIR RAPHAEL: Just to clarify, we're leaving these on the consent calendar, but we're now going to discuss them.

All right. So, Gerri.

MEMBER LAMB: A process question after Bruce's in terms of amplification. Is there

value in knowing that there is strong support for any particular concern versus an individual saying, yeah, I agree with this?

So, if everybody in the group says, yes, this is a significant concern and it needs to be addressed, is there value in knowing that there is consensus that this needs to be addressed?

MS. O'ROURKE: Again, I would say that's a little bit of a balancing act and where we'll look to Deb and Carol, but, yes, it's beneficial to know where the concerns are, consensus concern versus one individual person.

We do try to reflect all of that in the reports that we'll be generating, but knowing the strength of the concern is valuable, but again without having the same conversation all day.

CO-CHAIR SALIBA: Yeah. So, I think, Gerri, there's sort of that idea of saturation. At some point we'll reach saturation. And unless we hear someone say that they think the term

"significant" is clear and obvious and there's nothing, you know, I think after we have a few comments from people about it, we start to sort of understand the sentiment.

CO-CHAIR RAPHAEL: I mean, I was just going to ask Sarah how you think about this, because on one hand I can argue that we don't want to put people into a straitjacket. I mean, you rely on clinical judgment at the end of the day and you don't want to become too prescriptive, because there's no way we can anticipate all the possible situations.

On the other hand, you know, in terms of what Jim is sharing with frail elderly with, you know, where there can be so many medications and, therefore, it's unlikely you can entirely avoid adverse reaction, so how should we think about that?

MS. SAMPSEL: I think it's important -- we're always going back to balance, but I think a couple ways. First of all, we heard from Alan that CMS wants to hear some of these

concerns as they continue testing the measures and moving them forward for full development and potential implementation and endorsement in the future.

So, that's where I think knowing your strong support of a measure and the concept behind the measure is important to convey to us as staff, but do I need every single person in the room to tell me that? No, we're watching you all, you know.

If somebody crawls under the table with their hands over their head, we're probably going to understand you don't understand that count or you don't agree with that comment, but at the same time you're right.

I mean, some of the issues that Jim brought up and others of you may bring up about each individual measure that maybe those issues, you know, we didn't see in preliminary analysis, but we would want to reflect in the report, that's where we will need you to say, hey, this is something really important and we would want

to see this as part of our workgroup recommendation.

CO-CHAIR RAPHAEL: Clarke.

MR. ROSS: Thank you. I wanted to make an observation from the perspective of your workgroup of persons dually eligible for Medicare or Medicaid. It's a unique entity within the National Quality Forum, because it's focused on the individual maximizing the health and well-being of the individual.

And just an observation, I was the liaison to this workgroup last year, the IMPACT Act's purpose is standardization across settings to improve the health and well-being of individual patients or persons or consumers.

And I heard last year in the discussion of a number of measure, proposed measures, one provider type saying, well, they may do it in that group, but it doesn't -- we don't do it in this group.

Again, just to remind people, the focus is on what is -- how do we maximize the

health and well-being of the individual who many of these people will experience two or more of these settings in a short period of time.

And so, in my -- my advice is please keep in mind the individual beneficiary. And if something is working in one setting type, working well, then the question would be, what will it take to get us to have it work in all the other settings rather than leave us out because we don't currently do it that way.

CO-CHAIR RAPHAEL: Thank you, Clarke. Robyn.

MEMBER GRANT: My question then, and I guess concern, relates to the part potentially clinically significant medication issues that are identified during the course of care and followed up with the physician afterwards.

I will take Alan's word for it that all three of those elements are in OASIS, because I am not familiar with OASIS. But in terms of Number 4 for skilled nursing facilities, now granted it's been a while since I have dug into

the minimum dataset, but I'm just -- it strikes me just from memory that I'm not sure that that's where you would go to find out if there had been a medication issue identified or followed up by the physician.

That last one particularly, followed up by the physician, seems to be that's going to be in the medical record and not in the assessment. So, I just wanted to raise that as a question.

And then for the other two settings, IRF and long-term care hospital settings, I don't know about the assessment data, but I just wonder if perhaps the same things have applied that some of that information might not be in the assessment, but rather in the medical record.

Did you want to say something?

MS. O'ROURKE: Let's let CMS -- do you all want to respond to that?

MEMBER LEVITT: Just to tell you I do have my coffee-stained copy of OASIS that I carry -- actually carry around everywhere, Robyn, if

you want to take a look.

MS. O'ROURKE: Thank you. I trust you.

(Laughter.)

CO-CHAIR RAPHAEL: I hope it was good coffee, Alan. All right. Bruce.

MEMBER LEFF: So, I'm going to pile on. So I think, and it may be there already, but I think in terms of the guidance providing a clear definition of "review" versus "reconciliation" would be useful, because quite honestly I was thinking about it.

I could totally see your definition and I think it does make sense. But before I heard what you said, I was thinking of it in a very different way. I was thinking of "reconciliation" as you have more than one list and you have to do something to make that one list.

I thought of "review" as you have a list and you're reviewing it for clinically significant trouble that could happen for Jim's

patient who's on 25 medicines, but I don't necessarily need to go back and forth between two lists between settings. So, having that guidance would be helpful if it's not there.

I do think the feasibility issue may be a little bit different for home health compared to some of the other settings just because in these other settings at least in theory of medical provider/physician, MP is maybe on site rather than the physician in home health who is at a distance. So, that's an important feasibility issue to consider along with the continued development.

And I think also that clinically significant, you know, identifying that clinically significant event in the settings may vary as well.

CO-CHAIR RAPHAEL: Thank you. Let's go to Gene.

MEMBER NUCCIO: I wanted to share a couple of things. First, the items or variates of the items have been on the OASIS instrument

for several years, as Alan said.

The primary discussion among the multi-representative IMPACT team has included people from home health, from skilled nursing, from IRF and from long-term care. And the issues that we are raising here have been discussed at length at those meetings, especially the issue of what's the difference between medication reconciliation versus medication review.

And the general definition has been, as Alan suggested, that reconciliation is simply check box. The review is much more in depth looking at potential interactions for care coordination issues. The issue of timely initiation of care has been raised both -- because that varies from setting to setting.

The other thing that I wanted to point out that's not been pointed out yet is that the measure that's being suggested across these settings is a comprehensive measure in the sense that it looks not just at what happens to the patient as they -- the patient enters care, but

looks at the patient throughout the care process for the provider.

And that is a major change from many of the process measures where there's simply a check box that happens at the start of care and no reflection on what is the ongoing care that goes on for that patient.

CO-CHAIR RAPHAEL: Cari.

MEMBER LEVY: Thank you. Just two things I don't think we've talked about yet. One is -- basically two cautions. One is with the reconciliation, maybe I don't have the definition exactly right, so correct me, is to include the home drug regimen, because often the individual is going from home to hospital to one of these settings and we forget the home list.

And so, when they go back home, they're very, very confused about what has happened in the interim and often we don't know what they were on at home and a lot has changed in the hospital.

And the second is if what's happening

right now where I get a list from our clinical pharmacist, that's 17 pages long with all the clinically significant interactions between drugs, if I get that I can't make heads or tails of it.

And so, to the extent that we can be mindful about these reviews, that would be great and specific in the recommendations.

CO-CHAIR RAPHAEL: Thank you. Deb, did you want to say something?

CO-CHAIR SALIBA: I just wanted to ask a question. I mean, I think it's pretty clear that there is questions about significance and defining significance.

Do you folks have suggestions for what that might be that we could feed back?

CO-CHAIR RAPHAEL: Do you want to respond?

MEMBER THOMAS: Yes. And actually in the written comments that ASCP provided, there is in the skilled nursing facility and state DSOM manual, there is description of medication

regimen review and the term "clinical significance."

So, whether we would adopt that or not, but it does provide a little more elaboration of what that would be.

The number, I actually have it. I can send the -- send that to you all, but I think it's 463.60 in the section of the statute, but it is somewhere in there, but if you all find that and pull that up, but so I think that could be helpful.

And that actually was in the recommendations from ASCP as far as standardizing the terms, because it's gone from drug regimen review in skilled nursing facilities now to the term "medication regimen review." Are they the same thing, you know, refer to things in the same way across all of these settings?

And it's now by statute in, you know, for CMS for long-term care and skilled nursing facilities have the pharmacies provide a review, regimen review every month for every beneficiary

or resident.

So, I think that that could be helpful to use that. It's two or three sentences, actually. I believe that would help describe that.

I have other comments, but I'll wait. Okay. In terms of this issue of medication reconciliation being distinct from the drug regimen review, I think we really need to be very careful and actually do that.

I would consider medication reconciliation may be a step in the drug regimen or the medication regimen review that always would follow, you know, periodicity and follow up with depending on what circumstances arise with the disease states and the medication changes.

And it's not just a list to check off the box. It implies that there is, as Cari had said, there's several lists. There's a list at the pharmacy. There's a list at the patient's house. There's a list at the hospital where they came from and hopefully, you know, when they

transferred they got that list, but maybe that list is not even reconciled.

And so, the reconciliation piece is really complex and it's difficult making this whole process very difficult, but I would want to say we need to have a very distinct statement defining that process and maybe it is part of the measure.

And then otherwise in comments you made, Carol, as far as how prescriptive, I think we have some guidance from a current MTM TEP panel that's underway as far as some things that we can do to identify what the problems are and issues and they can be categorized so that it's not just a yes or no, there's a problem and then we've addressed it with the physician, but what the problem was.

And it can be as simple as a drop-down that could be added to the current perhaps elements, data collection and how we might -- how they might have been addressed as well on the physician, the prescriber side of how we address

those. So, I think those are important, too.

MEMBER WINSTEL: Thank you. To pile on both with some of the things that Bruce said, and also Cari, I'd like to say that getting the list of medications that are in the home setting is incredibly important.

And I'd like to see that home setting list incorporated into all of the other setting measures and to make sure that these measures as a group are harmonized across settings. And that there is something that refers to if the patient is coming to short-term rehab from a hospital setting, that we go all the way upstream in either reconciliation or review so that by the time they get to short-term rehab or skilled nursing, we're looking at both the home list and the hospital list and making sure that there is complete review, not using the word "review" literally in that point, but that we have everything.

Also, I would be remiss if I didn't say that sometimes the patient is not the best

one to report on what they are taking and that -- and to encourage input from the family caregivers if there is not a home health provider at the beginning of that patient's journey.

CO-CHAIR RAPHAEL: Liz.

MEMBER PALENA HALL: I would just encourage as reading through the comments, there are a couple comments on provider burden. And just thinking about how technology might be able to, you know, address some of the burden, I was considering communication as between, for instance, the home health agency or -- and the physician. There might be an opportunity there also just with the EHR being able to help with the process generally with medication.

MEMBER MULDOON: Related to med rec and medical regimen review, it seems to me that we should think about it as two steps. First, give me the list of reconciled medication. It's only when that has done, ask the physician and the PharmD, which is the level of expertise we're going to require on this thing, to say now that

you've got the list, think through very hard what could happen, do they need it, is it being effective.

Because although we have no debate in this room, I think, about why it's important and what has to be done, the debate will be about how do you do it.

And perhaps the experience in short-term hospitals who have gone before us can do that, but, you know, split out what we want for patients and what actually the tasks of the day will be for the pharmacist, the nurse and the physician, because that's where our stumbling block in implementation and rulemaking will be.

CO-CHAIR RAPHAEL: Paul.

MEMBER MULHAUSEN: So, I think my thoughts flow nicely from what Sean has said and I've been reflecting on Alan's comments about not wanting to be too proscriptive. I've been thinking about the public comments about what's the role of the interdisciplinary team here. And then I've been thinking about the ambiguity and

the numerator on measure specifications.

And so, my first thought would be that much of what we're looking at in the numerator is not necessarily tied to the drug regimen review, which I don't -- I'm not confused by at all. But one way in my mind to potentially operationalize the drug regimen review is to find who should do it, which gets at Sean's comments about, you know, who can actually take a review of the medications and synthesize that in the spirit of the review that Alan has described to us. So, that would be one way that I would like to try to offer something a little more concrete and potentially helpful to CMS.

The ambiguity around identifying significant medication issues during the course of care, in my mind, is not necessarily tied to the drug regimen review. So, we're asking two elements of this.

Take care of the problems that are found on the drug regimen review, as well as find the problems over the course of care and take are

of those, which, to me, introduces way too much ambiguity and I, quite frankly, think that CMS has struggled in its ability to define what is clinically significant.

We spent a lot of time trying to define what drugs aren't friendly to the frail elder. Out in the universe of physicians, that remains controversial. So, I think that simplifying the measure, focusing on the review process and who could do it might be helpful.

CO-CHAIR RAPHAEL: Jim.

MEMBER LETT: Thank you. Two things. One, I would certainly strongly support defining "drug regimen review" and "medication reconciliation," but an appendage to that is people in the community and, for the most part, post-acute care is a community sport, take a stunning array of things that are non-prescription, over the counter, their neighbor's pills, the dog's antibiotics because they had some left and they got a cold -- a vitamin supplement.

So, I would want us to expand our consciousness around that however we define those two entities to include nonprescription medications.

Second piece, I just took a wild stab in the dark at Deb's suggestion, what is significant in a drug interaction. And just some things that came to me is, one, they extend post-acute stay. Two, they require transportation to the emergency department or the hospital.

Three, they are forced to stop the medication as a result of those symptoms. Four, they caused -- symptoms which caused the patient to call their provider about them or interfered with their normal lifestyle or activities of daily living. And five, last, but not least, death.

MEMBER LEFF: Yeah, I just wanted to endorse Paul's comments. I thought those were very compelling. Sort of the compoundness of that numerator I thought that was good to point out.

Second, just a caution. Technology may ultimately help with this. But if my initial growing pangs with Epic even within a single system is any indication, right now the technology will in no way solve this.

MEMBER LAMB: Two comments. I wanted to elaborate a bit on the does this measure fill a gap in the program measure set? And to frame it just a little bit differently, but similar to Gene, which is in from the care coordination standpoint, and this is an element of important care coordination, is that right now many of our measures are kind of one part of the process.

Don Casey, who co-chairs, says it's one side of the handshake. This is, in my view, not only important content, but from a measurement science standpoint is can we really do closed-loop measures in a meaningful and feasible way. Because this measure has, as I think we're all saying, has multiple components that have to come together to get a positive on it. So, from a closed-loop standpoint this is

important work.

The other is what Paul was saying and I think the public comment, which is attribution. I think we're all saying that this measure doesn't get accomplished without lots of people being involved. And I really think it's time to pay attention to the attribution issue. So, it's very timely with NQF looking at this, because the closed-loop isn't going to happen.

And while the physician is a critical piece of it, it's also the appropriate physician for the complication and who else is involved in the process whether it be the pharmacist, the care coordinator, the nurse and so forth.

So, this is one that I think is important to pay attention to from closed-loop and attribution.

CO-CHAIR RAPHAEL: Two more comments and then move to a vote. Jennifer, did you want to add something? Oh, okay. Gene.

MEMBER NUCCIO: If I might share, there's a manual that's being developed,

instruction guidance for these particular set of three items.

And if I could share the current verbiage regarding clinical -- potentially clinical significant medications are those issues that in the care provider's clinical judgment require action by midnight of the next calendar day as the issues possess an actual or potential threat to the patient's health and safety.

Clinically significant medication issues can be the result of drug reactions, ineffective drug therapy, side effects, drug interactions, multiple drug therapy, medication omissions, drug dosage errors or non-adherence to prescribed medication regimen.

And then the instructions go on to define each of those kinds of things. So, for example, side effects could be potential bleeding of an anticoagulant, a drug interaction, serious drug-to-drug or food-to-drug interactions.

And indeed the point that I think I can remember either Bruce or Jim mentioned about

the over-the-counter medications, that would be included.

And we had a very long discussion about herbals as part of the medication -- self-medication that patients might do and those were included. And I will make no comment about living in Colorado for herbals.

(Laughter.)

CO-CHAIR RAPHAEL: You know, I think this set of four measures really kind of very much connects to our attempting to work on function, care coordination, safety and cost. I think it really crosses all of those lines.

I would just say that, you know, from having been in the home healthcare field, and this is just something that's going to have to be dealt with, when you go into a home and you see the number of medications from many specialists, plus over-the-counter, and now you have a new set of four medications from the hospital and you're trying to put all of this together, and then you want to call a physician and you have the

hospitalist who discharged and you can't get a hold of the hospitalist because you want to change your med, I mean, I think there are some real world issues here that are not insurmountable, but that we just have to be cognizant of.

I've seen a lot of issues and it goes back to, I think, Liz, how do we improve communication so it's really easy to problem solve in a coordinated and joint way, which right now it is not.

So, I think with that, let us move now to the vote. On all four of these -- oh, Alan, did you have an inspirational concluding comment for us before we go to our vote?

MEMBER LEVITT: No, it's not inspirational, first of all. Thank you. No, thank you all for your comments. I mean, this, you know, this is why we, you know, have the workgroup is to get this sort of feedback.

As Gene mentioned, this has all been discussed, these sorts of issues. And the

wording and the reason we've done what we've done is really to try not to narrow things down or to take so much time.

This is why Congress has set timelines for us on these measures, because we'd all be sitting here all the time discussing should we do herbals, should we do, you know. Everyone is going to have a different definition and way and thought about how to do this.

And meanwhile, we all know that these sorts of issues and items that I'm talking about here one day should be never events. They should be things that should not be happening.

Unfortunately, they do still happen and, you know, we're trying to develop measures that will hopefully help to influence behavior to try to help to make these really never events.

And as you understand, we really try to be giving each setting the chance to look at this. And our main reason is not to say, well, you did, you know, one thing and you did the other, but that, you know, you're doing it and

that you're really reviewing these records for these type of events and trying to prevent it from happening and not waiting for the perfect measure, which, you know, we will all define differently to come along.

But we do -- we really did -- we want to get kind of a consensus from the community, because we do represent what your viewpoint is on these things. And, you know, if the consensus is that you wish for us to continue the measure development, but really want much more or better-defined guidance as to what these things mean, you know, that's what we can take back from the Committee. And we do thank you for that.

CO-CHAIR RAPHAEL: We have a staff recommendation, and that is encourage continued development. I believe that's Number 1, if I can see far enough on the voting screen; is that correct?

MS. O'ROURKE: So, we actually have that for all of the medication reconciliation measures under consideration.

CO-CHAIR RAPHAEL: Right.

MS. O'ROURKE: So, we don't need to take a formal vote if no one has an objection.

CO-CHAIR RAPHAEL: Oh, okay. So, we don't need to use our little --

MS. O'ROURKE: Just pass by consensus. You don't need to use your blue clicker if no one has an issue with --

(Laughter.)

CO-CHAIR RAPHAEL: All right. Then we have approved encourage continued development for all four. And with that, we're going to take a 15-minute break.

MEMBER LEVITT: Can I just be sure -- I just wanted to be sure, Carol.

CO-CHAIR RAPHAEL: Yes.

MEMBER LEVITT: And so, the Committee as a whole feels that we should give further guidance. Is that kind of -- I'm getting the nods. Okay. Thank you.

(Whereupon, the above-entitled matter went off the record at 10:58 a.m. and resumed at

11:18 a.m.)

CO-CHAIR RAPHAEL: Before we resume our review of three measures under consideration having to do with discharge to community, during the break, a small group of us had a discussion with someone who is a member of the MAP Coordinating Committee, who raised a question which I wanted him to raise for the entire group.

DR. GIFFORD: My name is David Gifford. I work with the American Healthcare Association, but also on the MAP, also a measure steward, so full disclosure. The question that came up was on the MAP, when we develop these criteria, at least I was under the impression that the measures under consideration, when they were not fully specified, were following a different path.

