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POST-ACUTE CARE/LONG-TERM CARE WORKGROUP

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WEDNESDAY
DECEMBER 13, 2017

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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., Gerri Lamb and Paul Mulhausen, Workgroup Co-Chairs, presiding.

MEMBERS PRESENT:
GERRI LAMB, RN, PhD, Co-Chair
PAUL MULHAUSEN, MD, MHS, Co-Chair
MARY ELLEN DEBARDELEBEN, MBA, MPH, HealthSouth Corporation *
AMY GOTWALS, National Association of Area Agencies on Aging *
ROBYN GRANT, MSW, National Consumer Voice for Quality Long-Term Care
KURT HOPPE, MD, American Academy of Physical Medicine and Rehabilitation
FREDERICK ISASI, JD, MPH, Families USA
JAMES LETT, II, MD, CMD, National Transitions of Care Coalition
DHEERAJ MAHAJAN, MD, CMD, The Society for Post-Acute and Long-Term Care Medicine
KURT MERKELZ, MD, Compassus
SEAN MULDOON, MD, Kindred Healthcare
PAMELA ROBERTS, PhD, OTR/L, SCFES, CPHQ, FAOTA, American Occupational Therapy Association

DEB SALIBA, MD, MPH, American Geriatric Society
THERESA SCHMIDT, National Partnership for Hospice Innovation
HEATHER SMITH, PT, MPH, American Physical Therapy Association
CAROL SPENCE, PhD, RN, National Hospice and Palliative Care Organization
ARTHUR STONE, MD, National Pressure Ulcer Advisory Panel
KATHLEEN UNROE, MD, MHA, American Geriatric Society *

SUBJECT MATTER EXPERTS (VOTING):
CONSTANCE DAHLIN, MSN, ANP-BC, ACHPN, FPCN, FAAN
KIM ELLIOTT, PhD, CPH
CAROLINE FIFE, MD, CWS, FUHM
EUGENE NUCCIO, PhD
ASHISH TRIVEDI, Pharm.D.

FEDERAL GOVERNMENT MEMBERS (NON-VOTING):
ALAN LEVITT, MD, Centers for Medicare and Medicaid Service
ELIZABETH PALENA HALL, MIS, MBA, RN, Office of the National Coordinator for Health Information Technology

MAP MEDICAID ADULT CORE SET TASK FORCE LIAISON:
MARISSA SCHLEIFER, Rph, MS, Medicaid Adult Core Set Task Force Chair

NQF STAFF:
ELISA MUNTHALI, MPH, Acting Senior Vice President
ERIN O'ROURKE, Senior Director
KAREN JOHNSON, Senior Director
TAROON AMIN, NQF Contractor
MIRANDA KUWAHARA, Project Analyst
JEAN-LUC TILLY, Senior Project Manager

ALSO PRESENT:

NICHOLAS CASTLE, PhD, University of Pittsburgh *
DAVID GIFFORD, MD, MPH, American Health Care Association
THEODORE LONG, MD, MHS, Centers for Medicare & Medicaid Services
STACE MANDL, RN, BSN, BSW, PHN, Centers for Medicare & Medicaid Services
TARA MCMULLEN, PhD, MPH, Centers for Medicare & Medicaid Services
MARY ELLEN PRATT, Centers for Medicare & Medicaid Services
CAROL SCHWARTZ, Centers for Medicare & Medicaid Services
PIERRE YONG, MD, MPH, MS, Centers for Medicare & Medicaid Services

*** present by teleconference**

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

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

9:12 a.m.

MS. O'ROURKE: Okay, so I think we are ready to get started. Thank you all for making the trip into an unseasonably cold Washington D.C., and especially given that we only had one measure under consideration this year. However, we are excited you all still came to join us. This is actually a meeting we are pretty excited about.

Since we started convening this group -- was it seven years ago, now? We have seen such changes in the post-acute, long-term care world. And, you know, from those early days where the PAC/LTC Group put together their coordination strategy. And then we saw so much of what the group had said carried over into the IMPACT Act and the changes that have come from what the Affordable Care Act put in and then IMPACT built on. And we have a little bit of a pause this year where we can actually step back and think about some of the long-term issues

facing quality measurement in this setting. And we're excited to have all of you and to take advantage of your expertise to help us think through where we want to go from here and tackle some of these outstanding thorny measurement science issues, if you will.

We have teed up conversations on risk adjustment and attribution that we want to get your input in. We also want to make sure that we're thinking about improving quality for the most vulnerable so we have invited Karen Johnson, who is heading up our new Rural Workgroup. We also have Marissa representing the new MAP Medicaid Workgroup just to make sure that as we think about these things we are keeping an eye on the populations that tend to get left behind and thinking about improving quality for everyone. So we're excited to have you, and thank you for joining us. With that I think I will turn it over to our co-chairs, Gerri and Paul, to welcome and see if they have any reflections on our goals for today.

CO-CHAIR LAMB: Well welcome everyone. Really glad to see everyone here and I would like to echo a couple of things that Erin just shared. First I would like to say I am absolutely delighted to be co-chairing with Paul this year. So we are all ready to facilitate a really dynamic, lively conversation. And in talking to many of you we know you are up for it.

So going to what Erin was saying, I hope you have noticed that the agenda has been crafted for us to have a rich dialogue -- to really situate our discussion about post-acute, long-term care in the context of what is happening, the strategic directions that -- that are happening in performance measurement. And it is a time for all of us to, as Erin was saying, step back and really reflect on the current state of PAC/Long-Term Care measures -- where we hope it will go. And we're really fortunate to have many folks from CMS here with us to be part of that conversation with us. So we are just going to launch a really, I think, robust, meaningful

conversation that we can kind of go forward with PAC/Long-Term Care in the future. So, Paul?

CO-CHAIR MULHAUSEN: Thanks, Gerri. So I have to say my thank-yous, first. So, Gerri in my view has been a terrific mentor as we have been preparing for this meeting and I thank you for that and am deeply appreciative. And then the NQF staff, Miranda and Jean-Luc and Erin have been just terrific in terms of helping us to put together the agenda for this meeting and bringing us all together. So -- and then thank you to all of you for getting out here for this meeting.

It is an exciting time in my opinion -- certainly an interesting time, in my opinion, to be thinking about quality, to be thinking about value, to be thinking through how we measure quality. And with all of the activity that's taking place in the world of healthcare quality measurement, how to most effectively measure quality and bring some of that energy into the post-acute care environment is really our task today. So thanks for being here. I too

am looking forward to a very exciting dialogue and I thank you for the privilege to join you as a co-chair.

MS. O'ROURKE: Thank you both. And thank you for taking on the co-chair role. We appreciate your leadership so far and throughout the day. So I would like to introduce Elisa Munthali, our acting Senior Vice President, to lead everyone through introductions and disclosures of interest.

MS. MUNTHALI: Thanks, Erin. And I wanted to thank all of you for being on this workgroup. And so what we are going to do today is to combine our introductions with disclosures of interest. We are doing it in two parts because there are two types of members that serve on this workgroup. The first is organizational members, and many of you are organizational members, and the second is subject matter experts. And I will start with the organizational members. You represent -- I just wanted to remind you -- you represent the

interests of a particular organization and we expect you to bring those interests to the table and to your discussions. Because of your status as an organizational representative, we ask you only one question that's specific to you as an individual. And this is if you have any interests that are in excess of $10,000 that are related to the work in front of you.

And so what we will ask you to do is I will ask --- we'll start clock-wise, and we will go around the room. We will ask you to tell us who you're with and to orally disclose what you did on the form. So we'll start after Allen, I think. We'll start over here on this side -- to my left. Raj.

MEMBER MAHAJAN: I am Raj Mahajan. I am from Chicago and I am representing AMDA, the Society for Post-Acute and Long-Term Care Medicine. I do not have any disclosures.

MEMBER NUCCIO: Gene Nuccio from the University of Colorado Anschutz Medical Campus. I am the SME on Home Healthcare and have no

conflicts.

MEMBER ELLIOTT: Did you want the subject matter experts?

MS. MUNTHALI: Not yet. So that's a lengthier process. That's okay, we have that recorded.

MEMBER ROBERTS: Pam Roberts, I represent American Occupational Therapy Association and I am from Los Angeles, California so the cold is a bit chilly today. But I have no disclosures.

MEMBER MULDOON: My name is Sean Muldoon. I am a full-time employee of Kindred Healthcare, a provider of post-acute care services.

MEMBER SMITH: Hello, Heather Smith. I represent the American Physical Therapy Association and I have no disclosures.

MEMBER SALIBA: Hello, I am Deb Saliba and I am President of the American Geriatric Society.

MEMBER SPENCE: Carol Spence, I

represent the National Hospice and Palliative Care Organization and I have no disclosures.