It had the equivalent of sort of still being a measure that had to come back to the future to -- that it was not considered on the MUC list. Because once a measure gets considered, with or without consideration by the

MAP, it's on the MUC list forever, and CMS can then put it in any future proposed rule, without specifying why they addressed it. But if it's not endorsed -- sorry, not the word endorsed -- if it's not recommended through the MAP process, the measures, if CMS decides to put them in a proposed rule, they have to specify in the rule why they are putting a measure in that the MAP did not support.

It's sort of the discussion that you were having about why -- the details of the measures, if several committee members said, "If all these are going to be just encouraged further development, why do we really care about what the details are because they'll have to bring them back to us?"

I asked the question to Erin, "Does CMS have to bring them back?" The interpretation I got from Erin, and I think it's worth clarifying, is that measures that are not fully specified, that get a vote of consensus that they encourage further development is the equivalent

of a fully specified measure being recommended with no conditions.

Then CMS is on the MUC list, and CMS can then put it in the rule. I guess I would like to clarify that because I also had heard from several other people that was not the case. I think that would change the nature of the dialogue and the discussion, and certainly it would change how the MAP views the comments that come from this group back to the MAP in January.

MS. O'ROURKE: I can start, and then I'll look to Alan, if you could help us clarify how CMS uses some of these recommendations. We had developed the two pathways when we had started getting measures that were earlier and earlier in development.

MAP had expressed a desire to not vote down, if you will, innovative measures because they were still going through the development process. We came up with this alternate pathway, the measures under development pathway, where you'll see the recommendation of encourage

further consideration or do not encourage further consideration, or encourage further development, do not encourage further consideration.

However, we cannot require CMS to put a measure back on the MUC list and bring it back to MAP. The guidance of that pathway is that ideally, they would do that, but our understanding is that we cannot require that of them. So I'd ask if Alan or Tara could clarify that a bit.

MEMBER LEVITT: I'll start first. That's true. I do think that the first measure that we just talked about, the issue wasn't the actual measure items and specification of the items, but was the guidance to be given for those items. We certainly will use the MAP's recommendation in our future development of this measure.

Certainly, the IMPACT Act and the timelines that Congress has specified for measure development are timelines that are tight, that, as you mentioned, specifications changed even

from when they first came in until now. We've done testing on many of the measures already, and we're continuing that and really do value the MAP process and the recommendations and suggestions that the MAP does give us, and we will continue to do that in our measure development.

But in addition, we also do have to continue to look at the statutory guidelines that are there, in terms of the measure development, and work within those guidelines, while using all these resources we luckily have.

DR. GIFFORD: So that means the answers you don't have to bring them back, you consider them supported by the MAP process when they went through that boat? Because there is a statutory requirement that if it's not supported by this -- and the statutory requirements are that you meet certain timelines and go forward, you can say that in the proposed rule and put it forward and say, "We're putting it forward even though the MAP process didn't support it because it has to meet the time frame and everything

else there."

DR. MCMULLEN: I think what Alan was delineating was that CMS has our marching orders by Congress to develop quality measures for the IMPACT Act, and to standardize those quality measures by a specified application date. In this case, the specified application date for this quality measure, for IRFs, LTACs, and SNFs is 2016.

So we go through the pre-rule making process to be able to receive the input by the MAP, so that we can, in the process of doing that, propose this measure in our NPRMs. If the measure did not receive favorable input by the MAP, of course we'd probably put it back on our MUC list, as we do appreciate this process. It's quintessentially a part of the pre-rule making cycle.

DR. GIFFORD: Probably put it back on the list?

DR. MCMULLEN: Well, these are discussions that we would have to have with our

leadership. That's it.

MEMBER LEVITT: As you know, last year, for example, we had an ad hoc MUC list that was done at a certain time because we needed to -- but like I said, we appreciate support. Certainly, the first measure that we just discussed, we heard the support for the specifications and for the idea of the measure and to continue the development with these recommendations for the guidance. We're going to take these recommendations back, in terms of looking at it.

DR. MCMULLEN: May I add that this measure is fully specified. We have posted the specifications for this quality measure on our CMS website for public comment. We've had technical expert input. The specifications, actually, as they live, you can go Google our public comment page. They're there. We are in the process of finalizing the summary document and posting -- I believe that summary document was just posted for medication reg. We're moving

through the development phase. We're getting ready to pilot the measure to test out the feasibility of the items, in terms of the coding. We're moving through the development as it stands today.

Originally, when the measures under consideration list was open, there weren't full specifications for the measures. That was simply because of the timelines in the pre-rule-making cycle, which is a bit out of CMS's hands. We can't really comment to those timelines.

Per an agreement with the National Quality Forum, we actually updated the MUC list and put full specifications. Whether those specifications were commented on the NQF public comment is not my job, but we actually -- CMS actually did provide those specifications.

DR. GIFFORD: I guess I would encourage the workgroup to maybe go back and look at the voting criteria that you have for measures under consideration because I don't think this fully was laid out. I think it may change the

amplification comment discussion that may want to occur given this feedback.

CO-CHAIR RAPHAEL: I'm going to ask the operator to open the lines for any public comment.

OPERATOR: At this time, if you'd like to make a comment, please press star, then the No. 1. There are no public comments at this time.

CO-CHAIR RAPHAEL: Let me turn to members of the audience. Please introduce yourself, and we welcome your comments.

MR. BAIRD: Thank you. My name is Andrew Baird. I'm from HealthSouth. We are a large post-acute care provider, primarily in the rehabilitation hospital space and the home health space.

My primary comment around this measure -- and I appreciate all your time and consideration of these concepts and, like you said, balance is of the essence in these discussions -- we know that in the law, the term

was discharge to community, and that the measure is actually structured so that it said discharge to community plus staying in community for 31 days. I'm not necessarily going to speak about that distinction between the law and the specification, but I do note that it is an additional re-admissions measure, essentially. This is a measure that is a discharge to community for people who go home, and then stay home.

That is already encapsulated in at least two other measures that rehab hospitals already report on. My ultimate comment is that under public reporting and the discharge planning requirements, the rule that was recently released by CMS, the idea of sharing quality data, in fact, IMPACT Act data, with patients during their discharge process, I'd just like to underscore the fact that the different flavors of essentially the same population that may be delivered to the patient and what efforts are being made to make sure that those numbers are

distinct from one another?

For example, there is the all-cause unplanned re-admission measure, which captures everyone who comes back. This measures people who come back who went home. There is a potentially preventable re-admissions measure that is being developed that will track certain diagnoses and who those come home. I'd just like to underscore the fact that if these are essentially two or three, or sometimes, even, in some cases, four measures -- for example, in rehab hospitals, we also have a within-stay measure that's being proposed, as do other post-acute care settings -- that there be some effort around the idea of what it means to distribute or indicate to the patients what these different measures about re-admissions mean.

Because while it's called discharge to community, I believe the measurement specification that is discharge to community within -- and staying home within 31 days is actually a re-admissions measure. I just want to

underscore that. Thank you.

MS. KEEFE: Good morning. My name's Alyssa Keefe. I'm with the California Hospital Association. We also represent post-acute providers, including SNF, LTAC, IRFs, and home health agencies. Appreciate the opportunity to comment. I first want to commend NQF staff on the materials for these workgroup meetings. I have been here since the beginning, and we had volumes of paper this thick. This online discussion guide is tremendously helpful because one of the key goals in the MAP process was to engage providers early about what measures CMS was considering, so that they could get an early indicator and begin to prepare for implementation of these measures.

I was able to open my screen, click on measure specifications, go to CMS technical expert panel documents, and share these measures with providers on a series of member calls that involved over 100 hospitals and post-acute care providers last week, so I just want to commend

the staff for the tremendous work because I think that was one of the key goals of the stakeholder engagement.

Second, just to the process point earlier, I would encourage the MAP to continue on measures that have not been fully brought forward through the NQF process and technically, I think, in this process, the ones for the IMPACT Act are still considered under development. We have not seen testing data. We have not had them all piloted yet. And then encourage continued development, I believe is an appropriate recommendation for this group because there are other measures that will be considered in quality reporting programs that don't have the accelerated timeline of the IMPACT Act, where you really do need to assess is it ready for inclusion because there may actually be additional time for that consideration and could be prioritized against additional measures.

So I would just offer that the staff recommendations on these measures that were all

just put out for public comment over the last few weeks is an appropriate recommendation. Then lastly, just briefly, on the discharge to community measure, this measure is well underway in development. We have providers that stand ready to pilot test some of these measures if CMS would like some additional providers to do so.

But one of the things that we learned in the re-admissions measures is that discharge coding -- discharge status codes on claims are a challenge. When we implemented in the hospital re-admissions penalty program, we had to add discharge codes to appropriately account for the planned re-admissions. We believe there are a number of factors that could be considered by NUBC for updated education and refinement of the discharge codes. With that, I'll leave my comments to the comments that have been previously submitted to the TEP that I know CMS has, and appreciate the opportunity to comment. Thank you.

DR. KOENIG: Good morning. My name is

Lane Koenig. I'm director of policy and research for the National Association of Long-Term Care Hospitals. Thank you for the opportunity to make comments this morning. I should say National Association of Long-Term Care Hospitals represents about 80 long-term care hospitals throughout the nation. We've got some concerns regarding the discharge to the community measure, particularly as intended in the IMPACT Act as a cross-setting measure.

Long-term care hospitals are acute-care hospitals, they meet the requirements of an acute-care hospital. For the very sick and ill patients that are treated in long-term care hospital, the goal is not always to send them home because that might not be an appropriate setting for these sick patients, but it's to get them to the next level of care and appropriate level of care. Discharge to community, the way it's currently constructed, if implemented, we have concerns that it would create incentives that won't be in the beneficiaries' interests if

really where they should be going is to a lower-level care, they're not quite ready to go home.

What makes this a unique problem for long-term care hospitals is, as I said, because they are acute-care hospitals. Therefore, once the patient no longer needs acute level of care, then they need to go to the next appropriate setting. That may not be home. Thank you for the opportunity to comment.

DR. GIFFORD: I'm David Gifford from American Healthcare Association. We think this is a very important measure. It actually aligns with our national quality initiative goals, so we would like to see this implemented as soon as possible, but we have some concerns about the measure that should be continued development and probably are not ready for rule making because of the specifications. In particular, our concerns are similar to the previous one, commenting on Measure 462 and 523, by the way, both the home health and the SNF, that the way the measure's

currently constructed, it double counts admissions to different providers, so individuals who go to an IRF, and then get discharged later from an IRF to a SNF or home health, are counted in the SNF and home health, as well as counted in the IRF measure, so there's a double counting of admissions.

It also disadvantages home health and SNF, in that individuals discharged from IRF and LTAC to a SNF and home health, they couldn't go home because they usually are sicker, regardless of risk adjustment, you're enriching the sample for home health and SNF, who are not going to be able to discharge home. The intent of the IMPACT Act is to do cross-setting comparison, so we think that definition is not dissimilar.

I think the other aspect is we don't believe it's fully specified. This is going to be based off of claims, and it's going to require ICD-10 codes, and we don't know what the ICD-10 codes are. The risk adjustment models are not specified, just categories of variables are

specified out there, so we don't think it's ready for full specification. We think that the exclusion, or not counting individuals who discharge home who die in the next 30 days, is going to create a disadvantage to the care of getting people home, to die at home, but encouraging people to die in an institutional setting. So we would encourage some way to include deaths in the next 30 days as a successful discharge home, if it's within hospice or some other aspect to do it.

We also think that individuals who are discharged home, who are re-admitted to a SNF within the next 30 days, should not be counted as successful discharge back to the community. Right now, they are counted as a successful discharge. Risk adjustment, there's no risk adjustments for sociodemographic characteristics, I think something that NQF has said very clearly they need to be identified.

Functional status, probably the single most important predictors of being discharged

home, and cognitive status, are excluded from the measure because it's a claims-only measure, when that information is available in the new PAC assessments with Section GG and the care tool. We would say that those individuals really need to be included. Last is the risk adjustment variables differ between settings, which makes some sense, but in many areas of the country, there are no LTACs and IRFs, and the SNFs provide the same level of service. Therefore, the risk adjustment for IRF and LTAC should apply to the SNF, as well, and have the same characteristics across them all. Thank you very much for that.

CO-CHAIR RAPHAEL: All right, is there anything that's come in on the chat room?

MS. IBRAGIMOVA: Not at this time.

CO-CHAIR RAPHAEL: Okay, thank you. I'm going to turn it over to Sarah to provide a brief overview of the discharge to community measures and the staff's preliminary analysis and recommendations.

MS. SAMPSEL: Certainly, thank you.

As with the last set of measures, this is a set of four measures across the different settings of care, home health, inpatient rehab, long-term care hospital, and the skilled nursing facilities. These are outcome measures. All of the staff recommendations are encourage continued development, based on the information that we received as to their current status. They all address the impact domain of discharge to community, and we do know that CMS is in the process of testing and fully specifying the measures, and that they are based on claims data. We find that in one of the criteria for NQF preliminary analysis on determining if the measures would be valuable to any setting have to do with are they outcome measures, and are they really driving us toward improved care?

Those ratings were included, as we did find these to be valuable measures not only because of being outcome measures, but because they do address not only the IMPACT Act domains, but also national quality strategy and

understanding what the next steps of care are, as well as alignment across settings.

CO-CHAIR RAPHAEL: So let me turn to Alan and see if you want to make any comments on this.

MEMBER LEVITT: Okay. First of all, once again, thank you for the comments that were made and for the summary of the measure. I think first and foremost, we have to remember who these measures are really for. These are measures that are not just to be implemented at a certain date, but within two years, are to be publicly reported. This is information that consumers, patients and their families, want. When Congress looked at this, it felt that a discharge to community measure was important, the idea of somebody who's entering a certain setting would want to know what percent of patients go home and stay home a month later from that setting.

That's very important information. Re-admissions are a part of that. I used to run an IRF. Patients come into my rehab hospital,

they don't all go home. They end up going -- transferred to acute care. They end up going to a lower level of care. They may not go home. Those patients are still in this measure.

Patients who do go home if, unfortunately, they pass away and they are not discharged to hospice, which is an exclusion in this measure, they would also, then, be included in the measure. Re-admissions or potentially preventable re-admissions are very important. They should be reported, but they are different than this measure. This is a measure that, as we mentioned -- I'll now say it for the 24th time, I think, IMPACT Act measure -- IMPACT Act resource and use in other measures are measures that are to be claims based, and may also include standardized patient assessment data. At this point, claims are the information that really is available to use for this type of measure.

The claims are being used, and the methodology for this measure is methodology that's been successful in other claims-based

measures used in hospital programs and the post-acute care setting. It has been a successful methodology. I'm trying to think. Discharge codes, we're trying to get some other information. I do know that from looking at 2013 data, the agreement was 98.8 percent between the claims and the IRF-PAI discharge.

We can get the other settings if the workgroup wants. We are, with all of our claims-based measures, looking at the conversation of ICD-9 to 10, trying to work through those, so that we can accurately represent patients as we make that conversion. As what's already been mentioned, SES is really important to us. We are concerned about that. We obviously don't want to report adversely on measures for settings that have their mission to take care of patients with lower socioeconomic status. We are participating in the NQF projects that are going on and looking at other factors that we may be able to use in our measures. Duly eligible we are using for now, and we're looking

for better things.

We're also looking towards part of the IMPACT Act, mentioned now 30 times, is ASPE. ASPE is doing a project with SES, as well. Those are additions that we look forward to adding to this measure and to all of our measures. I'm not sure if I addressed everything.

CO-CHAIR RAPHAEL: All right, thank you. Now let me ask workgroup members if you want to pull any of the measures from the consent calendar that we're reviewing?

(No audible response.)

CO-CHAIR RAPHAEL: Okay, if not, we're going to begin a discussion. Let me hear any comments or issues that any workgroup member wants to raise in regard to the discharge to community measures. Suzanne.

MEMBER KAUSERUD: Thank you. I had the honor of serving on one of the technical expert panels for this measure, so I have a little bit of knowledge of it, as well. One of the things we really struggled with was the

definition of discharge to community. One thing that I don't see that has been resolved and did come up in the public comments was that a discharge to home as the residential setting of a skilled nursing facility I don't believe truly meets the intent of discharge to community.

Yet with the claims coding, that is something that occurs. If you are in a skilled nursing facility in the residential portion, so I guess not the skilled portion, you go to acute care, then you go to the skilled nursing portion for a little bit of rehab, and then you're discharged back to the residential section, that's considered a discharge to community under the coding there.

We discussed in the workgroup that for inpatient rehab, any discharge to a nursing facility, whether it's skilled or residential, we generally code as skilled nursing facility. That was the first time I'd ever heard it discussed and realized that hey, it should maybe be a different code. I think there's some

inconsistency in how those codes are applied, as well, that creates some confusion. But I think the main point I'm trying to make is the codes that are available, the discharge codes that are available now, and the way they fall in the measure, someone discharging back to the residential portion of a nursing home would be counted as a discharge to the community. I just don't feel that meets the intent, or that it would be clear to the consumer when they're looking up this information online.

MEMBER AGOSTINI: Hi, thanks. I have a couple comments and a question. The first question, maybe to Alan or others, is the measure specifications are not complete, in terms of the risk adjustment, and I'm not sure if they're available, if that was articulated, and we just didn't see them all, in terms of SES and functional status and things that I think are terribly important, or are they not fully developed? So that was my first question.

MEMBER LEVITT: Yes, they should be in

the public comment documents. I can try to find them for you.

MEMBER AGOSTINI: That would be good. Because I do think we need to spend time thinking about making sure they're in alignment with the other re-admission-type models that previously exist.

The other comment I would just make is I do share the concern about the previous public comment that I really encourage the continued development of the measures, but I do have the concern for public -- consumers, families and caregivers on differentiating, as someone said, across these measures, planned re-admits, all cause re-admits, and then the discharge to the community measure.

I wholeheartedly believe in the concept, but I do think we're going to have a difficult time explaining to people, and I worry that people will cherry-pick measures that they want to emphasize, whether it's a planned re-admit rate or all cause or discharge to the

community. I just urge us to think about that on how the transparency of these measures would ultimately be received, and could we provide more clarity to, ultimately, patients and consumers who will be looking at these measures.

CO-CHAIR RAPHAEL: Liza.

MEMBER GREENBERG: Yes, hi. We had submitted some comments to the contractors, as well, so I'm sure some of these are already in the pipeline. We felt like this is where so many measures coming out at the same time really show that there's a need to make some cross-cutting decisions about how risk adjustment will be applied, how the re-admissions will be considered, I have concerns about the multiple countings of re-admissions, it gets captured in many measures, so the same emergency could potentially be dinged multiple times.

With this particular measure, the denominator for home health was different than from the other PAC providers. It included patients who had not had an inpatient stay prior

to admission to home health, which does it make it a different measure.

It's possible that population behaves just like the population that came from an inpatient facility, but we don't really know, so if we could see some data about that or the measure with the same denominator. If we're going to be using it for comparison, that would be important. Then we had one other concern about potentially having unintended consequence of reducing referrals to hospice because there's more of an emphasis on having people not discharged and bounce back to an inpatient facility. We think that exclusion should be anybody who's admitted to hospice at any time during that 31-day window, even if they go from the community to inpatient and back out to hospice, they should be excluded because we don't want to discourage hospitals from discharging to hospice.

MEMBER ROBERTS: Just a little bit of confusion. In looking at discharge to the

community, if you add the 31 days, you're really looking at the durability of outcomes of keeping somebody out in the community, which then does have an impact on the re-admission measure.

If it's really just a measure of looking at discharge to the community, it might be better to keep it separate than adding those 31 days. The other piece that hasn't been mentioned is discharge to the community has a lot to do with social support, and that may need to be considered in that.

MEMBER MULDOON: Perhaps the people who worked on the details of this could answer this. All post-acute settings will have, but particularly LTACs because they already have, a highly skewed outlier group. How do we solve the double bind that encourages us to have a high discharge to community rate, which means keep someone longer -- so long that they can go directly home versus the downside of that strategy is that it drives up costs.

It increases length of stay in a

fairly high-risk setting, and that puts us at some risk from retrospectal denial, instead according to traditional criteria. You didn't need to be there anyway. Why'd you keep them the extra five days?