MEMBER HALL: Hello, I am Liz Palena Hall. I am an ex officio member from the Office of the National Coordinator.

MEMBER TRIVEDI: Hi, I'm Ash Trivedi from Novartis Pharmaceuticals, I have no disclosures.

MEMBER GRANT: I am Robyn Grant with the National Consumer Voice for Quality Long-Term Care and I have no disclosures.

MEMBER MERKELZ: Good morning, I am Kurt Merkelz, I represent hospice with Compassus and I have no disclosures.

MEMBER LETT: Good morning, I am Jim Lett. I represent the National Transitions of Care Coalition. I am president of their Board of Directors and have nothing to declare.

MEMBER STONE: Morning, Art Stone. I am the representative from the National Pressure Ulcer Advisory Panel and I have nothing to disclose.

MEMBER HOPPE: Good morning, Kurt Hoppe. I represent the American Academy of Physical Medicine and Rehabilitation. I have nothing further to disclose.

MEMBER SCHMIDT: Hello, my name is Theresa Schmidt. I represent the National Partnership for Hospice Innovation and I have nothing to disclose.

MS. MUNTHALI: And I don't know if we have any organizational representatives on the phone. I think we were thinking that the National Association of Area Agencies on Aging may be on the phone, but intermittently during the day.

MEMBER UNROE: Hello, this is Kathleen Unroe. I am on the phone.

MS. MUNTHALI: Hello, Kathleen.

MEMBER UNROE: Hello, so I am also American Geriatrics Society. I am sorry to be here in Indiana, but nothing to disclose.

MS. MUNTHALI: Thank you. So thank you so much for the organizations that disclosed

and now we will be going into the disclosures of interests for subject matter experts. This was a lengthier form that you received and the reason why is you sit here not representing your organization, but we put you here based on the experience and activities that are related to this work for which you can help us, you know, to complete.

So we wanted to give you a couple of reminders. We want you to be able to disclose any of -- any grants, consulting, speaking arrangements that are relevant to this work. So only those that are relevant to this work -- not just those that you were paid for, but also those that you may have volunteered for or that you were not paid for.

And there are a couple of other additional reminders that are really important for you to remember. Just because you disclose does not mean you have a conflict of interest. We do this in the spirit of transparency and openness. And so I think we have gone through

all of the reminders. And so we will go around the room for those that haven't yet disclosed that are subject matter experts. And again, we will start clockwise, so to my left. And Eugene, I think we got your disclosure.

MEMBER ELLIOTT: Kim Elliott and I work for Health Services Advisory Group, and I have nothing to disclose.

MEMBER DAHLIN: Hello, I am Connie Dahlin. I work for the Hospice and Palliative Nurses Association, but I am representing the Coalition for Hospice and Palliative Care and I have nothing to disclose.

MEMBER FIFE: I am Caroline Fife, I am a physician in Houston and just to make sure that I am thorough, I am the Executive Director of a qualified clinical data registry called the U.S. Wound Registry, which I don't think is a conflict, but I will let you know that I do that anyway.

MS. MUNTHALI: Yes, and Co-Chairs.

CO-CHAIR LAMB: I didn't think we were

exempt.

(Laughter.)

CO-CHAIR LAMB: I am Gerri Lamb and I direct the Interprofessional Center at Arizona State University. And, Elisa, do we share any -- or does it need to be over $10,000?

MS. MUNTHALI: Over $10,000.

CO-CHAIR LAMB: Okay. I have no conflicts.

CO-CHAIR MULHAUSEN: So this is Paul Mulhausen. I am the Chief Medical Officer for Telligen, which is a health management firm that supports CMS and a number of its quality reporting initiatives. And that's my one conflict.

MS. MUNTHALI: Thank you. And we also have some federal members that are with us. They are non-voting members of this workgroup. And so I will start with Pierre.

DR. YONG: Hello, Pierre Yong from CMS.

MEMBER LEVITT: Alan Levitt from CMS.

I have nothing to disclose except this is my fifth year at the Committee, so I think I deserve a pin.

(Laughter.)

MS. MUNTHALI: Any other federal members? On the phone? Perhaps from ONC?

MEMBER HALL: Oh, this is Liz Palena Hall. I had introduced myself in the first go-around.

MS. MUNTHALI: Thank you. So now that you've heard all of the disclosures, I am going to ask the group if you have any questions of each other?

(No audible response.)

MS. MUNTHALI: It doesn't look like you do. I just wanted to remind you, if at any time you remember that you have a conflict, please speak up. You can do so in real time or you can approach your co-chairs. Or you can approach any one of us on the NQF staff. So I just want to ask before I leave again, if you have anything you would like to ask your

colleagues?

(No audible response.)

MS. MUNTHALI: Great, thank you.

MS. O'ROURKE: So I think I would also like to ask the NQF team to introduce themselves. I am Erin O'Rourke. I am the Senior Director supporting the Workgroup.

MR. TILLY: I am Jean-Luc Tilly, a Senior Project Manager supporting the Workgroup.

MS. KUWAHARA: Good morning everyone, my name is Miranda Kuwahara. I am the Project Analyst for this work.

MR. AMIN: Hello everyone, I am Taroon Amin. I am a consultant to NQF supporting the MAP Coordinating Committee.

MS. O'ROURKE: Great, so if we could just move on to our agenda slide. One more. Just want to do our few housekeeping comments before we start with the agenda.

If you could, please, make sure you turn on your microphone before you speak so the transcriptionist can capture it. Also, for the

folks on the phone, to do so you just push the red speak button once and then to push it again to turn it off. We can only have three of them on at a time, so apologies if we have to remind you to turn the microphone off. Otherwise, if you want to speak in the room, please lift your tent card up so the co-chairs know you want to get in the queue and can call on you. Let us know if you can't get on the wifi and we can send you the log-in and the passwords. And the restrooms are right past the elevator to your right.

So with that, just to cover our agenda briefly. We are going to turn it over to Pierre to share some opening remarks and review the new Meaningful Measures Framework. After that we will be providing you with an overview of the new MAP Rural Health Group -- to cover what that group is charged with doing. We will also have an update on the implementation of the IMPACT Act and some updates on the work around the PROMIS tool.

After that we are going to have a conversation about the application of the Merit-based Incentive Payment System in post-acute care and long-term care. This was actually suggested by our co-chairs as a potential discussion when they saw the list of measures under consideration and to think about what input this group could provide to the Clinician Workgroup who is primarily charged with reviewing measures for that group and the Coordinating Committee to overcome some of the challenges that clinicians practicing post-acute care and long-term care may experience participating in that challenge -- or, in that program -- and what guidance the group may have to overcome some of those challenges. If there's any particular measurement gaps or input the group would like to share with CMS. After that we will cover the pre-rulemaking approach as we get into our main task at hand. And then go through each of the programs the group is tasked with reviewing.

Obviously we only have our one measure

that's under consideration for the Skilled Nursing Facility Quality Reporting Program. However, we will ask you to spend a bit of time thinking about potential gaps in the Hospice, LTCH, IRF and Home Health programs -- in particular, thinking about the work that Pierre will share and Stace and Tara will share about the update of the IMPACT Act and how we can continue to foster alignment across the settings, are there any gaps that the workgroup would like to name across all of the settings.

I think we also want to think about how we can overcome some of the challenges to get to the next generations of measures, if you will. There's been quite a few gaps the group has named for years, but we're having challenges actually developing those measures. Obviously, NQF is not a measure developer, but what input the group may have for measure developers on where to focus and how to get to some of the concepts around care coordination and patient engagement that you've named previously. After that we will provide an

overview of NQF's attribution work and ask the group for some input on any special considerations that panel should take into account for post-acute and long-term care settings.

We then want to provide you with an overview of NQF's new Equity Program. And then finally end the day with an overview from CMS on the criteria they are considering for measure removal and to get input from this group on what you think about them all. So it is a pretty full agenda and we are excited to have you join us and help us think through some of these cross-cutting more -- longer-facing issues while we have a break from reviewing measures under consideration. So I think with that, was there anything else? Oh, yes.

CO-CHAIR MULHAUSEN: So when I hear Erin review the agenda it reinforces a thought that Gerri brought to the table which was, this is really an opportunity for us to collectively think strategically around the future of quality

measurement and post-acute care and long-term care and to share those strategic thinking -- that strategic thinking with CMS.

So although we have a single action item on the agenda, this is -- the team here has really put together a very unique opportunity for us to think about what's missing, what can we do, how can we make the programs that aren't necessarily focused on post-acute and long-term care work better for those who are dedicated to post-acute and long-term care. And as I heard you review the agenda, I got more excited about this strategic opportunity.

MS. O'ROURKE: Excellent, so I think with that why don't I turn it over to Pierre for some welcoming comments and to review the Meaningful Measures Framework?