MEMBER LEVITT: I didn't know how you wanted to do this, Carol, in terms of having more comments or whatever. I can go through some of them right now if you want.

MEMBER PALENA HALL: My comment was more around the SES conversation. I just wanted to point out that ONC recently published, later in the fall of this year, its updated 2015 certification criteria and standards. Part of that includes certification criteria and standards around capturing race and ethnicity data, as well as other social and psychological and behavioral data. That would include items such as financial resource strain, stress, depression, physical activity, alcohol use, and social connection and isolation, which might be relevant to some of the SES conversation, so just

wanted to make you aware.

CO-CHAIR RAPHAEL: Alan.

MEMBER LEVITT: First of all, to start, again, this is a measure that Congress has mandated to be done. It is claims based. We build our house with the Legos we have. I mean Legos because they're all -- some of them are attached to other Legos. You can't take off one Lego without waiting for that Lego to do something else with another Lego. You end up building it the best you can, and we've done that.

We've done that with our other measures. In terms of acuity, Sean, obviously we try to handle that, in terms of risk adjustment. We do always worry about unintended consequences of all of our measures, what's going to happen, in terms of behavior. But again, this is information that Congress feels -- and patients' families want to know are they going to be able to go home from a certain setting? Certainly, that setting can also explain why they may be

best served not going home right away and to go somewhere else, in order for them to continue to get better.

As I'm saying, this is a measure we're using for reporting and reporting to the public. The issue with nursing home, it's true that because we are using claims, and we are using the code, as Suzanne mentioned, patients who are either short or long-stay nursing home residents that are discharged to a hospital, and then they come back as a SNF patient, and then they get discharged from the SNF to the nursing home, will be counted as being discharged to the nursing home.

How do we handle that? Well, a couple of things. One is when we report this measure, we can certainly -- our reporting of the measure, as we do with measures, in terms of explaining to patients and families what that means, particular in a nursing home setting, that this does also include nursing home residents who are discharged back to the nursing home. So there's an

explanation that's given. Secondly, there are certain nursing homes that do have a higher percentage of patients that tend to get transferred back to the acute-care hospital.

This measure indirectly may be able to also recognize that there are certain nursing homes that are doing that because they'll have such a high rate of their residents that don't go home because they're back to their place of original residence. Again, that's a limitation of claims.

As we continue to build our measures with the Legos we have, we can continue to look at that with the advice of the entire community as to what we should do. Sorry, Liz, I forgot the issue with home health. What was that again? Very important issue.

For those of you not familiar with home health, home health is an unbelievably heterogeneous group, goes anywhere from a couple of patients a year to thousands, tens of thousands of patients. When we're sitting around

building our measures, we're trying to figure out how can we include the largest group of home health agencies, so they can be reported upon, and also reported upon fairly? The referral into a home health agency comes two ways. They come from a hospital, and then they also come from the community. I forget the exact stats, but it's about 50 percent or more, actually, are community referrals that come in.

If we went ahead and we did not include the community referrals and just used just the home health patients that came from hospitals, we would have probably -- I think it was about 44 percent of the agencies, even if we used three years' of data, that would not be able to report on this measure. By including all the patients and doing the best we possibly can to risk adjust -- because you're absolutely right, Liz.

For the most part, they are different types of patients. I do have stats of what the differences are in their discharge rates, and

they are different. But what we do, like we always do, is try to account for that difference within our risk adjustment and, therefore, allow to be able to report on as many agencies as we fairly can. I'm not sure if there was anything else.

CO-CHAIR RAPHAEL: Tara, did you want to jump in?

DR. MCMULLEN: No, just to add to Dr. Levitt's responses, we sent the specifications and the risk adjustment model to Catherine. Catherine, I emailed that to you. In the email, I also listed out the risk adjustment and the adjusters, highlighted the three adjusters for function. LTAC is the only setting that we do not currently have adjuster for function in our risk adjustment model, but we're moving in that direction, undoubtedly. So if anyone's interested, that information, Catherine has that, if she wants to disseminate to the group, or it's on the CMS website.

CO-CHAIR RAPHAEL: Okay. I'm going to

ask Kim and Gene to be quick in their comments because we need to move to a vote, so Kim first.

MEMBER ELLIOTT: I'll be really quick. My only concern, when I look at these measures, is that it might incentivize behavior that we don't want. I know that there's a risk adjustment model, but I haven't seen a lot of the detail of that, so I will go to the CMS site to look at it. I'm concerned that perhaps then we will see facilities perhaps not wanting to accept some of the patients that aren't necessarily ready to discharge home or will be more challenging to discharge home. I guess that would be my comment.

CO-CHAIR RAPHAEL: The last comment on this.

MEMBER NUCCIO: I'll be quick. I have three psychometric concerns. One is in addition to the risk adjustment model, the rationale for choosing to use a numerator that's a risk-adjusted estimate of performance, and then several other risk adjustment kinds of values in

that particular metric.

The second has been brought up, the difference in denominators across the multiple settings. The third is sort of an overarching issue. That is one of the goals of these measures is to be publicly reported. I am very concerned that with all the exclusions that are being presented across these measures, we're going to have a very accurate measure on a very small portion of the population. That's my third concern.

CO-CHAIR RAPHAEL: All right.

(Off mic comment)

MS. O'ROURKE: That is correct. If no one has an objection to the staff's preliminary analysis of encourage continued development, there's not a need for a formal vote at this time.

CO-CHAIR RAPHAEL: We are going to go on to the next category, which has to do with potentially preventable re-admission rates. I think there are five, if I recall, measures under

consideration, so let me turn to the operator to open the lines for public comment.

OPERATOR: At this time, if you would like to make a comment, please press star, then the No. 1. No, no public comments at this time.

CO-CHAIR RAPHAEL: Thank you. I'm going to turn to the audience. Is there anyone in the audience who wants to make a comment on this? Anything in the chat box?

MS. IBRAGIMOVA: No, not at this time.

CO-CHAIR RAPHAEL: Okay, so Sarah, I'm turning to you to give us an overview and the recommendation of the staff.

MS. SAMPSEL: Sure. There are actually four measures here, and again across the same settings of home health, inpatient rehab, long-term care and the skilled nursing facilities. Again, these four measures were put on a consent calendar for the IMPACT Act. Again, the domain would be the potentially preventable hospital re-admissions.

These are all safety measures, as well

as kind of overarching measures that address a number of national quality strategy aims that I think the industry has been trying to go towards for some time. These are measures that the staff have recommended, continued, or encouraged continued development, based on where they are in development and getting their specifications finalized and going through the public comment period.

These are all outcome measures, and they are similar to currently endorsed measures, so you should have found some notes in your discussion guide based on the endorsement process for those similar measures. I think the other thing that I would just mention, again, is this is part of, with the IMPACT Act, encouraging alignment across the settings and summarize, again, that our recommendation is to encourage continued development and seek additional input from the MAP workgroup on this.

CO-CHAIR RAPHAEL: Alan or Tara, do you want to comment on this?

MEMBER LEVITT: Well, first of all, I want to introduce Dr. Joel Andress. He used to be here for ESRD, and we've lost ESRD, but we still get to keep Joel, so we're very lucky. He's part of the workgroup. I'm very interested in the committee -- the committee has questions and stuff, certainly Joel and I are both available for it.

It's a similar type of description, a similar type of rules of engagement, so to speak, of what we are able to use and how we end up designing these types of measures. Again, we've successfully done these type of measures in other settings for re-admissions, and now we've gone to the potentially preventable. Did you want to add anything, Joel?

CO-CHAIR RAPHAEL: Let me turn to the workgroup and ask if any workgroup member would like to pull any of the measures on the consent calendar? All right, then let me open this up for discussion. Suzanne?

MEMBER KAUSERUD: A few things that

applies to this measure and some other measures. I very much so appreciate, having an 11 year old and a 15 year old, my stepsons, at home, I very much appreciate the Lego analogy. It makes a whole lot of sense.

I think there's -- again, looking at just claims data when there's such a rich dataset out there with the other patient assessment instruments, I hope that we will be able to move, in the future, to be able to use some of that information that's also collected off the IRF-PAI or the MDS or the OASIS.

Because having additional information about functional status, intended discharge location, admission location, where they come from before the acute-care stay, cognitive function, the different complexities would be valuable in this case and others -- or in this measure and others. Additionally, potentially preventable is kind of problematic just because, again, running off the claims data, if we have a spinal cord injury tetraplegic who is

unexpectedly admitted to acute care from inpatient rehab for autonomic dysreflexia, the acute-care claim is unlikely to say autonomic dysreflexia. It might be hypertension or something on the admission there. In this scenario, something that we might not have been able to prevent at all would look like a preventable admission.

There are other areas, like -- what's one that we talk about a lot -- the DVTs being linked to inadequate prophylaxis. We're finding -- and I think there's literature out there to support it, as well -- that sometimes even when you give adequate prophylaxis, you end up with a DVT or PE in a certain percentage of the population.

So there are some areas that might have small numbers associated with them, but could have an impact, particularly for smaller providers, if they happen to have one case. I think those are the key points that I wanted to make. Oh, actually I did have one more question.

I guess just to clarify -- sorry, I'm looking at my notes -- if you could clarify your intent about replacing the existing IRF QRP measure with this one, or will there be two re-admissions measures in the quality reporting program?

CO-CHAIR RAPHAEL: Jim.

MEMBER LETT: Thank you, a couple of things. You can cut me off and I'll come back later if they get too many. Trust you on that, please -- or trust me on that, that I will. A couple of things. One, I always worry about collateral effects, unintended consequences in a measure like this.

We have to think about, No. 1, emergency department and observation state visits. Maybe you drive them up as you drive down 30-day re-admission rates. Secondly, more risk adjustment, particularly socioeconomic status that has such a massive effect on quality indicators. I would anticipate it'll have one on transitions, but I have not seen, personally, data on that.

I worry that unless you really, really risk adjust, you're going to see facilities decline complex medical patients coming to their facilities if it's going to look very bad on their re-admission data, particularly in rural and urban areas, where there may not be an IRF or an LTAC available, and they may, generously, to keep people in their communities, take really high-risk, complex patients, and unless they're risk adjusted for that, there may well be a problem. Second thing is, again, the definition of community, and we have to resolve that. The third thing, to me, comes -- and I will speak to the SNF measures, not the home health one, because I don't really feel I'm deep into that, but I feel comfortable in the SNF area.

I'm concerned about double jeopardy because when you look at 497, that is a potentially preventable within the stay re-admission measure, but you're also going to be judged -- and forgive me, I don't have the number. You're also going to be judged on 30-day

re-admissions, so is there a potential double jeopardy in terms of one re-admission counting against two measures?

I'm still unclear about assignation. That is if a patient leaves the acute hospital with a three-day qualifying stay, who then goes to a SNF and stays a relatively short period of time, that patient is discharged to the community with a home health agency, and then that patient is re-admitted to the hospital within a relatively short period of time, is it really the SNF's fault? Should they be assigned "the penalty" because they, in good faith, completed their treatment, handed them off to another member of the post-acute community.

I'm not saying there's any fault involved, but when you have let go of the patient, handed them over with a warm handoff, how can you control the re-admission to the hospital if someone has left your facility a week prior? Those were -- socioeconomic status we talked about.

I'm sorry; I'm looking at my notes. Oh, on 496, potentially preventable 30-day post-admission re-admission measure, one of the exclusions is patients who are transferred to the same level of care or a hospital at the end of their IRF stay. There is the same exclusion under 498.

I didn't just technically understand why they were excluded. Aren't those re-admissions? The last, but not least, is the potentially preventable definition, which I think is really the devil in the details. I assume we're talking about the ambulatory sensitive conditions that MEDPAC came out with a number of years ago. I'd like to hear a little bit more about what's preventable. Thank you.

MEMBER ROBERTS: Within that IRF measure, question. If that is a re-admission, now they have a new one for within the IRF measure. The IRFs already have a financial penalty for people that are going back to the hospital, so that would be a double penalty for

them, so that should be looked at.

CO-CHAIR RAPHAEL: Lisa.

MEMBER WINSTEL: Thank you. Just a quick comment. With all due respect to Dr. Leff, the handoff to home health issue, it could also be that perhaps there was a premature discharge, so that needs to be looked at from both sides.

I'm also wondering if there is some way, on the home health measure, to take into account the number of contact hours that were part of the home health benefit. A re-admission based on a home health benefit that is just six hours a week that have not occurred yet, and there is a re-admission in that interim time, that home health agency should, perhaps, not receive a penalty if the prescription and recommendation for home health was insufficient.

MEMBER MULDOON: In the spirit of QI, I want just everyone to recognize that the providers will not know this rate until we're told by CMS because we have no way of doing that follow up. In order for us to do any QI on this

number that you will tell us, we're going to need to know who the patients were, where they went, so that we can then decide did we send them to the right place or the wrong place. Otherwise, we'll just read them and weep, not be able to act on it.

CO-CHAIR RAPHAEL: Liza.

MEMBER GREENBERG: With this measure, in particular, I feel like we're taking the term potentially preventable to its furthest extreme because we really have gone beyond where the evidence falls on what's preventable, particularly in home health, which is the sector I'm commenting on.

There really isn't any strong evidence about what happens 30 days after a discharge from home health, and there could be so many intervening interactions with that patient. To the extent that we do know how to keep people from having re-admissions, it's really condition specific. We've taken a population that we -- or a setting we don't much about, post-discharge

from home health, and added it to the conditions of interest very substantially. We know the most about CHF and certain acute conditions, but less about the pretty broad portfolio that are in this measure. I have some concerns about the strength of the evidence for the full continuum of the measure.

MEMBER GRANT: I guess I just want to build on this question and concern about potentially preventable. I'd like to know if it's tied to very specific diagnoses and those diagnoses are evidence based, if they are the same diagnosis across all settings.

CO-CHAIR RAPHAEL: Building on that, as I sort of thought about this, one of the issues for me is in home health care, you rarely get someone with one diagnosis. Even though they come in because of COPD or CHF, they have three or four other key conditions that they're grappling with. I think one of the challenges will be how do you separate out what's attributable just to that COPD episode and what

is not attributable to that COPD episode in the real world. I think that's one thing that I think gets tangled up. The other for me that gets tangled up is that so much care in home health is also provided by caregivers, who are a very broad group these days.

And so, if they don't know how to flush a catheter, or they haven't really been prepared well for what can be difficult medical tasks, or they just haven't been instructed on what you can expect as side effects of medications, very often, their default position, they panic, and they just call 911, in our instance, and the person lands back in the emergency room. So it's how to prevent that default from occurring. Not that we can -- any kind of measure can, in fact, deal with all of those, but I think we do need to be mindful of some of those issues as they play out. So now to you, Alan and Joel.

MEMBER LEVITT: I'm going to pass it to Joel, and then Joel can pass it back.

DR. ANDRESS: Can I do that right now? Actually, I want to kind of address on one very particular issue before we get started. I believe we have RTI on one, and we've got Abt, which is another contractor that worked on the measure. I'll actually begin with discussing the technical specifications on how we define PPR. But we essentially had a list of diagnostic codes that were viewed by our technical expert panel in order to identify what codes were likely to reflect a re-admission that was potentially preventable.

To the issue of preventability, in general, I think it's important to note that this was an early and quite vibrant discussion within the TEP. I'll say not necessarily in the direction that I was anticipating, given the feedback I've gotten in other -- among other groups on re-admissions.

Also they had some trepidation on the very concept of identifying a potentially preventable re-admission measure, particularly

using diagnostic codes since, of course, diagnostic codes are neither designed nor built for the purpose of identifying preventability. Though, if we implement these measures, that thinking would change.

I think the issue is that it's not condition specific in all ways. Some things are certainly condition specific, in terms of the clinical care you're providing your patients, but it's also process specific. How is the flow of information being handled as patients are moving from one setting to another? In that case, I think to some extent, you could make an argument that most re-admissions are potentially preventable within that framework.

Now does that mean that, from a particular set of diagnostic codes, every re-admission would have been preventable by the facility if only they'd done their job better? I think that the answer's probably no, and that's why we originally developed the all cause re-admission measures, because we recognized

there was going to be some fuzz, and they were designed to deal with what we thought was generally distributed noise within the measure.

There would always be patients who were unpreventable, to one extent or another. I think the concept of preventability, therefore, has been addressed pretty broadly in the development of the all cause measures. I just wanted to make the point that it's not -- I don't think it's really, and the TEP, I think, was generally supportive of this, it's not about the condition. It's about the processes that occur as you're treating patients with the condition.

The fact is that some processes are common across most, if not all, conditions that patients are treated for in your settings. I just wanted to kind of hit on that before I went after the -- I went after, kind of sounds adversarial -- before I address some of the concerns that have been raised here.

First of all, the idea, I think, of using just claims data, as Alan has pointed out,

we've got what we've got. We'd like to have more, of course. There are some areas in which we anticipate having more available to us shortly. I think the standardized functional data that we're anticipating, again, as part of the IMPACT Act, is something we're certainly interested in.

With these measures, where the claims data currently give us access to functional status information about the patients, we've incorporated those in the risk adjustment. They're not standardized. They're not common across all settings, and not all settings have them, but we certainly look forward to having the data that will be collected in the future for consideration in risk adjustment. That was something that was addressed at the TEP, and certainly they were interested in seeing the measure augmented. Also, point out there's some concerns about the timeline, in terms of how this has been rushed.

We've already invited the TEP members

to continue working with us for further development and modifications of these measures. We anticipate that there will need to be things that we look at that we simply haven't had time to address yet, which is, I think, as close as I can get to saying the timeline was not terribly beneficial to the development of the best measure possible.

The other area that is impacted by this is socioeconomic status. As most of you are aware, we've talked about the different process that are ongoing. I'll simply say specifically for the all cause re-admission measures that are already endorsed by NQF, we have submitted analytical plans for addressing socioeconomic status analyses over the course of the next couple of years. Our intention is to mirror those with the potentially preventable re-admissions measures. We have done the analyses that we can currently do with the dataset we have. Unfortunately, most of the analyses we're interested in doing will require

additional data sources that we'll need to roll into it, and we haven't had time to address them yet.

Which is why we invited the TEP to join us in continuing development work as we look to augment the measure with a variety of areas in SES, not just income, but also area information and other characteristics that we can discuss for some time. I think in terms of clarifying the intent of whether or not we're going to replace the all cause re-admission measures with these measures, I don't know the extent to which we can actually get into the rule-making issue.

I think the answer to that is that -- the best answer I can give to that is that we're certainly aware of the potential for confusion with the measures. I think there's potentially some value, at least analytically, in having both measures being tracked, because we can finally get into the true value of identifying that potentially preventable measure, versus an all cause measure. Are they truly that different?

Do facilities look different in their performance? Does it have a differential impact in the programs where it's implemented? What that's going to mean in terms of what's being publicly reported I can't say, certainly not across four programs in the immediate, but it's certainly something we're aware of.

Unintended consequences, observation stays and ED visits, this was something we considered very early on in the process, when we were thinking about these measures and what the statute allowed us to do. The statute very specifically calls out re-admissions, as opposed to hospitalizations. So it was our understanding of the measures, as we had to develop them for the IMPACT Act, that we needed to limit our view to hospital re-admissions.

We have been aware of observation stays and ED use issues for some time, and we're continuing to track them analytically, if not in a measure. Although, as I think the home health team will be aware, we are, in fact, tracking

them with a home health ED use measure. Those are additional measures that may continue in development in the future. I think they may, in fact, be worthwhile, although the rates of observation stays up until now, in the data we have, remain relatively small, in the order of 1 or 2 percent of events. They are, however, increasing within that limited scope.

In terms of -- getting back to this issue of the lack of SES adjustment and the potential for facilities to decline complex, high-risk patients, I would point out that -- and this has been raised before, and it'll be raised again, I suspect. There are a lot of facilities that do accept a lot of those patients and perform very well on re-admission measures, hospital mortality measures, and the complications measures that work in a very similar fashion.