DR. YONG: Great, thank you to Erin, Gerri and Paul, and the rest of the NQF staff. So, very nice to see many familiar faces around the table and see some new faces as well. My name is Pierre Yong, I am the Director of the

Quality Measurement and Value-Based Incentives Group at CMS. And we have primary responsibility for the programs that you are talking about today.

And so, very happy to see you all. We weren't sure last week if we were going to be here. There's discussion, obviously, with the shutdown about, like, what would happen with MAP if we didn't actually get the continuing resolution. But luckily there was the CR that was passed, so we have a two-week reprieve. So we don't know what's going to happen at the 22nd, but, you know, wish us well.

But really excited about today. I think that like Paul was just saying -- and Gerri was saying earlier -- there's really a tremendous, I think, opportunity today with you in the room to really gather your thoughts about, you know, sort of, bigger picture strategic thinking relative to the PAC programs. And so, you know, there are a number of CMS staff here in the room as well as on the phone and we will be

here all day. So really want to take advantage of, you know, your presence here to sort of get your insightful thoughts about a variety of topics.

So, I apologize in advance, because I am sure many of you have actually heard this presentation before. I think by tomorrow I am going to nominate Erin to do this because I think Erin has heard this particular presentation probably like eight or nine times at this point. So, we are doing it across all the workgroups.

So you may have heard our administrator, Seema Verma, talk a little bit about some of the priorities that they have set forth for our work at CMS. And in particular one initiative is called Patients Over Paperwork, which really relates to sort of thinking about how we can at CMS be really supportive of the work that -- and the clinical care that is happening out across the country in a supportive way. And really sort of trying to minimize the burden as well as the -- any sort of -- how to

support the workflow so that we are not, sort of, interfering or getting in the way of clinical care. Because that's, I think, why we all entered healthcare in the first place, really, right? To really improve patient care.

So if we move to the next slide, the Meaningful Measures Framework is really a framework that we developed to really help us and think through at a strategic level, across all of our quality reporting and accountability programs, what really would be the most Meaningful Measures to focus on and include in our programs. One of the things that we've heard at prior MAPs -- but also in other settings, too -- is that we've had a proliferation of measures to be included in our program. So one, is that really helpful? Two, are those the right measures? And three, it seems like with all of those measures it is hard then to tell what really is the most important topics that we should be focusing on. What are the biggest opportunities to improve and target quality

improvement efforts, really, to drive quality improvement.

So the Meaningful Measures Framework sort of came out of all of that feedback as a way for us to think about how to focus our work. And so on this slide -- I am not going to go through everything -- are some of the sort of larger goals that we are working towards at CMS. And if you move to the next slide, please? The framework itself really has an initial set of 18 Meaningful Measure areas. They are topical areas. And we will quickly go through those and welcome your feedback to see if there are any gaps or if these are the right areas and make sure they resonate with you.

But underpinning that there's -- because those are just topical areas, there are other things we -- elements of measures that we also want to consider when we think about what are the right measures. We want to think about measures that really address high-impact areas, that safeguard public health -- which I think is

what the 18 initial Meaningful Measure areas really target. But we want to make sure that actual measures themselves -- because the 18 areas are just topical areas, they're not the actual measures, right? So we want to make sure that the measures themselves are patient-centered and meaningful to patients and to providers, and are relevant to their care practice.

We have long preferred outcome measures. We've heard this, I think, from -- in many of our discussions both at the MAP and in other conversations as well. That doesn't mean that there isn't a role for process measures. It just means -- because often times there's not an outcome measure available for a particular quality area. But it means that if there are outcome measures, that those probably are the preference. Burden is something we talked a little bit about earlier, but particularly looking at the level of burden associated with collecting data, reporting data, reviewing data -- all of that is -- is another factor that we are

considering.

We want to look for opportunities for improvement, so you know if a measure is topped out, if everybody is performing it at 100 percent, then is there really a point to including it? Not to say it may not be important -- we had a whole discussion yesterday about, like, the role of -- at the Clinician Workgroup, the role of safe surgery checklists --- where most everybody is doing it already.

But is there still opportunity for improvement, particularly in programs which are really supposed to drive quality. And in particular when you're moving to value-based purchasing programs where you're then trying to determine payments based on performance, if everybody is performing the same, I think it becomes very much harder to then differentiate between performance amongst providers.

We want to address measure needs that really help sort of move towards population-based payment through alternative payment models. And

then alignment is really another key consideration -- not just within and across our PAC programs, for example, with the IMPACT measures -- but really within CMS programs, for example with Medicaid. And then a lot of the work we are doing with commercial payers through the Core Measures Collaborative. Can we move to the next slide, please?

This just identifies some of the sources -- key sources -- that we drew upon when we were developing this initial framework and included the NQF work, of course, so -- if you move to the next slide. This graphic for those familiar with it is from the LAN, the Learning and Action Network, white paper -- population health white paper on measurement. If you look on the right side, what they have conceptualized nicely are these atomistic performance measures on the bottom of the slide. And you can think of those as any of the individual measures that we have in our programs, what they've termed little dots, or level-three dots. And really encouraged

us to really move towards really level-one and level-two dots -- or, big dots, excuse me, level one and level two -- which really are these larger sort of performance measures.

And so what we thought -- we thought this was really helpful and helped us think about how to develop the framework as we think the Meaningful Measure areas are really more of these level-one, level-two areas that we want to focus on. They're not actual measures, as I mentioned before. So if you move to the next slide.

This is -- these are the initial set of the 18 that I mentioned. I will quickly review them. They are grouped into six domains and they are supported by these sort of cross-cutting considerations that we think are really important to consider regardless of whether, which domain you are in and which specific Meaningful Measure area. So, elimination of disparities, tracked and measurable outcomes, safeguarding public health, achieving cost savings, improving access for rural communities

and reducing burden.

So if you move to the next slide, the first domain is about safety. And here we have two Meaningful Measure areas -- the first being healthcare-associated infections and the second being preventable healthcare harm. On the right side of the slide -- and I know it's a little bit busy and we won't go through all the details, though I am happy to answer any questions if folks have them -- are these more level-three dots. And we've been starting to think about how we can use this in our program. So one way is sort of looking across our measures in our programs and seeing, do we already have measures in -- associated that track to this particular Meaningful Measure area.

For the first example, healthcare-associated infections, where we have the CLABSI measure, the central line-associated bloodstream infection measure which we have in several of our programs including some of the PAC programs. So you can see how we already have measures that

track to each individual Meaningful Measure area. If you move to the next slide.

The next domain is strengthening person and family engagement. Here we have Meaningful Measure areas including care that is personalized and aligned with the patient's goals, end-of-life care according to preferences and patient's experience and functional outcomes. And I am not going to go through the details of each slide in the interest of time, so we can maximize time for feedback and discussion. So if you move to the next slide, please.

The third area is promoting effective communication and coordination of care. And here we have medication management, admission and re-admissions to hospitals, and seamless transfer of health information. If you move to the next slide is -- the next domain is promoting effective prevention and treatment of chronic disease. And here we have a large number of Meaningful Measure areas given the scope of the larger domain. But here we have preventive care,

management of chronic conditions, prevention, treatment and management of mental health, prevention and treatment of opioid and substance use disorders, and risk-adjusted mortality.

If you move to the next slide, here this next domain is around working with communities to promote best practices of healthy living. And here we have equity of care as well as community engagement. And I wanted to pause a second on equity of care because I think you can think about it in a couple of different ways. But equity of care in particular, I think, could be measures around equity of care. But we've been thinking about it a little bit more broadly than that, as not just measures, because I think at CMS in particular we have several policy levers that we can use, for example.

So the folks that are familiar with the Hospital Readmissions Reduction Program may have -- know that this past year we have restructured the program moving forward so that we are actually assessing performance based on a

stratification model. So we are comparing hospitals to other hospitals based on proportions of dual-eligibles that they care for. So there is a stratification approach, which is more on the payment side as opposed to an actual measure. So we think of this as -- the equity of care Meaningful Measure areas as broader than measures, per se, is I think the larger point.

So if you move to the next slide -- making care affordable is the next domain. And here we have appropriate use of healthcare, patient-focused episode of care, and risk-adjusted total cost of care. Move to the next slide. I think -- as we've been doing and had the opportunity to do a number of presentations about this, which -- in particular, I think the feedback and the questions have been particularly helpful. I think a couple of common questions have come up that I just wanted to address quickly.

One, I think there's -- folks have asked if this is new sort of quality reporting

program, and I think folks hopefully understand it's not a quality reporting program. It's really an overarching strategy for how we think about quality and quality measures and quality improvement at CMS. It doesn't by itself impose any new reporting requirements or new measures that people have to report. That's not -- it really is a strategy -- an overarching umbrella strategy for us to think about quality measurement and improvement at CMS.

One question is sort of -- or, two related questions, maybe, are one, how will it be used? And two, how will it actually reduce burden for me as, you know, either clinician or facility? And I think those are related questions. So we've been really trying to get a lot of stakeholder input, and so welcome that discussion today. I think we've already started to think about how this could apply to the various quality-related activities at CMS. So we've applied it, for example, to the MUC list. And you can -- you've noticed that you have only

one measure on the MUC list and that is, I think can be traced to sort of application of the framework as we review the MUC list.

And that's been true across the workgroups. I mean, we've -- on the MUC list we took less than a quarter of actually the total submissions for this past year. So we've really tried to focus on what we really think would be the most Meaningful Measures to potentially include in our programs, to include on the MUC list.

We've also started to think about how we can apply this as we look at the existing measures in our programs. So -- and this means across all of our programs. It's all the PAC programs, clinician program, the hospital programs -- I mean, there's 17 programs in total that we're working on. So later on the agenda we will have a discussion which we are hoping to get your feedback on, and we're having across the workgroups as well, about getting your thoughts on the criteria we should be using to think about

measure removals as we continue to evaluate these measure sets across the program. So, I think that's another way we've been thinking about using the framework.

And I think a third is sort of -- as we've been thinking and looking through the measure sets, obviously gaps appear. And I know that's a big point of discussion that we will talk about today. So I think this also then feeds into measure development work, right? So what are the right measures we should be working on. And so I think those are some key areas. I will say, it's not being only applied on the quality measure space of the quality reporting programs. We've also been working really closely with our colleagues who work in the quality improvement space, for example, so those of you who know Dennis Wagner and Jeneen Iwugo, Paul McGann who head our quality improvement work in the QIN-QIO work, for example, partnership with patients. So they have also been working really closely with us on thinking through how we apply

this framework in terms of their work because they really go hand in hand. We've also been working with our colleagues in the Medicaid space as well, for example.

And I think through that as we sort of review the measure sets and then think through measure development, I think that's where hopefully we will see -- and where providers will then see how -- where the implications for burden will take place. Because as we potentially make changes to program requirements, those will go through our normal rulemaking cycle. So it will be proposed and then we will seek public comment and finalize in the next rule cycle. So I think that's where folks will see some proposals relating to this in next year's rule cycle.

So if you move to the next slide, that's, I think, all I have in terms of the presentation. So I am going to stop here, but really do welcome any sort of feedback or questions, clarifications, from folks here.

CO-CHAIR LAMB: Thanks, Pierre.

Pierre, you're going to be with us the whole day?

DR. YONG: Yes, I will be at the table, in and out, yes.

CO-CHAIR LAMB: Okay, great. So, thank you for a wonderful foundation for our discussion. I think Meaningful Measures gives us a frame to move forward. So, comments? Recommendations? Caroline?

MEMBER FIFE: Caroline Fife. If you want to know why this won't work under MIPS for clinicians, I will be glad to tell you. Probably not so relevant to the organization here, but if you want to see my scars from running a QCDR, I will be glad to show you outside.

CO-CHAIR LAMB: Raj?

MEMBER MAHAJAN: So, I have a very foundational question, and it's really three words here. I understand why those came up, but who and how was this done? Because almost -- it looked like came out of nowhere -- the whole Meaningful -- because we were working on adding more measures and making it more burdensome,

again -- I'm just -- as I said, I am being a little cynical here, too. But is there more? I mean, and you're right, this is the ninth time I am hearing this presentation. But is there more material on the granularity of how this work was developed? What feedback? Whose feedback went there? Was there some evidence used, or --

I just want to see -- it just looks like it came out of nowhere and then maybe with change of leadership will go away and we'll go back to where we were. I'm just kind of -- little concerned, or just raising this question.

DR. YONG: Yes, thank you, Raj. So I don't think it came out of nowhere. So if you go back to a couple -- I didn't go into details, so if you go back a couple slides. Keep on going. There's been a lot of work done out by a number of a bodies -- keep on going, one more. One more. Thank you. Both -- across sort of -- in different sort of bodies of work. So there's been a lot of work done by the Health Care Payment Learning and Action Network. I

referenced that diagram that came from the Population Health white paper that talked about this and had some suggestions. National Quality Forum is actually doing a lot of strategic work around sort of, you know, a similar concept. So that sort of came into play. The National Academy of Medicine last year put out the Vital Signs Core Metrics Report. So we drew on that. There's been a lot of work at the Core Measures Collaborative.

So there's been a lot of work at different bodies of work that sort of -- and there have been a lot of discussions. We've had this discussion at various MAP Workgroup meetings, too. So we reviewed all of that material and certainly took that material in order to develop this. So I don't -- so we drew on a lot of sources to come up to this. So I don't -- hopefully it's -- while it is a -- new for CMS, or at least -- framework per se, it draws on a lot of existing sources which I think overlap pretty well.

MEMBER MAHAJAN: You know, I just -- thank you for that. And as I said, I completely understand why and we welcome this.

CO-CHAIR LAMB: A thought here is, you know, as we look at the six domains, okay, it doesn't seem in my mind that there's any question about their relevance to PAC long-term care. So I am thinking to kind of use this foundationally and keep looping back as we go through each of our areas to take a look at how can we inform the play-out of the Meaningful Measures? My understanding is that from what Pierre is saying where, you know, the focus is on the level one and two. And I think we have the expertise in the room to take a look at what is meaningful level one and two for PAC long-term care? And get that into the dialogue.

The other question I would have for Pierre is as -- and he has heard me say this before on some of the webinars -- is as we move to a healthcare system that reflects all of our perspectives, all of the diverse perspectives of

all of the professionals, all the community workers, all the lay workers in healthcare, how do we bring them into this dialogue? It strikes me that the framework -- and it may just be an initial choice of words -- but it focuses on a particular component -- physician payment, physician practice -- which is, my guess, is not the full intent of the framework. But as we move towards representing that the healthcare system is pretty complex, has lots of players -- we now have a National Center on Interprofessional Practice and Education that's looking at that. Pierre, is -- has there been any thought about how to get all of these voices into this and engaged?

DR. YONG: Thanks, Gerri, and I think that's a great question. I mean, I think we are -- we've gotten many, many requests to sort of talk about the framework, to -- so that people can one, understand it, but two, also to get feedback on it. I think you have a great point that, you know, the healthcare system is very

complex. And there's many folks who may not be represented on the MAP, for example, that, you know, may have relevant input to provide. And so we are doing our best to sort of reach out to folks. Like, we had a national webinar. We had over 4,000 people on this webinar. And maybe some of you had attended -- it was the same presentation. There was nothing new on that.

But -- so we've been doing a lot of work trying to get that input. And I think it's an initial draft, right? I mean, it's not final and it -- we haven't -- I hope you didn't hear from me that it was final. It is an initial sort of stake in the sand, if you will. And so we are taking this input and we have been discussing internally about, you know, potential changes that we might want to make to tweak and improve the framework. But we do hope that folks can see that there's utility to the framework. And I think it's something that as we move forward, particularly with, you know, rulemaking next year, I think you'll see some -- how we start to

apply the framework in much more concrete ways.

CO-CHAIR MULHAUSEN: So, this is my third time through this, Pierre, and I actually -- it's starting to fall together for me. And when I look at the infographics, I can see how it supports the National Quality Strategy. It makes sense to me. There are a couple of things that I react to. And I honestly am not sure how constructive this reaction is. But I spend a lot of time with physician colleagues and I have listened for years to them complain about the Meaningful Use Program. And that was always our example of high burden, low meaning reporting requirements.

And when I look at this I go, this is a response to the Meaningful Use reaction. And I -- and that reaction to that reaction -- which is all in my head, I have no idea if it was driven centrally at all -- is that it strikes me as -- I view it optically as a move to push things back. And I am not sure I mind if you want -- if CMS wants to push things back on the issues about

advancing care information -- whatever that category is in MIPS -- but I get concerned, I think, to some extent that it's part of a broader agenda to role back quality measure -- and I am not sure the problems we had as a practitioner community with the Meaningful Use Program are the same issues in the other domains of quality. And I just want to reflect on that reaction that I have, and it comes from the language. And I don't -- the language is where it is, but that is how I react to it.

And then the second challenge I am faced with -- so, if we can go to the slide that shows the healthcare-acquired infections. So I really love this idea of rolling -- not useless -- measures that may feel less valuable into something that feels more valuable. But I think one of the goals is to reduce reporting burden, right? And I love the idea of using this framework to winnow out measures.