I think what we're going to end up finding is we're probably going to end up risk adjusting for SES in some fashion someday, and

the SES adjustment will have a much more muted impact than people are expecting it to have. The conversation's then going to turn about whether or not we're risk adjusting for the right elements of SES to capture the variation. But I will be honest. I don't know -- I don't know that the risk adjustment for SES is going to have the program impact for facility assessment that's hoped for, but that's why we do the analysis, because my opinion isn't really what matters.

To the issue of double jeopardy, I'll note that most of these measures are going to quality reporting. Your performance doesn't actually penalize you on these programs, as far as I'm aware. It's just that if you reported the data which, of course, you're reporting because you like to get paid, and these data require claims data, which you're already submitting, or hospitals are submitting because they like to get paid, too -- in that sense, double jeopardy is not there.

For the SNF re-admission measures,

there's sort of a special thing going on that we've talked about, with regard to the implementation of the 30-day hybrid measure in a VBP program, as the only measure. If I had my druthers, I think we'd probably do two combined measures, where you had a within the stay, and then a post-discharge measure, and they kind of sat together.

Alas, the statute does not allow that. So we built that measure with the intent of making the measure as resistant to potential gaming as possible. If we had used a within the stay definition, which I think has been suggested on multiple occasions, you end up with a measure where the best move for a SNF that wants to avoid a re-admission is to discharge the patient early, which we probably don't want to have happen.

MEMBER LEVITT: Joel, is there any way that the workgroup, if they have other questions, they can get them to you?

DR. ANDRESS: Sure. I have an email. My name is -- we can do that.

MS. O'ROURKE: Sure. If you have remaining questions, send them to the MAP PAC/LTC mailbox, because that way the whole project team can access that, and we'll compile them and work to get them to CMS.

MEMBER LEFF: Just a technical question on the risk adjustment. Does the model account for number of transitions that someone has? We had done some work years back on home health transitions, and patterns can be very complicated. So someone who goes from a hospital, to a SNF, to home health in the community is probably someone different who goes from the hospital to SNF, directly home, sort of in the way that if you're flying from here to the West Coast and you have two stops to make versus a non-stop, the odds of you getting screwed up go up exponentially, probably. I was just curious if that's part of the model?

DR. ANDRESS: So I'll say at present, it is not. We simply require that there have been an acute-care discharge, in the case of the

within the stay measure I think you're -- not the within the stay, the post 30-day discharge. We simply require there have been an acute-care discharge within 30 days prior to the start of the post-acute-care stay.

CO-CHAIR RAPHAEL: Erin wanted to make an announcement before we broke for lunch.

MS. O'ROURKE: Yes, I just wanted to give a reminder that we have lunch provided for the workgroup members and NQF staff members supporting the meeting. Members of the public, if you need a recommendation for where you can get a quick lunch before we reconvene, please see our meeting staff at the front desk.

CO-CHAIR RAPHAEL: We are going to reconvene at 1:00.

MS. IBRAGIMOVA: One more announcement is that we have, also, dinner reservations for workgroup members tonight at 6:30 at Mio. That's 1110 Vermont Northwest, a few blocks away. So if you do come --

CO-CHAIR RAPHAEL: Wait, repeat that

again.

MS. IBRAGIMOVA: It's Mio.

CO-CHAIR RAPHAEL: Spell it.

MS. IBRAGIMOVA: M-I-O. We can email the --

CO-CHAIR RAPHAEL: 1110 --

MS. IBRAGIMOVA: 1110 Vermont Northwest. It's a few blocks away. We can email the address to the workgroup.

CO-CHAIR RAPHAEL: What time?

MS. IBRAGIMOVA: 6:30. So if you plan on attending, please let us know. We have those reservations set. Thanks.

CO-CHAIR RAPHAEL: Okay, thank you. We'll resume at 1:00.

(Whereupon, the above-entitled matter went off the record at 12:29 p.m. and resumed at 1:00 p.m.)

CO-CHAIR RAPHAEL: Okay, we're going to resume our meeting. Can I ask all of the workgroup members to take your seats? First of all, I'd like to thank NQF for a really delicious

lunch. A number of workgroup members commented on what they thought was a particularly delicious lunch, so thank you to whoever is responsible for that. Secondly, we've had a new workgroup member join us, Sandy Markwood. Welcome, Sandy. I think we just need you to do disclosure.

MEMBER MARKWOOD: Is there something formal you need me to say?

MS. O'ROURKE: Basically, what we would need you to do is introduce yourself, the organization you're representing, and then if you have any conflicts of interest or disclosure about anything pertinent to the work of this workgroup.

MEMBER MARKWOOD: Sure. Good afternoon, Sandy Markwood. I'm the CEO of the National Association of Area Agencies on Aging, so I'm representing community based organizations. I am pleased to be on the workgroup, and I have nothing to disclose that is a conflict with this meeting or this committee.

CO-CHAIR RAPHAEL: Thank you, Sandy.

I understand, Pam, you had a modification in your disclosure.

MEMBER ROBERTS: Just to be totally transparent, I just wanted to disclose I did pilot the care tool. I was one of the demonstration sites. I've also been a UDS contractor, and I also am on the NQF re-admissions committee.

CO-CHAIR RAPHAEL: Thank you. It's been brought to my attention that during the public participation part that involved the potentially preventable re-admissions measure, that there were some people in the audience who wanted to make comments, and for whatever reason, where they were stationed, it wasn't obvious that they wanted to participate.

So we need to just backtrack and make sure that anyone in the audience who wants to comment on that IMPACT-related potential preventable re-admissions measure has an opportunity to do so. This time, make sure you come right to the mic, okay?

MS. FEDELI-TURIANO: Good afternoon. In the interest of time, I will be very brief. I'm Nicole Fedeli-Turiano from University of Pittsburgh Medical Center. Just in regard and with respect to the PPPR, we would just, again, like to re-affirm and recommend that the measure be narrowed, perhaps, to three or four conditions currently, such as COPD, CHF, pneumonia, diabetes, those chronic-care pieces that were already in the home, as a home health provider, to care for.

We believe, in respect to the comment made about the Legos, I'd like to just take that inference -- put a little different twist on it, in terms of looking at the capabilities of the home health agencies, in respect to the current home health PPPS and the clinical and functional domain thresholds and just take note that it's a little daunting, with the tools in our current toolbox, to figure out how we're going to expand -- to all of those measures, like adverse drug events, UTI.

I'll just take one moment to give a pertinent example with adverse drug events. Perhaps we categorize being held accountable for those re-admissions related to drug events in which the drugs that the patient was on during the time of our service, certainly we would take accountability for that, but extending that -- I could just play out a scene where that patient would go visit their PCP on Day 46 and he or she would prescribe a new med.

That patient would then have an adverse event and be re-admitted, and it would somehow reflect on us because there would not be that communication there. So we are very cautionary about that. Again, we also, perhaps, look at what's coming down the pipe with the Senate Primary Care legislation that's due out at this week, at least draft language, and are hopeful that some of the tenets in that will allow us to better, as post-acute providers, be able to broaden our scope and really be patient-centered care, since they're going to

extend some payment to chronic care.

We're very hopeful about that. But we just would caution that in our current status, and within the parameters that we are covering, the home health piece, we have concerns about being able to be accountable for all of those measures on the PPPR. Thank you.

CO-CHAIR RAPHAEL: Is there anyone else in the audience who wanted to comment? All right.

CO-CHAIR SALIBA: Next on the agenda for today is measures under consideration for the inpatient rehab facility quality reporting program. We were going to start with public comments, as we've been doing so far today. Operator, is there anyone on the line that wants to make a public comment?

OPERATOR: If you'd like to make a public comment at this time, please press Star 1 on your telephone keypad. There are no public comments.

CO-CHAIR SALIBA: Thank you. Are

there members of the audience that want to make a comment?

MR. BAIRD: I think I'm the only one. My name is Andrew Baird, again. I'm with HealthSouth. We are a large inpatient rehab facility provider across most of the country. This is just a technical point for consideration about this measure, and it has to do with a unique admission time frame that works within the IRF payment system. The measure specification document states that the IRF within stay measure is intended to capture re-admissions within the stay. However, it does not include precisely when the stay begins.

IRFs are relatively unique, in that they have a special three-day period for which clinicians can determine whether or not a patient who has come to their facility actually meets IRF coverage criteria, and then if something between when they arrive and when they are formally admitted, something occurs where the patient may no longer meet such coverage criteria, they are

paid at a much reduced rate, and the patient can potentially go to another site of care, sometimes back to the hospital, if necessary.

This policy is really intended to help make sure that the people who are going to be admitted to IRFs are correctly admitted to IRFs, because there's a long list of very specific criteria that IRF patients need to meet. Because the measure specification does not indicate precisely when the re-admissions measure should start measuring quote, unquote, within stay measures, we think it would be appropriate to start on Day 4, instead of the day that they show up, in order to account for this pre-existing policy that is already designed to tenor the payment and, therefore, sort of penalize IRFs for bringing in people who potentially do not meet the IRF coverage criteria up front. It's just, again, a technical point, but I think it's something that the way that the measure is specified doesn't account for that very unique IRF admission time frame. Thank you.

CO-CHAIR SALIBA: Are there any other comments from the audience? I'm going to hand it over to Katie Streeter to orient us to this section.

MS. STREETER: Thank you. There's one measure on this consent calendar. It is the potentially preventable within stay re-admission measure for inpatient rehab facilities. This measure is in early development, so the staff recommendation is encourage continued development. The reason why this measure is by itself is because it is not required under the IMPACT Act and, therefore, did not fit with the other groupings.

CO-CHAIR SALIBA: All right. Alan and Tara, any comments for CMS about this?

MEMBER LEVITT: I'll play Joel, since Joel's not here. Anyhow, this, again, is within -- oh, Joel.

CO-CHAIR SALIBA: Somebody put Joel in the corner.

MEMBER LEVITT: Let's see how well I

do, Joel. This is a within stay measure. Regarding the three-day period, as former, IRF leader, so to speak, in my unit, the three-day rule is a financial -- is really financial, not quality based. From the patient and the family standpoint, having to bounce back, as we used to call it, due to medical complication, they don't -- they look at it as a medical complication.

The IRF does have a responsibility -- again, it's all attribution, it's not all or none -- in terms of when accepting a patient, to try to accept patients who are medically stable enough to tolerate the rehab program. Sometimes we make the right decision, and sometimes we don't. But again, it's felt that we really should include that window within a stay because it is potentially preventable. I'll be able to talk about any other comments, or Joel will, coming up from the workgroup.

CO-CHAIR SALIBA: Thank you. I'm supposed to ask if anyone wants to pull any measures. We only have one measure. Does anyone

want to remove this measure from the consent calendar?

(No audible response.)

CO-CHAIR SALIBA: Okay, so now the floor's open for discussion. Does anyone have any comments or questions about this measure?

MEMBER KAUSERUD: I think, on behalf of the American Medical Rehab Providers Association, we did have the similar concern, which Alan has addressed, about those first three days. Really, in thought about measure, there's kind of two phases. I just kind of provide this for background; we participate in EQUATOR, the exchange data for rehab quality database.

They look at this measure in two ways. There's a first three days transfer back to acute care, and then after three days. The theory is that within the first three days, it's more about the admission decision and/or care in acute care, whether that's been wrapped up and completed. But then after three days, it's more result of either things that were maybe not managed in

inpatient rehab or that weren't avoidable at all. As a quality view, we kind of look at it as two portions. In that way, also, those first three days, it's just kind of a different reason, one I think is more about the admission and the patient stability at admission, and the other one is more just about ongoing care.

We feel like the measure, as it's going -- I know right now it wouldn't be a penalty, but again, just that piece about the double jeopardy, if it's a re-admission quality metric in pay for performance in the future, just worried about that double penalty, as far as taking the reduced payment for the stay, and then also, perhaps, the impact of the quality metric. That's it for me.

CO-CHAIR SALIBA: Thank you. Any other questions or comments about this measure? Jim?

MEMBER LETT: More a matter of understanding how it's reported out. If I'm reading this correctly, it's not reported out as

the traditional percentage of re-admissions. It will be a ratio of what you actually -- how you actually performed to an expected number for the average facility, which seems a little convoluted, and I had to read it several times before it started to make sense. I was curious as to why that was felt to be a more effective way, rather than the traditional percentages we've kind of all grown up with? How is it risk adjusted for an average facility?

CO-CHAIR SALIBA: Alan, if you want to go ahead and jump in?

MEMBER LEVITT: If you have an hour, we can have Mel Ingber go over the expected versus predicted. Joel, do you want to just respond quickly? This is, again, what --

DR. ANDRESS: You know you're in trouble when I'm the succinct one.

(Simultaneous speaking.)

MEMBER LEVITT: -- we've been doing with all of our re-admission measures, in terms of expected and predicted and ratio of it.

DR. ANDRESS: A measure like this can be expressed in one of two ways, and we've done both in different programs. I think we're trying to standardize those going forward. You can have a risk ratio, which is -- as you say, it's a value set about 1.0, where your performance is relative to everyone else. What you can do with that ratio, and what is done for the hospitals in their measures historically, is you standardize against the national raw rate. Sans risk adjustment, you look at the national raw rate, just multiply all the ratios by that, and that gets you the facility rate for that year. It's only good for that year.

The next year, you have to recalculate the raw rate and put it forward. You can actually get a rate value out of this. It slips my mind. I don't recall. Alan, did we finalize in the rule that this was going to be reported as a ratio? Because I think it's actually -- if memory serves, we're actually reporting this as -- going to report this as a rate.

MEMBER LEVITT: This has not been --

DR. ANDRESS: Has not been finalized in the rule?

MEMBER LEVITT: Right, has not been proposed.

DR. ANDRESS: That would certainly be something to discuss for the rule-making process, but you can report the measures either way. It's equally appropriate, from a statistical perspective, but of course, ratios have some unique difficulties in being interpreted by a broader population.

CO-CHAIR SALIBA: Jim, does that get your question?

MEMBER LETT: Sort of. Just to be clear, RAR is risk-adjusted ratio? You used the term RAR, I thought. That's risk-adjusted ratio?

DR. ANDRESS: Sorry, Alan was holding us up there.

(Laughter.)

CO-CHAIR SALIBA: I said raw. What you do is you take the --

MEMBER LETT: I apologize. It's R-A-W, not R-A-R.

DR. ANDRESS: Right. You use the inclusion and exclusion criteria of the measure to define what the raw numerator and denominator is for the country. You calculate that, and that's your raw national rate. You just multiply a facility's ratio by that. If the facility has a ratio of 1.5, and the national rate is 10 percent, then the facility's rate is 15 percent.

MEMBER LETT: So there is a single risk-adjusted, expected re-admission rate across the country, rather than extrapolated to different size facilities, rural versus urban versus suburban?

DR. ANDRESS: The national rate is not risk adjusted because you're not comparing facilities, you're just calculating the raw national rate. It's not -- you don't need to account for differences. You just need to know what the actual rate of re-admission is for the country. Then the risk adjusted portion is

embedded within the ratio. The risk adjustment -- keeps effect there, you're just multiplying it by the national rate so that it's easier to interpret.

MEMBER LETT: So each facility should be risk adjusted, in order to be compared to the national rate? We've already talked about the difficulty around socioeconomic status may be way off in an urban or a very rural nursing facility.

DR. ANDRESS: Right. If you included SES or anything else in the risk adjustment, it would be embedded within the facility risk ratio, and then you're just multiplying it by the national rate. All that does is it makes it easier to interpret what you're looking at. The multiplication of the national rate has no -- it has no consequences for the facility's performance relative to other facilities, because they're all being multiplied by the same thing.

CO-CHAIR SALIBA: Any other questions or comments? Hearing none, we'll move on, unless

someone had other concerns.

(No audible response.)

CO-CHAIR SALIBA: The next item on the agenda is the skilled nursing facility quality reporting program. There's several measures in this consent calendar, including functional outcome measure, change in mobility score, a change in self-care score, discharge mobility score, discharge self-care score, facility residents who received an antipsychotic medication, percent of skilled nursing residents who self-reported moderate to severe pain, and SNF residents who were assessed and appropriately given the influenza vaccine. I'd like to ask the operator to open the lines for public comment, measures under consideration for the SNF QRP, quality reporting program.

OPERATOR: At this time, if you'd like to make a comment, please press star, then the No. 1. There are no comments at this time.

CO-CHAIR SALIBA: Thank you. I'd like to open the floor to the audience for comments,

please.

MS. POTTER: Hi. I'm D.E.B. Potter. I'm from the Office of the Secretary for Planning and Evaluation. I'm also a member of the MAP duals workgroup. First of all, let me just say I'm here reporting as an individual. You should not take my comments as the official position of the Office of the Secretary, please.

I'm here to speak specifically to Measure 1133, which is the use of antipsychotics in the nursing home population. First of all, I think this is a very important concept, and I do not at all disagree with the importance of it. I also do not disagree with continued development of the measure. I recognize the importance of this measure for the dementia population, but I am specifically concerned about the behavioral health population.

As this measure is currently specified, it excludes the population with schizophrenia, Tourette's, and Huntington, but it does not exclude the population with bipolar

disease. The Food and Drug Administration has approved antipsychotics for the care of people with bipolar disease. Clinical guidelines recommend the treatment of bipolar disease with antipsychotics. NQF has actually endorsed a measure, NQF 211, that's specific to the nursing home population and the use of dementia was a physician quality alliance measure, however, that measure does not exclude the bipolar population.

Finally, there's two other NQF endorsed measures, 1932 and 1927, that are specific to the schizophrenia and bipolar population and their use of antipsychotics. So I recommend that CMS continue development of this measure, as well as the two similar measures that are on Nursing Home Compare, and that they include the bipolar population as an exclusion population.

I'm concerned that the population with serious mental illness will not necessarily get the treatment they need in a nursing home if they include or exclude, depending upon that

population. I want the population with dementia to get good care, but I also want the population with bipolar disease to get good care. Thank you.

DR. GIFFORD: My name is David Gifford. I'm going to wear two hats here. I'm going to distinguish them. My first hat is as a MAP member. I'm to exercise my MAP thing and actually pull some of these things off the consent calendar for discussion, Measures 1131, 1132, and 1133, pain, influenza, and antipsychotic should be pulled off and voted as fully developed measures.

They are fully developed, and they've been approved by NQF in the past. They are in use right now on Nursing Home Compare, so had the discussion there. On the fourth IRF measures, I'd also say -- and this was clarified in the last MAP meeting -- when there's NQF endorsed measures on the same topic, as alluded to in a previous speaker, this workgroup should consider those measures, not just the measures brought

forth by CMS in the discussion.

There are five other measures that are based off the care tool for functional improvement in self-care and mobility, NQF Measures 2613, 2612, 2286, 2287, and 2232, that should have discussion about the merits. I'll take off my hat and put on my AHCA hat. We strongly support the influenza and pain measure being approved without any conditions. The antipsychotic measure should get support with conditions with the bipolar, as the previous speaker added as an exclusion that measure. Then I think the discussion, we would just support a more robust discussion or some sort of alignment. Because right now, all the functional measures in the PAC setting that have been endorsed by NQF are based off the care tool.

Most of them are based off the full complement of the care tool. Last year, CMS added Section GG to all the post-acute assessment measures. They did differing items for the mobility and self-care. They don't match. I

mean, when they're the same, they're the same, but they don't have the same full listing.

So none of the measures, when they were specified or approved by the NQF panel, they were setting specific endorsed, even though some of the measure developers brought forth that the measure should be elsewhere. So I think there needs to be some harmonization of those measures in the approach going forward. That would be a condition that we would advocate for this group as they vote on those measures.

MR. HILLMAN: Hi, my name's Troy Hillman. I'm from the Uniform Data System for Medical Rehabilitation. I echo some of the comments that were made by Mr. Gifford for your consideration, related to the endorsed measures that are already within the portfolio and whether or not competing measure discussions need to continue, such that a best-in-class measure is chosen for functional assessment.

I'd also like to further draw some specific attention to the mobility measures.

When we were discussing the mobility measures, one of the things we wanted to point out is that there are 15 individual items, care tool-based items or care tool functional items, utilized in this measure. Eight of those measures are specific only to those patients who are walking at the time of their stay.

Based on data that's in the Uniform Data System database for inpatient rehab facilities, roughly 20 percent of those patients utilize a locomotion mode of wheelchair, meaning those wheelchair-dependent patients will only be assessed on half of the items utilized in each of these measures, both the discharge measure and the change measure, suggesting that it's possible that those wheelchair-dependent patients are not considered, and the outcomes that these types of patients will come up with, the outcomes that they'll see will be substandard to those patients who are walking during their stay in inpatient rehab and SNF, and if this is an IMPACT Act measure going forward, in home health and LTAC,

as well. We definitely want you to consider that as part of the measure calculation discussion and thank you so much for your time.

CO-CHAIR SALIBA: Any other comments from the audience?

(No audible response.)

CO-CHAIR SALIBA: Okay, thank you. We had a couple of suggestions, and I'm going to hand it over to NQF to advise us.

MS. O'ROURKE: Yes, just a few procedural points here. Only members of the post-acute-care, long-term care workgroup can pull measures off of the consent calendar for this meeting, so if you agree with the public comments that 1133, 1131, and 1132 should be pulled for discussion, we'd look for a workgroup member to also make that recommendation. Coordinating committee members can consider their measures at their meeting. At this meeting, this is the -- the ability to pull measures lies with post-acute-care, long-term care members, not all MAP members, generally.

(Off mic comment.)

MS. O'ROURKE: I think there was some misunderstanding. Coordinating committee members can pull at -- every MAP member can pull at their own meeting, to clarify. Coordinating committee members will be able to review all of the measures under consideration at their meeting and pull anything that they have concerns about.

However, there's no cross-workgroup pulling, if that makes sense. The chance for coordinating committee members to review would come at their meeting. Similarly, PAC workgroup members can't pull things from the hospital workgroup's consent calendars, and so on and so forth, only your own workgroup meetings can you pull off of the consent calendar.

CO-CHAIR SALIBA: Thank you. What I'd like to ask -- we're in the process of discussing the items. Before we talk about the consent calendar, I guess I would ask if there were any comments from CMS?

DR. MCMULLEN: Alan and I are both

going to handle this. Do you want us just to do global comments on all the measures, or do you want us to --

(Simultaneous speaking.)

CO-CHAIR SALIBA: Yes, just some global comments to get started before we decide about the consent calendar issue, and then as specific items come up, we'll hand it back over to you to talk about specific responses.

DR. MCMULLEN: Okay. This is Tara McMullen. I'm going to start with the function measures, and then I'm going to turn it over to Alan, Dr. Levitt, to talk about the antipsychotic QM. Because I think now we're okay with the last three. I don't know if we're talking about those. I'm going to leave it here. We have four function measures. These measures are developed with the data source of care from the care tool.

Alan spoke a little bit about that. The care tool was developed in PAC-PRD, the Deficit Reduction Act of 2005. These measures are setting specific at the current time.

However, they do meet a domain of the IMPACT Act to standardize function.

But CMS added these measures onto the MUC list for setting specific measures for the SNF Quality Reporting Program. We have submitted other function measures to National Quality Forum for consideration of endorsement, and those have been setting specific quality measures for the IRF quality reporting program, as well as the LTAC quality reporting program. We also have developed and finalized, for SNF Quality Reporting Program, the IRF quality reporting program, and the LTAC quality reporting program, a process measure that assesses function in self-care and mobility using the care data source.

That was the measure that was used in the mandate of the IMPACT Act. Just very briefly to address a few comments in opening up, there's been a lot of discussion about how IRF and SNF populations differentiate the case mix. In the development of these measures, these measures

really grow from that of the IRF measures that were finalized for the IRF quality reporting program.

The one thing that we like to denote as a difference between the IRF and the SNF measures are that for the two models, the self-care and mobility models, we have more than 75 risk adjusters for these SNF measures, including age, admission, the admission function, prior functioning, prior device use, primary diagnosis, comorbidities, as well as condition severity markers, such as incontinence and swallowing. We do exclude, at this time, persons under the age of 21 from this quality measure, and that's simply because we don't have enough data at this time to analyze that population.

But with the collection of more data, we will consider opening this up to basically dropping that age exclusion. There was a comment about exclusions overall in this quality measure, and if the exclusions in the SNF measure are analogous to that IRF quality measure. The SNF

quality measures actually have a few other measure exclusions, including exclusions of individuals in swing bed populations in critical access hospitals, as well as the residents who did not receive rehab therapy services.

That lines up with the ACQA measures that are currently endorsed. We also understand that in developing these measures, and if we choose to propose these measures in the future, there needs to be consideration in expanding the currently finalized Section GG, which holds the care items. There were comments about adding more items, so we will take that into consideration, as well as the wheelchair use. If you notice, in the IRF quality reporting program for the measures that were finalized, we do have items that assess wheelchair use and scooter use. Of course, there are always the comments about cognition, and whether CMS is going to begin developing cognitive items.

At the current time, the care items look at motor and cognitive function, but they're

not a true indicator of a true cognitive measure. CMS is moving in the direction to develop cognition-specific quality measures, and will take into consideration risk adjusting those measures by functional status. I'm going to turn it over to Alan.

MEMBER LEVITT: Yes, I guess I'm not sure, if the three measures have been pulled, does that mean that they're not going to --

CO-CHAIR SALIBA: They're not pulled yet, Alan.

PARTICIPANT: Oh, so we still talk about those.

MEMBER LEVITT: So I guess we should wait until a decision's made by the workgroup to talk about that?

CO-CHAIR SALIBA: I think whether they're pulled or not, you can still go ahead and give an overview right now. Then the decision will be made by the workgroup whether or not to separate out those items.

MEMBER LEVITT: Tara, do you want to

just talk a little bit about bipolar exclusion because I think that was the only --

DR. MCMULLEN: Yes, let's touch on that for a second. This antipsychotic quality measure, as most of you know, was first introduced in the Measures Application Partnership in 2012. The first year we did it, Catherine was here, or Erin was here. I remember Erin being here the whole time.

The measure itself, there is an incidence and prevalence measure, a short stay and a long stay. They're currently used in the nursing home quality initiative, and they were originally developed to back end the National Partnership for Dementia looking at the use of antipsychotics in nursing homes and whether you can decrease the use of antipsychotics.

At that time, CMS, we vetted a couple technical expert panels and stakeholders and subject matter experts about that bipolar exclusion, because it can go either way. A lot of people were worried about epidemics. A lot of

people were worried about things such as appropriate use in nursing homes and the quality of the beneficiary.

At the time that we presented this in 2012 to the Measures Application Partnership, and at the time that we presented this quality measure to our technical expert panel, there was a strong consensus to exclude bipolar in the measure.

So CMS has moved forward with benchmarking this quality measure in the nursing home quality initiative without the exclusion -- or with the exclusion of bipolar. This year, in considering this measure now for our new program, the SNF Quality Reporting Program, we basically took this measure -- it was analogous.

We said we're going to take the same exclusions and we're going to move forward. A lot of folks were worried about how bipolar would be coded, whether the coder would be able to differentiate -- what would be appropriate coding and whether you would increase error in your

measure. So there are some analytical issues, in terms of the exclusions. We bring this measure forward to the MAP today for discussion about the bipolar exclusion, whether it's appropriate that we maintain excluding that condition, or whether we should consider including it with the Huntington's, or including it in the quality measure, overall.

So that's kind of the history. We moved forward in that way, and we have data now to support, that exclusion actually gives us a significant measure no matter what, but I guess we pose this one back to the MAP. Do we want to keep moving in this direction?

CO-CHAIR SALIBA: Okay, thank you. My annotated agenda says that I'm supposed to now ask for our lead discussants, Kim and Pamela, to make any comments about this particular set of items and the process. Kim and Pamela, have you all decided how you all were going to divide this up to -- okay, Kim.

MEMBER ELLIOTT: I was going to

address the three that have been recommended for pulling off the calendar. I do agree that those particular measures have had quite a bit of vetting already, and they're pretty consistent with other measures used by other organizations. The population exclusions are pretty good, but I would say that bipolar should be included in the exclusions for the antipsychotic medication.

In addition to the clinical reasons, there's also a lot of concern about the skilled nursing facilities' willingness to accept members that have behavioral health conditions and residents that have behavioral health conditions. Without the exclusion, I think it would be even more challenging for many populations to be admitted into skilled nursing facilities.

MEMBER ROBERTS: The only other thing I wanted to bring up, which I think has been discussed in the past, is with the functional measures, that they are -- there will be an increased burden on the skilled nursing team with two different measures with the MDS, as well as

the new care-tool measures, although it does go to harmonize with the other areas, as well as the scales are different. So there'll just be some challenges.

CO-CHAIR SALIBA: Okay, so now's the time to discuss whether we're going to pull things from the consent calendar or not. I'd like to break it into two questions here because this is sort of a long list. I'm going to first ask if anyone wants to pull from the consent calendar any of the measures that are based on the IRF functional outcome measures?

So that would be measure change in mobility score for medical rehab patients, change in self-care score for medical rehab patients, discharge mobility score for medical rehab patients, discharge self-care score for medical rehabilitation patients. Does anyone want to ask that we pull some of those from the consent calendar?

(No audible response.)

CO-CHAIR SALIBA: Okay, so then the

next three on this list are the percent of SNF residents who receive an antipsychotic medication, percent of SNF residents who self-report moderate to severe pain, and percent of SNF residents who were assessed and appropriately given the influenza vaccination. Does anyone want to pull any of those from the consent calendar? Sean.

MEMBER MULDOON: After hearing that other comment, is it unusual to have fully-endorsed measurements still under consideration by this group?

MS. O'ROURKE: I will look up what -- technically, no. If the measure is fully endorsed, it should have been considered for a support, conditional support, or do not support decision. We went off of the information we had on the measures under consideration lists. Tara, Alan, was there a reason that these were marked as early in development?

DR. MCMULLEN: Is for function, or is this for the final three?

(Simultaneous speaking.)

MS. O'ROURKE: I think it's the final three.

DR. MCMULLEN: Oh, I understand. CMS was in the notion that -- so the nursing home quality initiative and the SNF Quality Reporting Program are two separate entities. If we are adopting these measures, of course we're going to have to tinker with the measures, in terms of case mix differences, but adopting them into our program, that we should vet them through the pre-rule-making process.

If, at some point, we choose to propose these measures in a rule, the nursing home quality initiative does not utilize, at this point in time, the rule-making process. It was more structural, I guess, in our logic. Yes, they're fully cooked, but they're in a new program, and if we do propose to use them, we will have to utilize our rule-making vehicle.

MEMBER LEVITT: Exactly, just because --

(Simultaneous speaking)

MEMBER LEVITT: Again, we're proposing them for a program now, so NQF endorsed measures --

(Simultaneous speaking)

CO-CHAIR SALIBA: Yes. I think the issue that was raised in the public comment period wasn't so much up or down on the measures, but whether they should be classified as still in development, versus classified as endorse/not endorse. You're thinking that because it's a different program that's why?

DR. MCMULLEN: Yes, that and looking at the way that the measures are defined, some of these are long stay, so you're looking at the mix of your skilled, as well as your nursing home population. As you know, with the SNF Quality Reporting Program, we're looking at that definitive at the time of admission to that Part APPS discharge or your OBRA discharge. You're looking at definitively the skilled stay. You're looking at a shorter stay. That was kind of the thinking of CMS, because we're going to have to

rerun these measures, test that stay, and see what the data look like. It might end up looking like a different measure just because of, actually, the population of interest.

CO-CHAIR SALIBA: Jim.

MEMBER LETT: Thank you. I find myself sufficiently confused to suggest that we withdraw those three and discuss them. If I'm confused, perhaps some others are, also.

CO-CHAIR SALIBA: Any other comments?

(No audible response.)

CO-CHAIR SALIBA: My understanding is if one person requests that it be withdrawn, then it's withdrawn from the consent calendar, so it's now withdrawn from the consent calendar. Not hearing any more discussion about the functional outcome measures, we'll move on from those, but we have pulled from the consent calendar the antipsychotic, moderate to severe pain, and influenza vaccination measures. Is everybody clear at least on that much?

MEMBER LEVITT: What does that mean to

us at CMS?

CO-CHAIR SALIBA: What that means, I think, now is that we have a discussion, and then decide -- then I think once it's been pulled from the consent calendar, then do we vote it? What were your thoughts? I'm looking to Sarah here.

MS. SAMPSEL: Yes, I know. What we'll do is we will vote individually on those three measures that were pulled from the consent calendar, so that we'll be able to record and hopefully, get you all to come to consensus on if you support the -- encourage continued development.

We'd like to -- this goes back to our conversation this morning -- glean any additional information from you that you would like CMS to consider, as they continue to adapt these measures to go into those specific programs. Then, we would vote en masse for the consent calendar, so for those four items that remain on the consent calendar.

MS. O'ROURKE: Yes, I can try to

clarify again. Hearing no objections, it sounds like the four functional status will pass on the consent calendar, with a recommendation of encourage further development. These three have now been pulled off, so we're going to take them individually, and we'll go measure by measure, and they will be subject to a vote. So maybe we should start with the antipsychotic measure and go there.

CO-CHAIR SALIBA: Let me ask one question, just to clarify what we're going to vote. Will the vote be the choice of the three development categories, or will the choice also include just endorsement as an option?

MS. O'ROURKE: It sounds like, from CMS' perspective, while these measures -- there is an NQF endorsed version of these measures, there might be substantial differences in how they would apply to the SNF QRP versus the nursing home quality initiative. So I think we --

MEMBER LEVITT: Yes, that's absolutely

correct. Again, as Tara said, we have a short stay version and a long stay version, and this is the SNF QRP version. The denominators may not be necessarily the same.

DR. MCMULLEN: You have to remember, with the SNF QRP, the providers are also held to a little bit different standards. They have to submit data, or they have the APU applied to them. The program itself is a federally mandated program, so the use of the measure may look a little bit different than it looks right now on Nursing Home Compare. The measure itself, as used in SNF Quality Reporting Program, will not be tied to a star at this time, so it is a different measure. It will be a different measure, maybe not in concept or in construct, but the way that it's identified, the specification, I guess, of the population.

CO-CHAIR SALIBA: So what I'm going to do is take each one of these separately, so that we can discuss them more clearly. Let's start with the SNF residents who newly received an

antipsychotic medication. Any comments, questions, thoughts? Kim, you look like you're --

MEMBER ELLIOTT: I think that because the measure calls for measurement of those that were already on an antipsychotic when they were admitted, and then were -- at each quarter measure to see whether they were on an antipsychotic makes a big difference. I think that will really start to separate out the populations that this would be applicable to. If you're bipolar, unless it's identified during the stay, you would already be coming in with that medication. So if the adjustment is made to include bipolar as an exclusion, I think it would be a better measure, more reliable.

CO-CHAIR SALIBA: Thank you. Other comments or questions about newly received antipsychotic medication? Paul.

MEMBER MULHAUSEN: So I've historically been very sympathetic to the way CMS has developed similar measures around

antipsychotic medication. But in terms of buy in from the provider community, it does seem to me that there might be more face validity if bipolar was excluded.

I agree that the measure that we have right now seems to be pretty good, and we can do a lot of work using that measure, but I constantly hear the gripe around colleagues and the people that I share care with in the skilled nursing facilities where they remain perplexed about why an FDA-approved indication for antipsychotics is not excluded.

CO-CHAIR SALIBA: I'm seeing some head nods around the table on that. Any other comments? Let's vote on that one. Let's vote on that one, since we just finished discussing it. Our options are up here on the board, and we finally get to use, I think, our fancy clickers, and we'll see if they work. The first vote, if you select 1, then you're encouraging continued development; 2 is do not encourage continued development; and 3 is that category we've been

discouraged from using, insufficient information. Cari?

MEMBER LEVY: Just a point of clarification. If we agree that the bipolar exclusion needs to be inserted, what do we vote?

CO-CHAIR SALIBA: I think you're just -- you would say that you want continued development because the measure as proposed, in part, does currently exclude -- or does not exclude. So you're saying you wanted more work to be done on that measure. Are there any questions about what we're voting on here? Alan?

MEMBER LEVITT: Again, just to, again, hopefully clarify a little bit. I would assume that's what it'd be, a continued development, but the workgroup recommends that bipolar is excluded.

CO-CHAIR SALIBA: Yes. Okay, everyone's clear on what you're voting on, right? Okay, are you ready for them to start voting?

MS. IBRAGIMOVA: Yes, the poll is open. You can vote now.

CO-CHAIR SALIBA: You're pointing towards --

MS. IBRAGIMOVA: You can point directly toward me.

(Voting.)

CO-CHAIR SALIBA: I think we're missing a few votes that we were looking for. How many are we expecting?

MS. IBRAGIMOVA: We are expecting 21 votes. We're missing --

CO-CHAIR SALIBA: Okay, so we're missing a couple. Everybody just reclick. You won't get counted twice, just point and click. Do we have anyone on the phone that is --

MS. IBRAGIMOVA: I got Carol Spence's vote.

CO-CHAIR SALIBA: You got it? Okay, thank you, Carol. Are we good? We're 21? Okay.

MS. IBRAGIMOVA: The results for MUC15-1133 are 100 percent encourage continued development.

CO-CHAIR SALIBA: Okay, thank you. So

now we'll move on to the next item that had been pulled from the consent calendar, percent of skilled nursing facility residents who self-report moderate to severe pain. Comments, questions, thoughts about this particular measure?

(No response.)

CO-CHAIR SALIBA: Okay, hearing no comments, I think we can go ahead and vote.

Let me let everything get set up here, though. It takes a minute to get the system ready to receive your votes, so we'll just wait just a second. It will be the same three options that we had before, to encourage continued development, do not encourage continued development, or insufficient information.

MS. IBRAGIMOVA: The voting poll is now open.

(Voting.)

CO-CHAIR SALIBA: We're still missing a few people's votes.

MS. IBRAGIMOVA: The results for

MUC15-1131 are 95 percent encourage continued development, 5 percent do not encourage continued development, and 0 percent insufficient information.

CO-CHAIR SALIBA: Now I know we've closed the comments and discussion, if you all will indulge me, as the chair, the do not encourage continued development, did any of those folks want to say if they're commenting that they think it's just ready for prime time and there's not any more need for continued development, or if they don't want to see the measure going forward?

MEMBER MULDOON: I don't know if I'm a full 5 percent, but I did do it, too. I just don't want it to be messed with anymore. I'm afraid that you'll have two different measures that sound the same, but are actually done differently. It's so convoluted how they do it in the MDS that I just say let's be done with it.

CO-CHAIR SALIBA: All right. I just wanted to make sure that we understood the intent

of that no vote. Any other thoughts before we move on? Let's move on now to the final one that was pulled from the consent calendar, percent of skilled nursing facility residents who were assessed and appropriately given the influenza vaccine.

MEMBER LEVY: That last comment brings up a good point. If we feel similarly that this one shouldn't be messed with and just go for it, should a vote of do not change be the appropriate vote?

CO-CHAIR SALIBA: The question here is if someone wants to say no more development is needed because it's ready for prime time, what should they vote, and how do we know that's what they're voting when they vote?

MS. O'ROURKE: I think the best way to capture that might be in the rationale. If you could raise those concerns via conversation, and we'll write them down and put them in the rationale section that goes along with the vote to CMS.

I don't know that I have guidelines on how you should vote about encouraging further development or not encouraging further consideration, but we do capture that rationale, and we can note that there are concerns that there might be two similar sounding measures now going into play for two different programs, and we'll pass those concerns along to CMS for them to reconcile.

DR. MCMULLEN: We take that into consideration, too. So Sean, your comment, that's very important for us. That actually weighs very heavily.

CO-CHAIR SALIBA: So it would be helpful to discuss any concerns that people have, either that we should just proceed with what's there, or that they're worried about slightly differing measures on the plate here. Any comments? Cari?