But when I look at this one, healthcare-acquired infections, and the granular

examples that are provided there, they are all healthcare-acquired infections that I've still got to keep track of. Now, if the intent is to roll that up into one consolidated measure, then I don't see how this works well for reducing reporting burden. If however the framework is used to create level three, level two measures that you look at in the whole list of the reporting program and go, this doesn't fit anywhere in our priority scheme and so let's winnow them, then I think I can see how this potentially works well.

And then a third thing I had -- I also react to this a little bit. I think CMS has been very conscientious about trying to produce measures that are meaningful. So I had the privilege of being very involved in the Physician Quality Reporting initiative and the generation of measures. And literally the way those measures were generated was to go to each specialty society and say what are measures that we should be doing for your specialty area? Now

admittedly, you go to every specialty area and end up with way too many measures. But it was each discipline said this is meaningful to us, this is where we would like to go.

And I'm -- to some extent I want to support that from my world view, CMS has been working very hard even before this initiative to try to create something that's relatively important, of value, and to me there's a lot of potential traction here for harmonization across payers as opposed to redefining the quality strategy. So, observations that I hope are helpful and maybe even an opportunity for you to reflect.

DR. YONG: Thanks, really appreciate those comments Paul and I think there are some great thoughts in there. So I will sort of give you some initial reactions and then Alan may have some additional thoughts to add on.

So I think the issue that you are bringing up about sort of how are we going to roll up into, like, single measures? I think the

goal here really is to use this framework to really get to, for each of our programs really the most parsimonious, most meaningful if you will, measure set for that particular program that meets the needs of that particular provider or clinician group that -- with -- that has the most minimal burden that seems -- you know, most minimal burden. So each program will still exist.

So each program will still have its own measure sets and needs to have measures that are applicable and specified for that particular facility, so whether it's an IRF or an acute care hospital, right, they're not going to -- the specs won't be exactly the same because they're different patient populations. So each measure still needs to be applicable to that individual program. So -- because there has been some thought, you know, if you look at the LAN white paper, for example, that they want -- they would like to move to really broad population health-based measures, which is sort of I think what you

were asking about. I think there is some -- you know, that's something worth discussing.

I think in the construct of the way our programs are constructed, that's a little bit hard to do right now, right? Because again, we have individual programs that have individual measures and so -- and those measures -- those facilities need to know which measures they need to report. So I think that's sort of -- right now we are looking at this in terms of our existing measure sets and really trying to focus on what is -- what should we be keeping versus what potentially might not be really helpful in driving improvement, right.

So hopefully that helps provide a little bit more context. I think the comment about sort of meaningful use -- I think we've gotten a little bit of this reaction. I think probably because of the meaningful term is where people reacting to. I do think we've -- we've -- we've tied a lot of talk with, you know, our colleagues around sort of meaningful use, having

a lot of conversations with providers and facilities as well. You know, today there's actually a -- a meeting between CMS leadership and ONC leadership to talk about sort of, you know, directions around meaningful use. And you know, we also think -- do think there's like, you know -- there's a Meaningful Measurement area around sort of transfer of health -- seamless transfer of health information. So it really does sort of address that.

But -- so we are thinking about this. But you're right, I think the framework itself is much broader than Meaningful Use, per se, itself. And finally, completely agree about sort of the opportunity for harmonization of pairs. It's something we hear a lot about, sort of, you know, as people are reporting not just to CMS and we realize we are not the only sort of pair with reporting requirements -- that folks are also reporting to other private pairs and to their states and to other initiatives. And so that there's a real opportunity for us to continue the

work that we've started with the Core Measures Collaborative around trying to sort of align measures for use across quality reporting programs -- across pairs. So hopefully that's helpful.

MEMBER LEVITT: Thank you -- thank you, Pierre. And again, these are really great comments that are being made -- and things that we have been thinking about ourselves. You know, we are all quality people. I guess that's why you're all thinking in your head of the unintended consequences of, you know, what would be done. And we think of those unintended consequences as well.

You're quality people, we're quality people. We need to look at the quality of our programs and the measures within our programs. We should always, you know, be doing this. This is a -- you know, a -- a certainly a strategy that every program should be doing as they continue to grow and develop. We -- to give you an example of, you know, what has been done again

with kind of this idea in mind, you remember what happened in Home Health two years ago where we reviewed the measure set and we moved 34 total measures -- six from the Home Health Quality Reporting Program.

Again, with some of this criteria. I mean, we're trying to develop measures that are meaningful for a particular program. They may be meaningful in one program, they may not be as Meaningful in other programs. Infection idea, you know, again the -- the devil is always in the details in terms of, you know, what the specifications are in the measure and then what is the goal of that measure? And how is it turned out in terms of how easy it is for the data to come in.

And so there are so many factors that are really involved in deciding about a measure that we -- we should be thinking about. So from the program standpoint, when we hear these things -- we actually embrace this because, you know, we are quality people, and we need to really look at

the quality of our measures and our programs.

CO-CHAIR LAMB: Gene?

MEMBER NUCCIO: Yes, thank you. Could you put the -- the big wheel slide on there, I think? Yes, right there.

First, when I hear the term meaningful use I -- I want to add that the next two words which is, to whom? Meaningful use to whom? Patients have one set of meaningful uses. Payers have a different set of meaningful uses. Providers have a third set of meaningful uses. And I think, if we don't take into consideration those three primary recipients of our -- of our work, we are missing what we're trying to do in terms of either selecting new measures for inclusion, be it at level two -- or I don't think anyone argues with level one -- better health. How could one really argue with better health? But it's certainly at the level two.

And then I -- Pierre, I wanted to thank you guys for creating what I want to call the de-MUC list.

(Laughter.)

MEMBER NUCCIO: That -- that maybe next year we'll have a list of, you know, 30 or 40 items that we de-MUC. The -- the other thing that -- that strikes me from the list that -- and it perhaps is a different slide that we had over here -- that you presented. But it has to do with the types of measures that we're considering. As we move to this level two kind of measure, it seems quite clear that process measures are not very effective because they're virtually all topped out. You know, which -- it's rewarding everybody for doing what they should be doing anyway. And -- and -- and so, you know, the emphasis on outcomes.

But the -- the -- implicit in that, and you use the word in some of the slides, is the word improvement. And clearly I know in the world of home health we've heard the word maintenance. That is, it's important to keep patients from requiring more extensive and expensive care. And so we should begin thinking

about maintenance kind of measures. You also mention in the -- in the framework here that the voice of the patient needs to be heard. And that patients before -- paperwork. The idea of promise measures would -- is obviously -- I know something that we will be talking about later on. But how you incorporate that into this issue.

And then finally within this framework I am finding it hard to find a content area that -- that I think is of growing interest and demand in the post-acute world. And that is dealing with psychological or mental, behavioral kinds of issues. It -- certainly Ellen knows that we've struggled to measure that effectively. And again, taking into consideration what a provider community can do to support that with limited resources. And certainly the next presentation on rural health and the dearth of support for that is something -- it's a macro issue that needs to be taken into consideration. I am sorry to sort of ramble through several things, but if you would like to comment we would be delighted

to hear.

DR. YONG: Yes, thanks Gene, I appreciate all those comments. I think you bring up some great points. I think in particular let me just address the last one in terms of the psychological, behavioral sort of quality issue, which I -- I think we agree is really important. So I think -- hopefully we -- I will point out how we thought about it in the current framework, but you can let us know and give us specific feedback if you think there are ways to make it clearer or better.

But you mentioned in particular sort of, you know, these macro issues and sort of, like, more community resources and stuff like that. And I think one of the cross-cutting, if you look on the slide itself on the lower left-hand side, one of the cross-cutting issues is improved access for rural communities. So I do -- so that's one way we have thought about that.

One of the other Meaningful Measure areas if you move forward -- two I will call out

in particular. Keep on going. One more. And one more. Here under the domain of the promotion of effective prevention and treatment of chronic illnesses, if you look at the third one we've called out in particular mental health. And in the fourth one we've called out in particular opioid and substance use disorders. So would ask if that sort of -- how that -- if that sort of addresses what you were pointing out or if you think there are ways we can do that differently. And if you move to the next slide, I'd point out the last one was the equity of care issue, which again is related to more of a macro issue as well, so.

MEMBER NUCCIO: That -- I will defer.

CO-CHAIR LAMB: Okay. And then we will come back to that. But let's hold that thought in terms of representing key areas back as we go through the different areas. Okay. Robyn, I noticed that you had your card up. Did you want to say anything or you want to keep moving, or -- keep moving? Okay. And Caroline?

MEMBER FIFE: So the problem is that under MIPS physicians pick any six measures that they wish to report. I've been running a qualified clinical data registry or -- before that a PQRI -- PQRS, before that a PQRI registry -- since 2008. And so physicians pick the six measures that give them the highest score. That means that I can report BMI and follow-up, or I could do a promise measure, which costs me money. And I could also report a QCDR measures, which are very specific to my specialty -- which are expensive and have a very high burden, but would give you a very clear window on whether I actually do things that are relevant to the needs of my patients.