MEMBER LEVY: I think the similar concern would be raised here is the measure is reporting the percentage of skilled nursing

facility residents who were assessed and appropriately given the seasonal influenza vaccine. Great. That sounds good. I think messing with it probably isn't necessary, but if others disagree, then we should hear that.

MEMBER MULHAUSEN: I don't disagree, which makes me confused about why we came up with the original preliminary recommendation and what it was on the part of the group that initially presented us with that preliminary analysis result, what their concern was. What I see here was that it's -- the measure is a little different from the NQF-endorsed measure. Everything else seems fairly consistent with what Cari has already articulated, so I'm curious if I'm just missing something. I guess it's a question for staff or for the key presenters.

MS. SAMPSEL: I think this goes back to the original conversation and the way Tara addressed it. When NQF staff get the measure information from CMS, it's almost a translation of if CMS says they're continuing to look at a

measure for use in a different program or a different adaptation of the measure, it's considered still in development.

For us as staff, our recommendations would then go by is there the potential for any type of changes to that measure specification that would move a material change from the endorsed measure? We would have gone along the line of any of these measures that did come in to us as CMS is still looking at as just the -- encourage continued development. It's kind of almost a nuance in the language because you're all correct. These are fully developed measures for use somewhere. It was a programmatic, more than a measure recommendation. We recommend CMS continue to look at this and determine whether it could be used in the program versus kind of that we're asking for changes to the measure specification on the endorsement side.

CO-CHAIR SALIBA: I think part of the confusion is that we haven't typically looked at measures in terms of their use. In this case,

you're saying that it's the use of the measure. But I think that Tara was also saying that some of the specifications might change because of the different uses.

MEMBER LEVITT: Yes, I just want to reiterate, again, that these have been very useful, helpful measures in Nursing Home Compare with the denominators of the short stay and long stay, short stay being less than 100 days, long stay more than 100 days.

The denominator for this measure would be patients who are receiving a SNF level of care, which is not necessarily needing the 100-day definition. The reason we would really qualify it better as under development, again, is to just go ahead and look at it with that denominator and go ahead. But again, if we get a very strong recommendation that things -- that you agree that once we look at this, if it does look like, through the testing, that things look the same, we would love to get that sort of support from you, if that's what you -- if that's

how you feel.

CO-CHAIR SALIBA: Okay, Jennifer?

MEMBER THOMAS: I'm just wondering, with the specifications that may change, would this be in the area of skilled nursing with short stays, could some of the options include some of those options that are included now in the home health assessment? It's not just that you either receive the vaccine or you refuse. There's things like drug shortages exist, there's no vaccine on the market or whatever, so during that time period, that might also be a consideration.

DR. MCMULLEN: The measure on the MUC list is the specs -- the description of what you see here, but I think the world is our oyster. The sky's the limit, in terms of what we can do in this domain. We always, actually, encourage folks -- stakeholders, everyone -- to write in to us and present these ideas to us because you're in the work. Sometimes it's good to get that outside perspective to see where you can align or harmonize. I tend not to use standardization in

this sense on purpose. But yes, that's a good idea.

MEMBER ELLIOTT: I just wanted to comment on the numerator and denominator, in respect to the October 1st through March 31st. I recognize in all measures, you do have to have hard cutoffs and start dates. However, oftentimes, now, the influenza vaccine is really recommended almost year round, particularly in different parts of the country where the seasons are a little bit different.

We do see the flu vaccinations being given, oftentimes, now in September, August time period. If we continue with these hard cutoffs, it would probably exclude some of the people that may be getting those vaccinations appropriately, so some thought could be given to that as that trend continues.

CO-CHAIR SALIBA: Jim.

MEMBER LETT: As the puller -- maybe I'm the pullee. I'm not sure which one I am, but as the person who suggested that we pull them and

look at them, my intent on this one was mainly is there anything special that we need to change or add, and I'm not hearing that at this point in time. I think the second thing is it might be interesting, as an unintended consequence, are these measures basically forcing people to get multiple vaccinations with the same vaccine?

That is, if you have this measure at all sites of post-acute care, plus, I might add, in the hospital, which also has the measure for it, particularly elders with dementia or others with dementia or cognitive impairment may not recall, the records may not be clear. Are people ending up with three and four pneumonia vaccines, three and four influenza vaccines?

I guess the third thing is it sounds like it might be worth, mechanically, just to see if there's a way to suggest fast tracking some of these measures, rather than just say yes, keep working on them, that we can say we like the way they are, go with it?

CO-CHAIR SALIBA: Thank you. Any

other comments or thoughts? Oh, Gene, I'm sorry. Go ahead.

MEMBER NUCCIO: Sorry. To answer your question, at least for home health, in the home health item, it specifically asks if they've received it from another provider. So if the agency has received it -- if the patient has received it at the nursing home, and then been transferred to home health, then that's recorded as having received.

CO-CHAIR SALIBA: Jim, I think your comment would call for making sure that's part of the transfer information that gets transferred with the individual across settings. Other comments, questions? I think we're ready to go for a vote on this one. Again, we've got our three options here. We're going to be voting on percent of skilled nursing facility residents who were assessed and appropriately given the influenza vaccine. We can vote 1, encourage continued development, 2, do not encourage, and 3, insufficient information.

MS. IBRAGIMOVA: The voting results for MUC15-1132 are now open.

(Voting.)

MS. IBRAGIMOVA: The results for SNF QRP MUC15-1132 are 95 percent encourage continued development, 5 percent do not encourage continued development, and 0 percent insufficient information.

CO-CHAIR SALIBA: Thank you. We're going to move on now to the input on measures under consideration under value-based purchasing program. I'd like to ask the operator to open the line for comments.

OPERATOR: At this time, if you would like to make a comment, please press star, then the number 1. There are no comments at this time.

CO-CHAIR SALIBA: Thank you. Are there any comments from members of the audience?

MR. MULLER: Hi, James Muller from the American Healthcare Association. The SNF value-based purchasing re-admission measure

within and without 30-day post-SNF stay re-admission measure, we believe that it should be aligned with the similar IRF measure and kept to be a purely within SNF stay re-admission measure. There's nothing in the PAMA that actually forces this to be a 30-day follow-up period, and the payment theme of the PAMA sort of suggests that it should be kept within the SNF stay. My comment, thank you.

CO-CHAIR SALIBA: Thank you. Any other comments from the audience? Laura, are there any comments in the chat box?

MS. IBRAGIMOVA: No, not at this time.

CO-CHAIR SALIBA: Katie, can you maybe give a brief overview of the value-based purchasing?

MS. STREETER: Sure. For the SNF value-based purchasing program, we have this one measure here. We actually -- the workgroup did review and discuss this measure, but not for this specific program. The reason why we have it separated is because this is required by PAMA and

not IMPACT Act, but this is the skilled nursing facility 30-day potentially preventable re-admission measure. It is also in early development, and our recommendation was encourage continued development.

CO-CHAIR SALIBA: CMS, do you have any comments before we discuss whether or not it stays on the consent calendar?

DR. ANDRESS: Sure. The decision to make this a 30-day re-admission measure stems from two issues. One is practical, and the other is an issue of policy. The practical issue is that this is essentially, I guess, a potentially preventable version of the SNF re-admission measure that is already being considered by this committee. It was finalized in rule making for use in the SNF value-based purchasing program. A particular quirk of this program is that there are only ever two measures that are statutorily allowed within it.

The first was the SNF re-admission measure, which is an all cause re-admission

measure, which is to be replaced by a potentially preventable re-admission measure as soon as is practicable, which I never thought I'd hear used outside of the movie Gettysburg, but there it is. Anyway, the issue with -- so the statute only allows those two measures.

That's the basis of the payment determination for SNFs in the VBP program, which puts this measure -- puts a great deal of responsibility on this measure, because a facility can lose up to two percent of its payment based upon its performance on this measure, or it can gain a substantial amount of money in the cost-savings setup that was mandated within the PAMA statute. There seems to us to be a substantial reason why we'd want to prevent issues such as gaming. This is an area where gaming would be fairly straightforward if we were to keep it as a within stay only measure. Because if it is designed as within stay, the only thing you have to do in order to avoid a re-admission for the SNF is to discharge your

patient prematurely, before they get re-admitted.

You kick them out, and even if they go back to the hospital after that, they die, the measure will not capture it, which means that the value-based purchasing program will not capture it. Now, as has been pointed out by commenters in the rule making, it does not seem that this is something that is likely to occur overmuch, given the ethical considerations in place.

But it seems to us that as a policy matter, it is incumbent upon CMS to not design value-based purchasing programs wherein there is, in fact, an incentive for kicking your patients out before they have received the care that they require. For that reason, we decided to retain the SNF re-admission measure's 30-day setup. This created some interesting issues around this measure, particularly with the potentially preventable re-admission definition. We developed this alongside the IMPACT Act measures, as well as the IRF within stay measure. When we did that, it became quickly apparent to us that the

definition of what is potentially preventable varies very much, in experts' minds, by whether you are within the facility or outside of the facility.

So we actually created two definitions, one which defines a class of codes for which a facility may potentially prevent a re-admission while the patient is within the facility, and another set of codes that is less inclusive, that defines potentially preventable re-admissions for patients who depart from the facility because this measure includes both time windows, potentially.

The potentially preventable definition uses the within stay definition for patients who are re-admitted while they were within the SNF and uses the post-discharge definition if they are re-admitted following discharge from the SNF, but still within the 30-day window. That is the rationale there for why we included the 30-day and some of the quirks around the measure as a consequence of our decision to retain that

structure.

CO-CHAIR SALIBA: Thank you. So now the question before the group is whether you want to keep this on the consent calendar or you want to pull it from the consent calendar? Anyone want to have it pulled from the consent calendar? Okay, Jim?

MEMBER LETT: Just a point of clarification. We can discuss it without pulling it, can't we?

CO-CHAIR SALIBA: Yes.

MEMBER LETT: So if I say no, then we can still discuss it?

CO-CHAIR SALIBA: Exactly.

MEMBER LETT: Okay, thank you.

CO-CHAIR SALIBA: Hearing no requests to take it from the consent calendar, we will move forward with discussion of this item on the consent calendar. Robyn?

MEMBER GRANT: From a resident perspective, our concern is one of unintended consequences. There is the possibility that the

measure could create a disincentive for nursing homes to send residents to the hospital for the care they need. We are aware of many situations that families have reported to us, and advocates on the ground, where there have been family members in the facility very concerned about the condition of their loved one. They have asked for their loved one to be sent to the hospital. For a variety of reasons, they have gotten pushback from facility staff who said, absolutely not. They've refused to send their loved one to the hospital.

Families, out of sheer desperation, have eventually called 911 and had an ambulance come and sent their loved one to the emergency room. What we hear back from family members is the hospital staff said that had we not gotten their loved one to the hospital when they did that they would very likely have died, or there would have been very serious consequences. I just wanted to raise that as a potential adverse consequence.

CO-CHAIR SALIBA: Thank you, Robyn. Other comments? Lisa?

MEMBER WINSTEL: I just don't want to waste anyone's time, but I really want to amplify what Robyn said. It's not the occasional story. We hear this from family members all the time, and it should be taken seriously. I don't have a recommendation for how CMS can address it in this measure, but it is something that has to be heard.

CO-CHAIR SALIBA: Jim?

MEMBER LETT: Oh, thank you. Back to the spirit of Sean's earlier comment about how do you do QI with this information? How can you make care better? To me, just somebody went back to the hospital within 30 days doesn't help me a lot.

If somebody went back to the hospital within 48 hours of admission to the SNF, then that was a failed hospital discharge. If they go back to the hospital within 48 hours of leaving the skilled nursing facility, I would personally

consider that a failed SNF discharge.

If you have a re-admission within, for example, the first seven to ten days from the SNF, then that may well be an issue around the quality of care of the SNF, not always, but could well be. How do you make this measure actionable is really what occurs to me. Lord knows too many measures is like having no measures, but it might be more useful were it broken up into time increments where you could say I have a problem with my intake process, as a post-acute provider, or I have a problem with my discharge process, as a post-acute provider. No action intended, but a thought for as we develop.

CO-CHAIR SALIBA: Jim, do you think the facility could do its own tracking of these issues within the facility to look at when their re-admissions are occurring?

CO-CHAIR RAPHAEL: Can I just say something? Because at the Visiting Nurse Service of New York, where we dealt with 50 hospitals, we actually charted re-admissions by hospitals, and

it was a dramatic, dramatic difference. The range was phenomenal between some high-performing hospitals and some where we had really just, I thought, astounding readmission rates.

I think there are things that you have to do on your own. You can't wait for this public reporting system to come and give you the information that you need. I think when you then go to the hospital and show them some of the data, then you have to begin to work on what's a combination of issues. It's work on both sides.

MEMBER LETT: To answer your question, yes. If you're an active, good post-acute provider, none of these numbers are a surprise to you. We used to, weekly, look at all unplanned transfers from the facility, whether it was to the emergency room or they actually were re-admitted, and we calculated our own re-admission rates.

We looked at all the folks who went out, whether they got admitted to the hospital or not, and we would compare our numbers with --

because of the hospital re-admission reduction program are almost, in all the urban, and I presume a lot more widespread than that areas, we would monthly, or at least quarterly, sometimes monthly, get the re-admission rates as calculated by the hospital, which we could then look at our re-admission rates.

We could look on when they went back and have a constructive, educational dialogue around yes, we had three people we had to send back to you within 24 hours or 48 hours. Where are we missing it? The same thing on the other end, but we don't always get the information when they leave the SNF that they ended up back in the hospital. In fact, we almost never do, unless they cycle back through from the hospital into the SNF. We go, oh, my goodness, you were in the hospital. The data that we get, if we have it timely, then it is absolutely wonderful because we can actually look at those charts, pull them, and see why people were discharged or what the process of care was while they were there.

Long answer to your question, yes, if we're doing our own re-admission data, it is absolutely wonderful, and we can figure out what we're doing wrong pretty darn quickly and defend our numbers to any outside entity, a managed care company, a hospital, whatever.

CO-CHAIR SALIBA: We started, when we send people home from the hospital, we follow up with them at 48 hours. We follow up with them at two weeks to see how they're doing post discharge. I have this fantasy that we could start doing that with post-acute care patients. Paul, you had your tent up.

MEMBER MULHAUSEN: This is part of my disclosure. I work for Telligen, and we are a CMS Quality Innovation Network, quality improvement organization. From my world view, there are numerous resources that CMS provides to providers to support achieving the goals of this kind of a measure. Advancing Excellence is a public/private partnership with a lot of help for skilled nursing facilities, in terms of tools

that can be used to do root cause analysis and monitor re-admissions.

There's a lot of push for interact through the Quality Innovation Network. From my perspective, we have, actually, an under-utilized resource being provided by CMS through the quality improvement organizations that aligns beautifully with this measure, in terms of supporting the provider community to succeed with this as the value-based purchasing outcome of interest.

MEMBER LEVITT: I was going to wait until all the comments were done, but assuming they are, first of all, I want to thank Paul for that lead-in. That was very nice, telling what CMS does do, and it is true. I do think we need to remember that this is a statutory measure. So again, we start off with the fact that Congress felt this is important, and it actually is an important measure. It is a within stay measure. It's not necessarily within stay measure. It's a 30-day from the start of stay measure. So for

most SNF patients, it would be a within stay measure. So for most of the residents who get transferred out, you would actually have the information on the resident to begin with because they would've been within stay while all this was occurring.

Just a general comment before I turn it over to Joel. The point of all these re-admission measures, it's kind of a shared attribution. CMS recognizes that, for example, in home health, how much does a home health agency have in terms of the effect? Is it 100 percent? Obviously it isn't.

But the point of these measures is that there are things that we can do, whether it's a within stay measure, in terms of the care that we're providing to the resident or the patient, or post-discharge, in terms of the discharge planning of the patient. There are things that we can do to affect the rates that we do have, or that compare to other, similar settings after risk adjustment. Again, that's

what we're trying to do here. We accept the fact that patients may come in and be bounced right back or whatever. But there are things we can do, in terms of assessing those patients prior to coming to us, to hopefully keep the patients where they belong until they're ready to come to the right setting. Is it 100 percent effective? Obviously it isn't, but there are pieces that we can do, and that's kind of where the shared accountability comes in. Joel, do you have specifics?

CO-CHAIR SALIBA: Before you move on, we had one other member that had a comment. Cari?

MEMBER LEVY: I'm sorry. I just wanted to raise one issue, which was we were able to hear Joe -- present recently. The unfortunate news was the interact tool doesn't appear to have an effect in randomized control trial in the community.

I worry if we're expecting facilities in the community to use a tool that doesn't have

an effect. I don't know if we're setting them up for success. I just wanted to put that out there. Then also, one of the other things that I wonder about is emergency room visits that don't result in admission, if that could be a signal for facilities that are not being mindful about assessing residents, and if there was some way to use that, as opposed to because of this issue that Jim brings up, where we have people who come, and then two days later, they're back in the hospital, and that's probably the hospital's fault, and not the SNF's fault. Anyway, just wanted to bring those two things.

DR. ANDRESS: I'm sorry, I'm going to be obnoxious and ask you if you could restate that last one? I missed the first part of it.

MEMBER LEVY: There's this percentage of folks who come in and go right back within one or two days, and that's likely not the nursing facility's fault. It's probably the -- it's a shared effort in not doing a good job by the patient.

DR. ANDRESS: Right. I think we do make some effort, analytically, at least, to pull apart when people are being re-admitted and so on. There's no clear -- there's not a drop-off point, where everybody's getting -- then all of a sudden, it just stops. There's actually a fairly slow progression down, where people are re-admitted sooner, but other than that, there's not just a clear point to cut it off. I think the shared accountability piece to it gets it right. We want both providers involved in any handoff to be conscientious about what's going on.

I think we've started to hit on that with hospitals and post-acute care settings. There are probably other areas where we really haven't. That's probably got to be a discussion, as we consider the proliferation of care provider types and different kinds of handoffs, exactly how you do that without inundating people with re-admission measures for home health to SNF, home health to the IRF, home health -- you can

just imagine how that expands rapidly.

To this issue of unintended consequences, I think this is an important one. It's something that's been raised and addressed in hospitals, but bears repeating. One of the earlier concerns, right, was that you're reducing re-admissions because they're just letting their patients die. So they die instead of getting re-admitted. That's why re-admission rates would go down. The analyses that we conducted in the hospital certainly have not borne that out. We don't have mortality measures in place in our quality programs for SNFs at this point. I would say that there's actually a pretty good illustration of why you want companion measures within a set, why you don't want to put your eggs in one basket, so to say, with a single measure.

We don't have that option with this program, but this program does not exist in a vacuum. You have the Quality Reporting Program. You have the Nursing Home Quality Initiative, where other measures can be implemented and have

an effect on the quality efforts of various providers. I think it's important to understand sort of the context in which a quality measure can exist.

I don't know that you necessarily get at a single measure that deals with all unintended consequences, but you can develop a suite of measures that make it increasingly difficult to game any one measure by your particular actions. I think that's certainly something we try to bear in mind as we develop not just a single measure, but an entire suite of them.

CO-CHAIR SALIBA: One thing I think that Cari raised was the issue of emergency department, of using that as part of the gaming of this measure.

DR. ANDRESS: Right. There's some interesting issues in addressing this. On one hand is if it never becomes a re-admission, was it something that rose to the level of being a re-admission in the first place and, therefore,

should be captured by the measure?

I think the other issue, of course, is do you have enough events -- is it a common enough occurrence that you can actually capture the event and say something meaningful about a facility's performance with it? Right now, we're observing these. We continue to track them, along with observation stays.

There is actually a couple of these measures in the home health setting, where we do include those as their own separate indicators. I can't say how that should be addressed. I can say that for measures that are in statute called out for re-admissions, it's probably problematic to include ED use, but that doesn't mean that we couldn't look at it in developing other measures, in the future, that do cover that area. I think it's certainly something worth capturing. Again, one of the advantages of those is they're probably, at least initially, the claims based, so it doesn't expand the reporting burden for the facilities.