The more work I do in order to show you how good of a job I actually do, the more burden and cost I have on myself and the lower my score will be. Because I can actually get through MIPS very well with a high score by using topped-out, old PQRS, now MIPS, measures creating zero incentive for me to do any of those things.

As a result, I game the system by reporting measures that are easy, that have no relevance whatsoever to my practice -- and so does everybody else. And that's the reason it doesn't work under MIPS.

It can work in these other sites of care where there is a defined group of measures that they all have to report. But under MIPS it cannot work. And then to make it more bizarre, under the QCDR system, if you do have a group of clinicians who are ridiculous enough to want to report measures that are very specific to their specialty, then they are reporting the measures they do well at and then next year CMS rejects those measures because their passing rate is too high. They are then, those measures, topped out.

When the docs who are -- did poorly on them didn't report them, which means there's a huge gap in practice for the non-reporters, and the only ones that don't have a gap in practice are the ones who did report. But you just lost measure because the ones who did report are of

course the ones who did well. So you lose the process or outcomes measures that you're successful at, which means, there's actually no reason to run a QCDR at all because the system is entirely designed so that only people who do well at a measure will actually pass it. Besides which, you have to report the measure for three years before you can get a decile score for it, which actually helps you with your outcome anyway.

So the whole thing is designed in order to use measures that are irrelevant to your practice, which you do really well at, which have no relevance whatsoever to anything that you actually do. So, if you want the rest of the story about why this is not working under MIPS, please see me after class.

(Laughter.)

DR. YONG: There's more, Caroline?

(Laughter.)

DR. YONG: No -- but, yes. I think yet, MIPS has unique challenges that are

different because of the way MIPS is structured. And so totally ---

(Simultaneous speaking.)

MEMBER FIFE: Yes, and those of us who really want to drive quality forward would -- we really want to see changes.

DR. YONG: Yes.

MEMBER FIFE: But, you know ---

DR. YONG: Of course, there's the other extreme which MedPAC is considering, right, which is just complete -- no choice at all and just moving towards ---

MEMBER FIFE: Yes.

DR. YONG: Like, root-based, you know, reporting on -- or actually, no reporting actually, right?

MEMBER FIFE: Yes.

DR. YONG: For population health based -- claims-based measures. So that's another extreme that they're probably --

(Simultaneous speaking.)

MEMBER FIFE: But I think

philosophically, the other thing that troubles me -- and everyone else has touched on this -- is that I -- I get it that everybody wants one ring to rule them all. But there must be somehow, some quality thing that is just going to be so fabulous that it's going to tell us whether you're a good orthopod or a good cardiologist or a good obstetrician, but it doesn't work that way because what is quality for a cardiologist is truly going to be different for orthopedic. So the concept somehow that we're going to have these massive, overarching measures -- you know, I take care of people that have non-healing chronic wounds. I just want to do a shout-out for some process measures because they're not tic-box measures.

When we -- some of our process measures, like nutritional screening, we have to do follow-up on that. And we just evaluated the Medicare five-percent data set and found that CMS in 2014 spent $96 billion on non-healing wounds. And most of them are related to poor nutrition.

And yet this year CMS decided to reject our nutritional screening measure. Well, what am I supposed to do with that?

So, you know, it is a tremendous problem trying to raise the bar on practice when you know that a specific thing is linked to a certain problem and you can't get paid for doing a better job, and nobody seems to like your way to target specific things you know would do better. It's just damnably frustrating.

CO-CHAIR LAMB: Thanks. Jim?

MEMBER LETT: Oh, thank you. Would you run it back to the large Meaningful Measures slide, please? What -- as I look at -- and this is a wonderful graphic. As I look at all the areas that are meaningful -- and I agree, they are, what I am -- I am really not seeing there and I would like you to consider -- and maybe this is a gap discussion -- at the top of the blue centered wheel it says improved CMS customer satisfaction. I would like to see that expanded to not just patients. And I -- just patients

sounds a little pejorative. Didn't mean it that way.

But your customers also include bedside nurses, CNAs at the nursing home, physician, NPs, PAs. And I would love to see a Meaningful Measure by CMS that actually measures their relevance and their utilization to the actual bedside caregivers. Because if we -- if you -- all of us are going to create a meaningful healthcare system, everybody has to be included. And everybody needs to feel that they can impact the system and that the system works for them.

At this point we are facing a huge workforce issue in post-acute care in geriatrics. And why is that? I am not smart enough to know it all. I know AGS has done some terrific work on it and AMDA is as well. But there's a lot of dissatisfaction by caregivers all the way from the top of the chain through everybody that touches the patient. And I would encourage CMS to seek out the satisfaction from those people -- if they are not satisfied, try to discern why

that is and make some meaningful changes in an attempt to get everybody engaged into the system. Thank you.

MEMBER MAHAJAN: I just want to echo Caroline and -- so, for us -- for -- and you -- you guys have heard us speak. For over four years we've been talking about having Meaningful Measures and how practitioners in post-acute, long-term care struggles with the way things stand with MIPS. We have it broken down from our users data, and the most commonly used measure by a nursing home doctor is sinusitis measure and -- because that's how you score the most.

So -- so we are extremely excited for this opportunity to heave Meaningful Measures developed that -- that align between different system, different pairs and health care setup. So thank you.

MEMBER FIFE: You could lose your hair over QCDR measures. They're terrible.

MEMBER MAHAJAN: I mean, I don't have any more opportunity, but ---

(Laughter.)

MEMBER MAHAJAN: But thank you for -- for bringing that up. Anybody has Zoloft, I will take that. And -- and just on -- on being comical, Meaningful Use became Advanced Care -- Advanced Care Planning for us. So most other people still confuse with Advancing Care Information to Advanced Care Planning, which is really relevant for us and -- and it's just -- I think terminology and word selection has been such a confusing alphabet soup. So it just -- it's getting -- yes.

CO-CHAIR LAMB: Thanks for all the questions and -- and the comments. This is just the start. I think that Erin and the NQF team here are keeping notes about everybody's comments. I am going to invite that those of you who have not felt the need to comment yet -- we know that nobody in this room is shy. So when the spirit moves you, please do. We are going to move on and we will use the same process of, you know, having the presentation and then

commenting. I think we are beginning to gather information about how to bring together PAC Long-Term Care into the current strategic environment. So, Erin, you want to move on?

MS. O'ROURKE: Excellent, so I think with that I am going to turn it over to Karen to share a bit about our new rural health work.

(Pause.)

MS. JOHNSON: Good morning, everyone. My name is Karen Johnson. I am one of the senior directors here at NQF and I am really excited to present our new work on rural MAP to you guys. So I have quite a bit -- quite a few slides that are giving some background. I am going to try to kind of go through those really quickly because it sounds like you guys have a lot to talk about, and I would rather get to the discussion points. So let me just start with background.

So we got into the rural health world, if you will, a couple years ago when we were funded by CMS with help from HRSA to do a project looking at challenges and hopefully

recommendations on performance measurement issues for rural providers. So they wanted us to talk about the challenges of measurement for these folks and put forward some recommendations on how to address those challenges.

And it was -- we stoked this project in a few ways. First of all to really think about CMS P4P type programs. We included a lot of rural providers who do not actually participate in these programs. So rural health centers, often critical-access hospitals -- they can do some of the work in a voluntary basis -- also FQHCs. So those guys are paid differently and therefore are not mandated to participate in a lot of those programs. Finally, we also had scoped it mainly for primary care look at mostly hospital and out-patient.

So some of the issues regarding measurement challenges -- these -- first of all, you know, they're kind of obvious. But they really actually make a huge impact on measurement. And they do not -- they are very

much inter-related. So geographic isolation can impact measurement in a lot of ways -- things like transportation problems and how does that reflect on measures? IT capability, shortage of staff -- all of these kinds of things are problems if you are isolated.

Small practice -- often people who are isolated have small practices, but other people do too. And it doesn't always work both ways. But when you're -- when you're a small practice you have fewer resources for things like reporting measures, right? For things like doing QI even if you are reporting measures. So you have that going on. So that is a real problem. You also have the -- kind of also the possibility that some services just aren't offered. So some of the measures just don't even apply, right? So small practice size -- definitely a challenge.

Heterogeneity -- to that we're -- it's in settings as well as patient populations. So people who are older in general live in rural areas. But not always, right? People often are

more socially disadvantaged, but not always. So all of these things really can make measurement challenging, particularly when you start thinking about risk adjustment and things like that. How do you do that and make things fair? Finally, low-case volume speaks to reliability and validity of measurement and even being able to participate and use the measures that are included in certain programs.

So those are the challenges. So what did this group do about it? Well, they actually made a quite surprising overarching recommendation, and that is that they would like to see all rural providers brought into the CMS fold and be included in these programs. So they -- they were looking for mandatory participation in programs. A lot of that had to do with this idea of they don't want to be left behind. Many rural providers are very proud of what they do. They feel like they do a really good job. And they want to be able to demonstrate that to, you know, their residents as well as others.

But along with this mandatory participation, a realization that many of these folks have never participated in these kinds of programs, so there needs to be some kind of phased approach, and you really need to make sure that you're considering low case volume. There were many supporting recommendations for -- that, you know, kind of support that overarching recommendation. And the ones listed on this slide are the ones that were specifically recommendations about measure selection. So you will notice that last bullet there is create a Measure Applications Partnership workgroup to advise CMS on this selection of measures.

So we are extremely excited that CMS has taken that committee's recommendation and has formed a Rural Health Workgroup. So -- and that's what I will be talking to you about today. But other things that they did as part of their recommendations a couple years ago was provide some guiding principles for selecting measures into programs and a couple other guiding

principles were really to utilize -- or, identify, really, core sets of measures and then also have a menu of optional measures for rural providers.

So the idea is the core sets should be used -- they should be measures that really work for most providers and most patients. And then you have optional ones that work, you know, maybe if you are a hospital that, you know, doesn't have an ICU, well there should be measures that you -- you know, you shouldn't be forced to do the ICU measures because they don't work for you. But there should be other things that -- that would work. And then of course, don't forget patients in a medical home models when -- when you're thinking about those things.

So that brings us to now, again. We have just been funded for this work. So we are a new workgroup. Again, very excited. And this year -- and we hope that we will be funded in future years -- but we are working on this year right now. We are actually going to develop a

set of criteria for selecting the measures. So two years ago we had guiding principles for selection. This time we are actually going to go a little further and say here are our actual criteria. And then we are going to identify core sets of the best -- what we think are the best available measures. And do the other MAP stuff that you guys are very used to -- rural relevant gaps, recommendations around alignment.

And then finally, we're also going to spend a little bit of time addressing some kind of a measurement topic that's relevant to rural residents. So that topic has not been decided on yet. So you guys might have some input for us on that. There will be interaction with other committees. So I get to be here today kind of introducing us. So we are going to do that for all the other workgroups. We are going to give a little bit of input to the Coordinating Committee on the measures that are on the MUC list this year -- very high-level input. And then finally in August of 2018 hopefully the Coordinating

Committee will take a look at what we come up with and bless that. So we will see how that goes.

So progress to date -- we have seated our workgroup. We have I think 25 members -- well, 28 if you count our federal liaisons. Very excited -- some of the usual suspects are around the table. We also have some other folks who aren't the usual folks that show up around these tables and -- including a mail carriers association -- a rural mail carriers association, which we thought was just great. So I can give you the roster if you're interested.

We had our first meeting a couple weeks ago. We have another one at 1:00 today. So we are moving fast on this project. So in our November 29th call we got some initial guidance from the workgroup. Okay, we have -- we know of at least probably 1,200 measures that are out there, right? So how do you -- how do you get a core set out of 1,200 measures. I mean, this is crazy. So our first foray into is to -- let's

look at NQF-endorsed measures. That gives us evidence-based, which we feel is very important. And when I say we, I mean the people who are on the workgroup now as well as the folks who are on the panel from a couple years ago. So having opportunity for improvement, having a strong evidence base were very important. Those are criteria that we look at for endorsement. So NQF endorsement they thought was a reasonable first cut.

Addressing low case volume and being cross cutting -- those work together, but they may not be completely overlapping. So that's -- we're looking at that now. And then finally there are probably going to be a few must-have topic areas. And a couple of the ones that have come up potentially -- we haven't definitively settled on these yet -- things like diabetes. That might be something that is particularly relevant to rural residents. The other one -- a couple of other ones that have definitely come up are transitions in care, hand-offs, that sort of

thing, and access to care has come up quite a bit. So that's where we are right now.

And that leads me to our discussion points. So I came up with a few questions here -- we don't actually have to do any of these questions. But let me just throw them out there and then let's just have a discussion. What are some of the key issues for PAC-LTC programs that you want us to keep in mind? Now, realize again that we are going to be focusing this year's work on in-patient, really, and out-patient settings. So not so much on post-acute settings. Again, hopefully in the future we can do that. But still, you guys don't work in a vacuum, so I know you have -- you could give us some advice there.

Does the initial guidance concerning the -- cross-cutting NQF endorsement -- certain conditions, does that ring true to you? Would there be other things that you might suggest? Going forward, what could we do to help you? Is there anything that we could tell you or think about for you guys? Finally, what advice could

you give this new workgroup about serving on that group? I am -- Alan, you said you've been here for five years, so you probably have some nuggets that you could share.

And I didn't have it on here, but I was thinking about it. That measurement topic area -- the -- some of the things that we floated, again, we're going to decide on this. But we floated several topic areas for this little measurement science project that we're going to do as part of the work. And a couple of them I thought I would specifically mention just to see if you had any flavor of that. One is to look at quality of care specific to swing beds -- so that might be something that you guys would really say, hey, that's really interesting to us. Maybe, you know, we'd love for you guys to look into that.

The other one that has come up -- we actually floated it as advanced care planning. But maybe thinking about it a little bit more broadly, this idea of community-based palliative

care. And I know you guys are really -- and Theresa is nodding -- so I know there would be a lot of interaction there, even, you know, with our focus on in-patient and out-patient. So that might be something.

And then another idea that we floated, actually, was post-acute care in rural areas. So what are the challenges in terms of data collection? Of implementation, QI efforts? So that's something that we could potentially take on at this time. So let me stop there and hand it over.

CO-CHAIR LAMB: Thanks, Karen. Kim?

MEMBER ELLIOTT: When I'm hearing you talk a lot about this, it really -- one of the things with access to care that I think we really need to keep in mind is all of the different opportunities that are available in the rural areas and for coordination of care, for transitions in care. And that may have to do with a telemedicine opportunities and perhaps some of the community worker opportunities that

really could make those connections happen much more easily for people in the rural areas. So I think those are really important factors that we keep at the forefront when we're thinking about access to care sorts of measures for rural health.

CO-CHAIR LAMB: Sean?

MEMBER MULDOON: My -- my comment will end with a -- with an inquiry that I'd like the workgroup to either tell me you're already taking care of or consider it. But I should start by saying I am a city boy, so this is all new to me. But I do get a -- it's sort of a weird reaction to the idea of rural relevant. And when I look at your list of things that say, sort of, you don't understand, we don't apply to this because we're different in these ways. And I -- and I certainly get the small case volume because this is fundamentally a measurement problem.

But, you know, an inner-city hospital could give you their five lists, why we should benefit from a carve-out, essentially. And --

and yet we're trying to establish national standards. And you don't get a buy in an inner-city hospital because you've got low SES. You know, because the answer is well, fix it. That's where you live. Go ahead and fix it.

And -- and so I would -- I would just ask, if it hasn't been already done, that there be a robust discussion about the down side of carving out rural health and to the degree it would prevent answering the question, what do we got to do in this subgroup to bring it up to a national standard? That is not any different than we say what do we got to do about the inner-city academic medical center that tends to underperform and bring it up to a national standard?

MS. JOHNSON: And let me just respond very quickly. As part of our work a couple years ago we kept trying to say what's really different about rural? And it turns out there really wasn't a whole lot totally different about rural, except maybe the geographic isolation. We just

felt that some of the problems that we mentioned were particularly salient to rural providers. But it is a little bit of a -- a difficult question. In terms of the downside, you know, I don't think that we've really hit that one. I think what -- where we're coming from is that, you know, 20 percent of the population lives in rural areas and they pretty much have been excluded -- to some extent because of the way payments work.

So, yes, I think that's probably part of -- of why there's been a focus on rural. But we can certainly, you know, put that on the list. Thank you.

CO-CHAIR LAMB: Theresa?

MEMBER SCHMIDT: Well, first of all, I applaud this work. I think the questions that you're asking are very critical. Many of our members at the National Partnership for Hospice Innovation are community-integrated providers who are safety nets in their communities. And they're oftentimes chafing under the burden of

regulatory requirements. Much less about quality measures and more about additional documentation requests and the financial scrutiny that they tend to be under.

And one of the -- the things that they're dealing with is sometimes changing regulations such as the removal of certificate of need in their states. So as you are considering these rural measures and focusing on access, I wonder if you would consider thinking about measures where the -- sorry, accountability level is more systemic so that states or communities could use to measure the impact of policy changes on the access to different provider types.