CO-CHAIR SALIBA: Alan, your tag is still up. Were you going to make another comment?

DR. ANDRESS: The other core issue that I think I want to touch before I shut up is the QI because this is something we've heard in the TEP that we convened for this and a number of other settings, which is that a lot of information isn't available to them.

The comorbidities that are identified for the patients who got re-admitted outside of the facility setting, who did not -- this is something that we've been looking at how to address, and there have been a number of legal and infrastructural issues. I think we're actually making some headway on this, so I can't make any promises now. I can say, though, that I am optimistic that we will be able to at least expand the depth of information that you're getting on re-admissions. That said, when you're receiving a re-admissions rate, I think it's probably best if you consider it as a signpost.

You are doing well on this; you are not doing well on that. But there are a number of efforts that have to be taken at the facility level to track the issues, in particular, that we're simply not going to be able to capture with a claims based measure.

CO-CHAIR SALIBA: Thank you. Any other questions or comments about this item? Again, it's on our consent calendar. We didn't take it off the consent calendar, so hearing no more new discussion, we will move on to the next item. We're a little bit ahead of schedule. Consulting over here with NQF folks, we're going to keep moving through, up until the scheduled break.

That does mean that if someone's not on the call right now that wants to comment, we'll have an open mic at the end of the day for people to comment, so they'll still have an opportunity.

We're moving on to the Long-Term Care Hospital Quality Reporting Program. There are

several items on the consent calendar, compliance with spontaneous breathing trial, including trach collar trial or continuous positive airway pressure breathing trial by day two of the LTAC stay, percent of patients who received an antipsychotic medication, and ventilator weaning. Operator, can you open the lines for comment?

OPERATOR: Yes, ma'am. At this time, if you would like to make a comment, please press star, then the number 1. There are no comments at this time.

CO-CHAIR SALIBA: Thank you. Are there any members of the audience who want to make a comment?

MS. POTTER: Similar to the comment I made on the skilled nursing facility antipsychotic, I'll make a similar comment on the antipsychotic in long-term care hospitals, which also excludes the bipolar population. Thank you.

CO-CHAIR SALIBA: Are there any other comments? Laura, any comments from the chat box?

MS. IBRAGIMOVA: No, there are no

comments.

CO-CHAIR SALIBA: Kate, do you want to fill us in a little bit on this one?

MS. STREETER: These are the three measures that are being considered for the Long-term Care Hospital Quality Reporting Program. They're all in early development, and our preliminary staff recommendation is to encourage continued development.

CO-CHAIR SALIBA: Before we ask for workgroup discussion about consent calendar, did CMS have any comments?

MEMBER LEVITT: Just, again, that if we are going to continue with measure development, if it's the workgroup's recommendation, again, that bipolar patients be excluded, we would want to hear that. I would point out one thing that may generate workgroup discussion is just to note that we had chosen, in this measure, that this is a prevalence measure, and not an incidence measure.

We chose that because the idea that

patients coming into the long-term care hospital facility may have been started on antipsychotic medication while they were in the ICU, and that the hope or the idea was that hopefully, they could get weaned while they were in the LTAC setting. Again, maybe that'll generate some workgroup discussion as to whether it's better to have a prevalence versus an incidence measure in this population.

CO-CHAIR SALIBA: Thank you. We had two discussants for this set of items, Sean and Bruce. How do you guys want to tag team it? Sean, you want to start?

MEMBER MULDOON: I think, maybe I'll do the weaning ones, because they're easier. I was on that TEP. These have been -- anything that this group probably will -- asking themselves what about this, what about that, ask me, I'll tell you. I know that it's come up in the other groups, and we just had to make some choices.

One piece of clarification that I

either am not reading right or we got mixed up is on the wean rate, one place in the specifications it says it's discharge dead or alive, and in here, it says live discharges. We went round and round on that.

I don't actually remember where we landed, but just resolve that apparent discrepancy. The TEP group is reasonably happy with these, in spite of all limitations that we've thought up, and this group may well think up, as well. I think I'll hold it there. If there's anyone that has a question about those two, we can deal with them now. The trickier one is the antipsychotic one, so I want to leave a little bit of time for that.

CO-CHAIR SALIBA: Bruce. Okay. I think our next discussion is whether or not we want to pull any of these measures from the consent calendar to have specific voting on. We'll still be able to discuss, whether they're on the consent calendar or not. Any move to pull anything? Okay.

So now we'll move on to discussion. I'm going to break it up a little bit, the way Sean did, for discussion, so that we can sort of stay on track with what we're talking about. Let's talk about the two ventilator measures first, the compliance with an SBT weaning trial by day two, or a continuous -- a CPAP trial by day two of the LTAC stay, and ventilator weaning or liberation rates. Any comments, discussion? Roger?

MEMBER HERR: I just want to thank Sean for talking about the work on the TEP. This is an area that I've seen variation in practice out there, so the two days, I think, is a great -- how you got there, I don't know, and if that's the right number of days, but I'm glad you're setting something there, and also the exclusion criteria because I see so much variation of what facilities do in this area. It's of great concern to me, so I'm glad this is being put forward, both of them.

CO-CHAIR SALIBA: Roger, that was

actually my question. Is this a standard of care, or is it still being resolved in the community about who gets trialed? Does everyone get trialed, and is two days -- Sean, can you help with that?

MEMBER MULDOON: This reflects two things. One is that by the time you come to an LTAC for weaning, you've long fallen off the care path. That leads to variation, where people say all the usual stuff didn't work. What will we try today?

That was the side of the room that said let's not button this down too much. But we could not ignore the fact that the Loyola study found that if you just let people settle down, and then let them breathe on their own, 18 percent of them popped off the vent. That is why we said not that you have to wean with spontaneous breathing trials, because that wasn't as clear, but once the patient settles down, how long is that? Forty-eight hours. Could have been 24, could have been longer. Give them a

shot at it. Just see what they can do.

Then that Loyola study also said if they last a long time, you can go this way. If they don't last a long time, you can go this way. If they've totally got no drive at all, they're probably in that category that means that they may even be an exclusion. There actually was some logic to it, even though we had to draw some bright lines.

CO-CHAIR SALIBA: Questions, comments? Thank you, Sean. Questions, comments? We're talking about breathing trial or CPAP trial by Day 2, and ventilator weaning or liberation rates. Okay. I think I've worn you guys out. The next one is percent of patients who received an antipsychotic medication. This is slightly different, as Alan was saying, from the one that we discussed for SNF. Comments, thoughts? Sean?

MEMBER MULDOON: I'll go ahead and tee up the debate. In the SNF, the desired behavior is to not use antipsychotics to calm people down. In the LTACs, for the ventilator patient, it is

how do you identify and treat delirium quickly? So the concern was the unintended consequence of this, which was -- is fairly loud, is that if you get dinged for using an antipsychotic without one of those exclusions, then you've taken away one of the many imperfect tools for promptly responding to delirium. That would be bad.

CO-CHAIR SALIBA: Comments? Jim.

MEMBER LETT: Just in looking at harmonization between the measures, it seems to make sense that we would ask the same of LTACs that we ask of SNFs, that is have an incidence rather than prevalence measure. Also, I would assume that we would like to discuss removing bipolar, or adding bipolar to the exclusions.

CO-CHAIR SALIBA: Other comments or questions about the antipsychotic?

MEMBER KAUSERUD: I will admit I have not reviewed this measure in super great detail, but it seems that you would be able to build in an exclusion for the purposes of identifying delirium, so just a thought.

CO-CHAIR SALIBA: Gene. Wait just a second. Gene hasn't -- let him go first.

MEMBER NUCCIO: It's just a question of clarification. Is a good outcome higher or lower? I don't know. If you're excluding that which should be excluded --

MEMBER LEVITT: Gene, that's always a bad sign when you have to ask a question like that.

MEMBER NUCCIO: That's my purpose.

CO-CHAIR SALIBA: I think we have started in the hospital, at least, discouraging the use of antipsychotics for the management of delirium. That's sort of -- it's not always appropriate, even in the hospital setting. The first thing is to avoid the development of delirium which, even in the best trials, is not 100 percent, but that an antipsychotic doesn't treat delirium. It only masks the symptoms of what's going on. We might not see that as always the right approach with all delirious patients. But it may be different, I guess, in other

settings. Other comments? Sean, I'm sorry. Yes, please.

MEMBER MULDOON: When we use antipsychotics, we mean typicals and atypicals?

CO-CHAIR SALIBA: Yes. Oh, I'm sorry. I shouldn't have answered for CMS.

(Simultaneous speaking.)

CO-CHAIR SALIBA: Alan.

MEMBER LEVITT: If I could just comment. I do want to point out that in the LTAC QRP, previous MAP recommendations have been to include a measure such as this, the use of antipsychotic medications. That's come from the workgroup before, and I guess this is our response. We do listen, believe it or not, to workgroup recommendations that this come forward. Again, we are interested in whether or not, assuming you still agree that a measure such as this is useful in this setting, whether or not a prevalence versus incidence measure would be the right way to go.

CO-CHAIR SALIBA: Bruce.

MEMBER LEFF: Yes, just a clarification. Would using a single dose of an antipsychotic versus having someone started on chronic use of the antipsychotic, those would be judged the same in this context of this measure? I need to give someone a good dose of Haloperidol because they're bucking the vent and I need to calm them down for their safety versus longer term, perhaps inappropriate use.

DR. MCMULLEN: It'd be longer term inappropriate use. It begs the question of harmonization, but what would the MAP think? Would that be appropriate for an LTAC, knowing that the stay's a little bit longer than a SNF in the first place?

CO-CHAIR SALIBA: So we've been asked to comment on a couple of things, it sounds like, the question of incidence and prevalence and which type of approach you would want for antipsychotic medication. Then I think the other question was given that it's not going to be just a one-time dose, what are we thinking this would

be, in terms of the duration of exposure that would meet the numerator? Any thoughts? Cari.

MEMBER LEVY: Well, if you want a thought, I was thinking, as Jim was mentioning the incidence issue, that yes, that's good. But the reality is the hospital has started these, often, and then you're stuck with them when they come over. If the LTAC can get rid of them, then that's part of the whole rehab plan. Is there any way to reward facilities for actually getting rid of them? I don't know if that can be part of the concept, as well.

CO-CHAIR SALIBA: Thank you. Paul.

MEMBER MULHAUSEN: In the spirit of amplification for what Cari just had to say, which is why I like the prevalence measure. I think the prevalence measure, assuming high is not good, then the prevalence measure, there is an incentive to be thinking about gradual dose reductions and gradually taking people off of them after their delirium has been effectively treated. I like the prevalence measure.

Although I'm sympathetic to this issue of harmonization, I don't think that's the intent here, so I like the prevalence measure.

CO-CHAIR SALIBA: Alan.

MEMBER LEVITT: Just to point out, in the nursing home setting, the short stay antipsychotic measure is incidence and the long stay is prevalence. It doesn't necessarily have to be the same measure. We've chosen prevalence because we thought it just made more sense and, again, are interested in what's going on. Again, we are sensitive. Sean, we are sensitive to changes in behavior. It is unfortunate that people sometimes are -- practitioners do things that may be inappropriate for a patient because they're afraid of the measure consequences of it. That's something we have to continue to monitor religiously because that does happen.

CO-CHAIR SALIBA: Thank you. Any other comments or questions? Not hearing any movement to take any off the consent calendar, we've discussed and provided feedback, so we're

going to consider this section complete, which gets us to almost the break. I think we're going to go ahead -- we were just talking. We're going to go ahead and take the break and come back at 3:15, so you're just getting a little bit longer break this time. We are ahead of schedule, as well. When we come back at 3:15, we'll actually be starting with the home health quality reporting program items. Thank you all.

(Whereupon, the above-entitled matter went off the record at 2:46 p.m. and resumed at 3:17 p.m.)

CO-CHAIR SALIBA: Thank you to everybody that came back on time, so let's get started. We're at the 4:15 item, which is the home health quality reporting program. What we have on our consent calendar for the home health quality reporting program is fall risk composite process measure and improvement in dyspnea in patients with a primary diagnosis of heart failure, COPD and/or asthma. I want to first open the lines to see if there are public

comments on the line. Operator?

OPERATOR: At this time, if you would like to make a comment, please press star, then the No. 1. There are no public comments at this time.

CO-CHAIR SALIBA: Thank you. Are there members in the audience who want to make a comment?

MS. LEE: Thank you. My name is Teresa Lee. I'm with the Alliance for Home Health Quality and Innovation. I want to thank this group, as well as CMS, for the opportunity to provide comments. Both of these measures that are on the consent calendar are of great interest to the home health community. One thing that we are noticing, and I think this is true for a lot of the other settings, is that many of the measures that are being presented, there are other similar measures that are already in use. In the falls area, there are actually, I want to say, three different measures. This composite might actually represent sort of a bringing

together of the three. The improvement in dyspnea measure, there is already an improvement in dyspnea measure that's in home health compare, but it's just not specific to these particular diagnosis groups.

One thing that we've been continuing to find is that as we think about these additional measures, it will also be really important to think, going forward, about what measures should be retained, and what might need to be retired down the road. While I'll still be interested to see the more detailed specs relating to each of these measures and maybe we can figure out, over time, what's the most meaningful, the ideal, I think, really, should be that we have a streamlined measure set.

Until that time, I think that, actually, education is just so critical for the audiences that are going to be using these measures, and for the audiences that are going to be looking at the data related to these measures. Because it can easily become somewhat confusing

as to what all of these many different overlapping measures may mean. In addition, the only other thing that I just wanted to add here is that one of these measures has to do with improvement, the dyspnea measure. We have a number of measures in the home health measure set that are used for various different purposes that involve improvement.

We don't really have any measures that go to stabilization. That's something that, as a home health community, we're very, very aware of and sensitized to in the wake of the GMO settlement, which has emphasized and underscored the fact that the benefit is not only for those who are seeking improvement, but also for those for whom stabilization is an appropriate goal.

We just want to encourage CMS to continue to look at measures for home health, but to not limit the goal to measuring improvement, but to continue to focus in on both improvement, as well as stabilization of function. Thank you for the opportunity to comment.

CO-CHAIR SALIBA: Are there other comments from the audience? Laura, anything in the chat box?

MS. IBRAGIMOVA: No, nothing in the chat box.

CO-CHAIR SALIBA: Okay, Peg, do you want to give an overview?

DR. TERRY: Certainly. I think I had a good head start with Teresa's comments. The first measure is the falls risk composite process measure. What this measure is, it's basically a measure which encompasses three aspects of the falls risk process measure.

The first one is the number of patients who were assessed for falls, so they do have to, in home health, have a multifactorial assessment for falls. The second one is was this risk what was determined whose risk was incorporated into the care plan, so was this incorporated into the care plan? The third one was this care plan implemented?

So there are three parts to this. I

want to say that this is a measure that is clearly under development. We recommended encourage continued development for this measure. We did find a study that we thought was relevant. It was by Dr. Tinetti. People may know Dr. Tinetti's name. She's done a lot of research in falls. Did find that if you actually put in place some strategies for prevention that you can actually reduce the risk of falls in home care patients. I think that's just a quick summary of this composite process measure.

CO-CHAIR SALIBA: Thank you. CMS?

MEMBER LEVITT: First of all, thank you, Teresa, and thank you, Peggy, both comments. We agree, in terms of, first of all, looking at trying to get a parsimonious set of measures together and really look forward to continuing to work with the home health stakeholder community to try to find that set.

Also looking, at the same time, whether some measures may be getting used by the community that we would want to keep reporting on

just because they're using them in their own quality efforts. It is a little bit of a balance, but this is an example of what we are looking at now is trying to take existing processes that may be looked at and combining them into a reasonable composite to try to make it into a composite measure that makes sense, that would be something that would be meaningful to the patients and families, would be meaningful to the stakeholder community, would not add burden, and would also hopefully decrease the number of measures that are out there and the confusion that may be associated with those measures.

I guess one of the questions that we'd be interested in would be if you agree that this is the way to go, particularly in this case, in this measure group, should we be looking to assign an outcome to it, as well, or should we just keep going the way we are going here, in terms of having three different items combined into one measure. So we would be interested in

the workgroup opinion as to whether or not, in our development, we should just continue going this way, or whether there are other ways to look at it.

CO-CHAIR SALIBA: We had two discussants from our group on this measure, Liza and Lisa. Who's first? Okay, Lisa.

MEMBER WINSTEL: I guess I am. I think, Alan, you might have just answered my first question for the discussion, which was is this meant to replace or add to some of the existing measures out there? I think that bringing clarity and having one comprehensive measure is a terrific goal. I find that one of the fuzziest areas is how to measure that the care plan was actually implemented. Because if it's implemented, and then it continues to have that implementation in the home after the discharge from home health, is not within home health's control. That, I think, becomes a question on how that can be measured.

MEMBER GREENBERG: This is Liza. I

think my thoughts are along the same lines as others that at the moment, there are a lot of falls measures. I, at first glance, don't really see how much this added to the portfolio. But thinking of it as a composite, I think it gets more valuable, particularly if you do add the outcomes.

I think without the outcomes, you're just enhancing emphasis on more process, and there's not always a very strong correlation between having a plan -- although you're going to be trying to measure implementation -- but having a plan doesn't necessarily correlate to all the pieces falling into place, the physician making a referral to PT, a patient using a cane, all the things that have to happen. It makes much more sense to pair that with an outcome measure about the actual rates of falls. I think adding outcomes and adding a component about patient experience, which I guess is already around, but seeing if there's a way to pair it with the information to understand how the patient is

engaging in that whole process.

CO-CHAIR RAPHAEL: I was just going to jump in on this because I also agree that right now, we have -- this is kind of risk of falls and how to reduce the risk of falls. We've also had, in the past, rates of falls, particularly with injury. To me, I think we have to find the bridge between the risks and the rates in as simple and as streamlined a way as we possibly can.

But I think the virtue of this is that if you see a patient in the home for congestive heart failure, this really enlarges your relationship and your frame because you're now thinking about the drug reviewing regimen that we talked about earlier because one of the causes of falls has to do with drugs. You're now thinking about balance and whether or not the person has balance, things that you wouldn't ordinarily think about if you just zoom in and deal with the CHF. I think that is an important change in how we're viewing this benefit and the

responsibilities of the post-acute care entity.

CO-CHAIR SALIBA: So now's the time that we talk about whether we're going to keep these on the consent calendar or not. Anyone want to remove one of these from the consent calendar?

MEMBER LEVITT: Are we done discussing the dyspnea measure?

CO-CHAIR SALIBA: I think we do the discussing whether or not we want to put it on the consent calendar first, and then we do the discussion. I'm sort of in a pattern here. Anyone want to remove one of these items from the consent calendar? Okay, now we'll discuss. Any comments, questions, thoughts? Alan, did you have your card up to say something?

MEMBER LEVITT: I was going to wait for the discussion. I just did want to mention, for the dyspnea measure, why is this measure here, if we've already got a dyspnea measure out there. This was actually -- when this came up for endorsement in the pulmonary and critical

care meeting here at the NQF and it was not recommended for endorsement, the reason from the committee was that they felt that it should be a measure that really, the denominator should be of these diagnoses, that it shouldn't just be of the general home health population.

That's why we've brought this measure here to the workgroup, to get your opinion as to whether or not you feel that this measure should be for the general home health population versus this more specific, diagnosis-specific population.

Just to point out that this may be a good idea, the down side to it is that it probably is -- about 10 percent of the population would end up being in the denominator, and it would cause reportability to go down to about 30 percent of the agencies if we decided to do this. So there is a down side to it. The up side is that was the committee's recommendation, as well, just to generate the discussion.

CO-CHAIR SALIBA: Alan, it would help

me to understand why they -- clearly these are diagnoses that are associated with shortness of breath, but why did they think that you needed to limit it to these particular conditions? What was their reasoning?