And the second comment I had is really a question about how this workgroup would interact in a little bit more detail with the other measure applications partnerships groups? So for example, you're beginning with in-patient and out-patient, if you identify some great measures that might be used in CMS programs for those areas, do they then go back through those

workgroups and be evaluated for inclusion or removal from those programs? Or does your work kind of happen along the side? So the cross-setting, cross-cutting and access measures I think for us are very much of interest. Thank you.

MS. JOHNSON: Well, thanks for that. I am not exactly sure what we would do going forward. We are so brand new that we don't have -- unlike I think the Medicaid liaison here -- at some point we would like to have one or two folks from our group actually sitting around your table and the other tables so that we definitely have that rural input as you're discussing the MUC list. What we have this year is pretty much me. And -- so it will be better hopefully in the future.

In terms of, you know, where we land how that might inform work in future, I don't know. I think that's probably more of a CMS question of how they would want to direct our interaction there. But it would be great if we

could say, hey, you know, we really like these. And that might -- I don't know if that would impact what they would consider taking off or putting on.

MEMBER HOPPE: I appreciate all the comments from my colleagues because I think they are -- they represent pretty much what rural patients that I have really talk about in rural health systems. I think one thing that you have to understand is the mindset is a little bit different in rural areas. They would rather have access to healthcare. And that probably ranks higher than quality.

One particular area of concern to most rural providers and to patients is transportation. So trying to aggregate services when patients don't have transportation, or providers don't have transportation in that area can be pretty profound. It can lead to a great deal of sort of islands of poverty and islands of poor care. And I think that your former comment about having Medicaid involved is very important

because a number of these patients are dual-eligible. And they suffer not only from chronic diseases, but also the poverty that reinforces the complications of those -- of those chronic diseases. So I think it's a good idea to include those other agencies as well.

CO-CHAIR LAMB: Deb?

MEMBER SALIBA: I want to start by saying that several year -- if you had asked me this question several years ago, I would have definitely agreed with Sean that it felt like the rural was always brought up as a reason that quality measures shouldn't be applied. But I've had, you know, several experiences over the last few years that have sort of changed -- shifted my perspective a bit that I want to share. One is that we did an analysis looking at who -- who is the population in rural communities? And you brought this up on your slide. It is a significant -- a much larger proportion of older adults in these communities with high levels of needs for long-term services and supports, for

chronic and advanced medical illness care.

So as you look at your measures, I think it will be really important to bear in mind that those are the populations that are really dominant. And I realize there are other populations there as well, but -- but these are the ones that have really faced considerable difficulty in accessing fundamental services. I have had the privilege of doing some trainings in rural communities, and the providers are hungry for this type of training. They really want -- they -- they feel, as you mentioned, isolated. They really want this training. But it really is that's an important area.

I think the other thing is to think about -- I don't know what federal partners you have at the table, but the VA does have an Office of Rural Health with a huge emphasis on trying to reach out to the rural communities and to provide access to services. So they could at least possibly be a resource to you.

In addition, another group that you

might want to think about is the Indian Health Service. So, I have done a series of projects with them over the years, and they are really trying to improve access and care coordination and use partners, both partners outside of IHS -- including the Veterans Administration -- to try to improve those things. You may already have them at the table, but if not, that's a good group to think about.

CO-CHAIR LAMB: Alan?

MEMBER LEVITT: Thank you. Thank you, Karen. This is really -- to me a very important topic and to us at CMS it is a very important topic. Just to add first to Kurt and Deb what they said is access is extremely important issue for our patient population because of functional impairment. So they even have an extra level of issues that access could be involved in.

Stace was sitting next to me -- this is something we talk about all the time -- looking at our programs. The question is, is how is it affecting rural providers? I do think in

particular for post-acute care, home health and hospice come up. Nineteen percent of home health agencies are qualified as rural. And, you know, what keeps me up at night -- for things -- are things like, you know, are what we are measuring first of all being measured by them? And secondly, are they scoring as well?

And Gene knows that, you know, even with our star ratings in home health, we -- you know, we look at every factor in it to try to, you know, make sure that we're doing the right thing. And one of them is urban versus rural. And we want to continue to -- to look at such things. So I would just continue to support what's going on. And certainly, I -- I -- occasionally disagree with Sean. But I do think that this is an extremely important topic in our area.

CO-CHAIR LAMB: Robyn?

MEMBER GRANT: Just another thing to just keep in mind is that from a consumer perspective -- particularly when it comes to

long-term care -- one of the things that we hear a lot about is lack of choice. So there may be one nursing home in town, and it is the only nursing home in town. And so, regardless of its measures, if I want to have nursing home care in my community, I have to go to that nursing home. And so that's -- that weighs heavily on people in terms of access and choice.

The other thing I was just going to ask is a question. So how does this effort in this workgroup jive with the Meaningful Measures Framework so that you don't go down the road and end up on the de-MUC list down the road?

MS. JOHNSON: That's really a good question and we've already brought in the framework to some extent as a way to help us decide on our criteria -- our selection criteria. So we -- we made sure that that -- people understood that, and then we'll kind of work our way down. It may go the other way, too. I think probably what we'll end up doing -- and who knows, this might blow up and we have to do it a

different way.

But I think we will probably end up taking a list of measures this big, getting it down to something reasonable that you can put your head around, and then start bringing in other concepts as alignment and this measurement that matters -- the prioritization kinds of things -- and look at it kind of -- once we get something, you know, that we can work with and look at it that way. I hope that answers your question.

MEMBER MAHAJAN: And I -- I completely agree. Anecdotally, especially behavior health, is such a huge access issue in rural areas. And the might -- I have a question for post-acute and long-term care side. Do we know what degree of risk-based models have penetrated into rural areas? Like the ACOs or bundle payments when it comes to -- because that -- they get a lot of waivers when it comes to the three-day stay and use of swing beds. And so -- I think that definitely becomes important if there is -- their

people who have that kind of agreements. And -- and that would also, you know, it would be good idea for people to start working on some kind of alternate payment model for physicians in that area so they have an incentive to -- to work. So yes, a question and a comment. Yes.

MS. JOHNSON: I am afraid I don't really know the answer to your question, unfortunately. I do know that there is -- and I don't know much about it. I guess I will learn over the next year. There is a -- kind of a -- a rural ACO that's going on that's kind of a -- I think a test case. But that's about what I know right now.

CO-CHAIR MULHAUSEN: Alan, did you want to reflect on the --

MEMBER LEVITT: Yes, just one comment on the Meaningful Measures and rural. I think it's very important in this area -- because one of the problems is because of the heterogeneity and the low volume is making this meaningful to rural providers, including them in our program.

You know, we have minimum number of patients for -- for our measures to be reported upon. And so that's one of the -- you know, I think that's a -- working with kind of looking at this idea of core with optional, maybe we could somehow integrate that within our PAC programs to include more of these providers because right now a lot of them aren't having measures publically reported.

CO-CHAIR MULHAUSEN: Connie?

MEMBER DAHLIN: So a couple things, thank you. I think one of the things that, you know, there may -- issues have been brought up, but I think to remember that this is also -- the care providers here are really diverse. There's a workforce shortage. There's a lot of access -- so it's not -- you don't have a lot of physicians a lot of times. You're really using advanced practice providers, CNAs, rehab.

And I think the other part of this coordination that has to happen in those communities between clinical providers and social

providers. And -- and so we don't really pick up that, right? Because there's lack of resources where you can say urban, you know, inner-city hospital. Yes, but they still get different amounts of money and access. And these smaller programs just don't have the resources to be even putting in for the personnel to do this measurement. And I think we forget about that. Because this is, as you've said, sometimes costly.

I think the other part that we need to think about is, you know, in -- within palliative care -- this home-based palliative care is really our next frontier. And what we noticed when we looked at the consensus project -- and you know, NQF had monitored those when we first developed the NCP Clinical Practice Guidelines -- and then I helped edit the Second and Third Edition -- what we've done in terms of moving this out is really understand that the providers in there are really also community and clinical.

And so, like, you have chaplains

acting as clinical. Or you have social workers. And that we can sort of talk about constructs of quality. But they have so much more of a challenge of trying to meet this interdisciplinary component, really thinking about, you know, what is it like for patients to die at home? Because yes, a lot of these people are geriatric patients and they are not sick enough for hospice, so they don't qualify for hospice. They don't qualify for home health because they don't have enough skilled need. I mean, so this is a population with huge needs.

And then I think the other part is we're looking to help programs across the country in these rural areas is yes, the pockets of the different diversity groups, I would say, or the underserved --- so how do we do that? Because there are such differences when you're working with the Indian health population versus the African-American population in the south -- southeast, which is the lowest palliative care content versus when you go, you know, across to

the Northwest