MEMBER LEVITT: Unfortunately, in 2012, I was still retired, before I decided to come back to do this work. I'm not sure, actually. It would be okay to ask one of our contractors if they know?

CO-CHAIR SALIBA: Yes, absolutely.

MEMBER LEVITT: Anybody from the ABT contracting team? Can we ask Dr. Nuccio, even though he's the ex-officio for this?

CO-CHAIR SALIBA: Yes. Just to explain, Dr. Nuccio has excused himself from discussing this as a panel member because he worked on the measures. But yes, certainly he can comment as a measure developer.

MEMBER NUCCIO: I think I'm the only member of the team that was here in 2012, when the NQF group said we should restrict it. Quite

frankly, there was a concern that the measure of just improvement in dyspnea was overly broad. It applied to too many people, and should only be applied to those folks with those particular diagnoses. Since then, we've had a technical expert panel come in and review the data from the measure that's reported publicly, which is the improvement in dyspnea measure for all patients, and compare the results with this one.

The technical expert panel said that we are treating symptoms of dyspnea, whether or not they have the actual diagnosis on the OASIS instrument. Because there is only a limited number of spaces that you can have for the diagnosis, either as primary or secondary, on the OASIS instrument, we're under-reporting to the point, as Alan pointed out, there's only about 3 to 5 percent that have dyspnea as a primary designation.

Whereas, we can report the measure of improvement in dyspnea if you have the symptoms related to shortness of breath for more than 50

percent of our patients. So it's a much broader measure, and is well risk adjusted, and CMS has requested that we continue to use the measure publicly.

CO-CHAIR SALIBA: I asked, in part, because from a patient-centered perspective, if someone's short of breath, it seems like you want to be figuring out what's going on and addressing it, regardless of the etiology. It sounds like your second panel sort of was leaning in that direction, as well.

MEMBER NUCCIO: Absolutely.

MEMBER LEVITT: Again, obviously, we listened to the recommendations of the NQF workgroups, and we bring that here. Again, we'd like you to discuss it and make a recommendation. If you feel that we should continue going this way, that's a recommendation we would listen to. If you think that we'd be better off being more inclusive with either all diagnoses or other -- however you would wish to look at this and think about it.

CO-CHAIR SALIBA: Thank you. Cari?

MEMBER LEVY: I was just going to comment. Many of the measures have to do with function and medications and that kind of thing. This really does speak to quality of life. I think it's an important measure to consider. Given what Gene is saying, inclusion of a broader population seems very reasonable with the knowledge that we have now. Those would be my comments.

CO-CHAIR SALIBA: Jim.

MEMBER LETT: Generally, with the two, I personally always have a problem with multi-part measures because if you fail the measure, you don't have actionable information. If you have a three-part process around falls, and you fail it, you don't know which of the three parts you need to work on.

Quality improvement wise, it's not actionable to me. The same thing with dyspnea. That is it's a two part. You have to both have dyspnea and also have a very specific diagnosis.

Going backwards, being patient centered, I agree with you 100 percent. Patients really don't care why they're short of breath. They're okay with no diagnosis, as long as you do something about their dyspnea.

As far as the falls, why not just go to outcomes? How many falls do you have? If you have very few falls, are we truly going to live and die by whether or not they follow the right process? Looking at it from the other way, if you do the right processes and you have a lot of falls, does that mean you pass the measure? Are we going to do this, this three-part falls issue, in all the sites of care, SNF, LTAC, IRFs and home health? If not, we shouldn't do it in one and not do it in the others, unless it offers, to me, humbly, a clear advantage. Also, you're asking for more reporting elements, which is more burdensome on the providers. So for parsimony's sake, maybe less is more sometimes.

CO-CHAIR SALIBA: Liza?

MEMBER GREENBERG: When I first

reviewed this measure, I didn't really understand what it added to the portfolio. It sounds like this group mostly agrees. I think it would be a step backwards to start excluding large components of the population. From a quality improvement point of view, you might look at your most at-risk populations from time to time to see if you're addressing their needs.

But I think when you report it to the public, a patient would want to know if I'm short of breath, will I get help, not do I fit in this category. I do think, though, that there needs to be some consideration -- to Teresa's point about stabilization, some people just won't improve. They will stabilize. Maybe a question about did your home health agency help you learn techniques to manage your shortness of breath or something that would help address whether they were trying to address the dyspnea, but not necessarily improving my comments.

CO-CHAIR SALIBA: Jim, is your card still up on purpose? Alan?

MEMBER LEVITT: A couple of things. First of all, Jim, this would be specifically a measure in home health. The items already exist. There actually have been measures -- singular measures associated with these items that have kind of been legacy measures.

That's one of the issues we're talking about is this huge group of measures that are out there, many of which are topped out, some of which may still yet be used by home health agencies in their own quality improvement activities.

That's why even if we decided to go ahead and develop composite measures such as this that may be more understandable for patients and families and may be more reportable, and there may be a greater performance gap or difference between agencies, would the agencies, themselves, still like to have those individual components reported on to themselves, which they can in their own files? That's one of the questions that we'll be working on with the stakeholder

community if we decide to go this way. We're not really adding anything new. We're just kind of taking what's there and putting it together.

I apologize I didn't talk about stabilization because that is important. We successfully were able to develop a star rating for home health compare this past year, and we did it with -- the stakeholder community really helped us a lot in the development of the star rating. Certainly, what we've learned from that is that we need stabilization measures.

It is something that is a priority of ours to try to look at that because as you know, the existing stabilization measures that were out there are not meaningful. So it is something we need to develop. They are important. Obviously agencies that take care of such patients as their mission, it's important. We obviously want to be able to show that these agencies are successful at what they do, so it is something we are looking.

CO-CHAIR SALIBA: Any other thoughts

or comments about either the falls or -- oh, I'm sorry, only looking in one direction. Gerri.

MEMBER LAMB: I just would like to follow up Jim's comment about the composite measures. I understand the need for disassociating for quality improvement. Speaking from the experience on the care coordination standing committee, I think there's a really strong need to connect process and outcome.

So I, for one, am very supportive of composite measures because it begins to allow us to connect the dots. From what you're saying, we can also take them apart, so that we can look at quality improvement. But I really see a huge need, particularly in the care coordination front, for bringing those pieces together, and then also voicing a vote of support for stabilization.

That was one of the things, going back to discharge to the community, when I looked at the rationale for why that was an important measure, it talked about optimization of function

and cognitive function. That's not always the case, particularly in home care. So I think the point of looking at stabilization is well taken, as well.

MEMBER WINSTEL: Just one quick point about falls assessment in the home. That's for you to recognize that being in the home actually is very different than falls assessment in any of the other settings. It would be really great if this particular home health measure could in some way include in the list of medication, transfers, falls history -- include that there be an assessment of the home for falls risks, whether that's the throw rugs or low lighting, etc., but really taking advantage of having that worker in the home.

MEMBER MARKWOOD: Thank you. Just building on Lisa's comment, one of the questions, just as a clarification on the falls prevention, is does this preclude -- because there are a lot of evidence-based, community-based fall prevention programs. What I'm wondering about,

is there any restriction or prohibition of a home health agency using other community-based, evidence-based programs for fall prevention?

CO-CHAIR SALIBA: I would think that would be a sign of a better organization if they were doing it.

MEMBER LEVITT: I'm trying to think of a situation where CMS says don't do more.

MEMBER MARKWOOD: But clarification there, I think that sometimes there's also the incentive to say utilizing community-based resources that exist, that will augment and further the goal, rather than just feeling like you have to do it within the context of just your agency.

CO-CHAIR SALIBA: Thank you. It's a good point. Erin.

MS. O'ROURKE: Thanks, Deb. I did find an old endorsement report about -- that can help clarify the question about where these conditions came from on the dyspnea measure. It looks like during the last endorsement review of

the previous NQF 179, the generic improvement in dyspnea measure, the pulmonary and critical care steering committee recommended that this measure was a little overly broad, and it might be more meaningful if restricted to patients with cardiopulmonary conditions. I believe that CMS was building on the recommendation that came from the last endorsement review of the dyspnea measure with this measure, if that can clarify the committee's --

CO-CHAIR SALIBA: I think I was asking what were they thinking.

CO-CHAIR RAPHAEL: I think they came from a view of looking at this as derived from diagnosis. We're trying to move to a broader patient-centered quality of life, so we're coming at it from a different perspective.

MEMBER LEVITT: It didn't have the holistic post-acute care members on that committee.

CO-CHAIR SALIBA: You need to implant a geriatrician on every one of these panels.

Sean.

MEMBER MULDOON: The reductionist view of that would be is it home care's role to recondition/decondition patients, and can you build a care plan around something that's not a medical diagnosis? If that's yes and yes, then broaden it.

CO-CHAIR SALIBA: Other thoughts, comments? Paul, you look like you want to say something?

MEMBER MULHAUSEN: I've been spending the last ten minutes here just trying to find a counter argument of what I've heard from the people who've been pursuing the more holistic view. I have struggled. I would go back to Deb's observation that when faced with someone with dyspnea, the task is to figure out why, which ultimately leads to a diagnosis, one would hope.

There are several elements here that are problematic for my world view. One is the primary diagnosis issue in dealing with a

population of people who fundamentally are going to have comorbidities, and highly likely that their primary diagnosis is not one of these conditions. They could live with the primary diagnosis.

Then the second would be to drive a diagnostic process that would inform the care plan would be very appropriate to incentivize. The conditioning and reconditioning part, I guess I would argue yes. If my patient was enrolling in a home health program, I would want them to be participating in helping the team, including me, create a program that would help them become better conditioned. Those are my reflections on yours, Sean. Thank you.

CO-CHAIR SALIBA: Cari.

MEMBER LEVY: Just one quick thing. Under exclusions, I don't see hospice as an exclusion. Is it? It probably should be -- no, I'm sorry, for dyspnea. Maybe for falls, hadn't thought about that. For dyspnea, maybe there's --

MEMBER LEVITT: Not for this measure,

in particular, because it's congestive heart failure and COPD/asthma in the hospice setting.

MEMBER LEVY: They could be getting hospice and home health at the same time.

MEMBER LEVITT: We could add that as a suggestion to the workgroup if you want to go forward.

MEMBER LEVY: Yes, maybe just for -- I haven't thought through it carefully, and I'm sure there's things I'm not thinking of, but it seems like it probably needs to be thought about --

(Simultaneous speaking)

CO-CHAIR SALIBA: Cari, would treating shortness of breath be a marker of quality even in hospice?

MEMBER LEVY: Well, it would. I'm just -- yes, maybe it's fine to leave it and not exclude it. I'm just thinking of the person who has lung cancer and a horrible pleural effusion, and they're never not going to be dyspneic.

CO-CHAIR RAPHAEL: It's hard to get

improvement. Dyspnea is very common.

CO-CHAIR SALIBA: Other comments, questions? Jim.

MEMBER LETT: I wanted to broaden the end of life beyond just being in the hospice program. A lot of times, we say hospice, we're thinking about end of life, when in fact, I would presume in this group, hospice means a specific Medicare designated plan. So end of life should expand way beyond that. Again, treating dyspnea at end of life, usually important, but there's only way it's going to get better.

CO-CHAIR SALIBA: Other comments, questions? Again, given that this was on the consent calendar, that means we don't vote, and we didn't take it off the consent calendar. We're not voting, so we're just moving forward to the next item on the agenda. Is everyone okay with that? Liza?

MEMBER GREENBERG: Would it be helpful to CMS for us to take it off the consent calendar and vote to do not continue or to discourage

continuation, or would that not matter to you?

MEMBER LEVITT: We can't tell you what to do and not to do, but again, as I think I had mentioned before, we were interested in which direction that the workgroup felt we should be going with this type of measure, so thank you, Liza.

CO-CHAIR SALIBA: Liza, are you suggesting we take it off the consent calendar and just do a quick straw vote?

MEMBER GREENBERG: Yes, the dyspnea measure.

CO-CHAIR SALIBA: We'll give her time to type in this for voting. We're going to vote on whether or not improvement in dyspnea in patients with a primary diagnosis of heart failure, COPD, and/or asthma should be continued development or do not encourage continued development or insufficient information. Pam.

MEMBER ROBERTS: If we want it expanded to other diagnoses, how should we vote?

CO-CHAIR SALIBA: I think you would

vote not to encourage -- you'd vote 2, do not encourage continued development, because what you want is for it to be the broader, as opposed to working on this specific measure.

MEMBER ROBERTS: Thank you.

CO-CHAIR SALIBA: Let us know when you're ready.

MS. IBRAGIMOVA: The voting for MUC15-207 is now open.

CO-CHAIR SALIBA: No, I think we're voting on 15-235. I think we're voting on 235. We're not voting on falls. We're voting on --

(Simultaneous speaking)

MS. IBRAGIMOVA: Sorry, 235.

CO-CHAIR SALIBA: Hold on a second. Wait for her to change it. I think she has to change it before -- oh, you can? Okay, so everybody can vote. I'm sorry. You're voting on 235.

(Voting.)

CO-CHAIR SALIBA: That's everybody because we had one recuse.

MS. IBRAGIMOVA: The voting results for MUC15-235 are 25 percent encourage continued development, 75 percent do not encourage continued development, and 0 percent insufficient information.

MEMBER LEVITT: Can I just ask would the recommendation of the workgroup be to expand to the general home health population or to other diagnoses or what? General? Thank you.

MEMBER GREENBERG: I thought we were discussing not changing it because we're going to continue to use the measure that we're using, not doing anything with this measure.

CO-CHAIR SALIBA: Which is general. I think what Alan was asking is would we want them to take this one and just expand the list and come up with more diagnoses, or just continue with general? We are now at sort of the end of the items that were teed up for today for discussion. It's an opportunity for public comment in general, about anything related to the quality measures across these settings, or any of

the discussions that we've had today. I'd like to start by asking the operator to open the lines for comment.

OPERATOR: At this time, if you would like to make a comment, please press star, then the No. 1. There are no comments at this time.

CO-CHAIR SALIBA: Are there any members of the audience that wish to make a comment?

MR. HILLMAN: Hi, not to prolong this any longer. I know it's 4:00, and you guys have done an extensive amount of work today. Just wanted to take a moment, from a commentary standpoint, to thank you all for your time.

Thanks, CMS, for coming here and answering some very difficult questions about some of these measures. Just in general, I had two main questions. I believe Mr. Gifford had alluded to this before, but if the NQF committee would consider once again defining the differences between continued development -- the continued development category versus last year, we saw a lot of these conditional support with

NQF endorsement.

One of the biggest questions we have, as a public, as a community, as a whole, is how do these measures -- how do they proceed? How do these measures get implemented, and does this continued development allow the opportunity for implementation of a measure who hasn't gone through the entire NQF endorsement process? Then just a generalized question -- again, I know they're not required to answer any of the questions from a public commentary standpoint, but realistically, will CMS ultimately be seeking NQF endorsement -- the official NQF endorsement for each of the measures that were discussed today and that will potentially be discussed tomorrow?

As a measure developer at UDSMR, we went through a full NQF endorsement process. We know the requirements that we were held to, the standards we were held to. Realistically, we just want to know whether each of these measures that we've discussed today, and we'll be

discussing tomorrow, will go through that same rigorous and extensive testing process? Thank you so much.

MS. LEE: My comment was somewhat similar to his, but I just think, as a practical matter -- this is my first time attending one of these meetings. To me, it just seems like continued development could mean that it's good or it's not good, and discontinuing could mean green light it, go forward, or wow, we've got a major problem with this measure. It just seems to me, from a process standpoint, that it deserves some consideration as to what should the different voting options be? It probably can't be changed for today and tomorrow, obviously, but going forward, it might make sense to really think about what might be more meaningful. Because I can just imagine that the NQF staff probably have a dickens of a time taking notes and making sure you capture it all accurately as to what was actually the feel of the room and what was discussed.

That's the only comment that I have, but otherwise, I think this is a really productive exercise because it enables the public, like me, and all of you, as subject matter experts around the room, to really fully think through some of these measures. I look forward to seeing still more information from CMS about each measure. Thank you.

MS. IBRAGIMOVA: There are no chats.

MEMBER GREENBERG: Can I just make one last comment? We put this in our public comments to our CMS. As the measures get more complex, it's much harder for us and the associations to respond to them intelligently. I just wanted to put a question or a suggestion on the table that maybe as certain models that are embedded in all of the measures come out, like your risk adjustment model or your groupings for potentially preventable re-admissions come out, that those be presented -- when the measure comes out for public comment, there be a slideshow that explains, walks the non-experts through it --

just gets better quality of comment back to CMS and helps us really understand what we're in. Then as ICD-10 becomes the thing, that really seeing those as they're mapped to ICD-10 will be important.

CO-CHAIR RAPHAEL: Very briefly, I think one comment I would make is that as you listen to all of this, the IMPACT Act is foundational, in terms of at least directionally in trying to move us to tie payments to the patient, not to the setting, to really think about how to align across post-acute care settings, how to ensure that people are getting the right care in the right place at the right time, and how we can work toward that. Something that we've grappled with before in this workgroup is how to deal with the tension between standardization and customization. That is recurring because we're dealing with four different settings with, very often, different patient populations, although there is some considerable overlap. I think the other things

that I heard was in regard to our work on medication reconciliation and drug regimen review.

I hope we gave CMS some guidance there that we want more guidance in return. I think two other points that were important is to think about the home setting, what medications you find in the home setting, and not to forget non-prescribed, over-the-counter drugs, which also need to be included in any work that we do in that area.

I think one point that was made in regard to potentially preventable re-admissions I thought was an interesting point, which is we were thinking very much about conditions, and I think it was Joel who said you also have to think at the process. Because we're trying to look at the process, as well as the conditions. I think the other thing we continue to struggle with is how to move along the spectrum from the process to the outcomes. That continues, from my mind, to be a formidable challenge to get to the

outcomes here. We often go back to the processes of care. Then another thing that I think we're grappling with is overlap. Parsimony is something we care deeply about, at least those of us who have been providers and have had to live through this.

So how do you not layer new things on? How do you remove, as well as improve? I think that saying if the Edsel had been a public sector program, it still would be in existence today, that sort of occurs to me, which is how do we really step back and think about what is it that we have that we really don't need, that isn't really showing its utility, or that we can replace with composite or other measures that are going to be more impactful?

Those are some of the things that occur to me. Then I will make one last comment. As I listen to all of this, we talk a lot about moving toward a value-based system and population health. Then we think about -- we were talking last about falls and breathing issues. We talked

about when you go into a home, you ought to examine the home, not just look at the patient. We are, to me, redefining, in a way, post-acute care and what we're responsible for in the post-acute-care sector because we're moving away from just the presenting condition that leads someone to be referred to a post-acute-care setting and saying that we have to look at the whole person and things that just weren't on the referral sheet that we got or on the e-referral that came over online. I think that is something that we need to think more about here, as we continue our work. Deb, I'll turn it over to you.

CO-CHAIR SALIBA: I think other ideas, in terms of the parsimony that came up today, was the idea of in our efforts to be responsive to concerns about measures that people have raised, that leads to refining and tweaking measures, and it may lead to slightly different measures.

That's something that we want to try to steer clear of. We may need to be willing to take a measure that's sort of a compromise, so

that it could be similar with other measures. I think the other thing is that the easy measures have been done. I think now we're at the stuff that's much more difficult and that takes a lot more thought to develop. I really appreciated the comments that people have made today. I think there was a lot of very helpful discussion. CMS was very open, in terms of providing us with background information, and that was much appreciated. I'd like to see if anybody else had some summary thoughts or comments about the day before we adjourn? Alan.

MEMBER LEVITT: I just wanted to thank everyone again. This was exactly what I wanted, we wanted at CMS was really to get a workgroup that we've worked with before to get the opinion as to how our measures are, how our programs are, and where we should be going forward and how we should be going forward, so thank you. We got another day ahead tomorrow.

(Whereupon, the above-entitled matter adjourned at 4:03 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Post-Acute Care/Long-Term Care

Before: NQF

Date: 12-14-15

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter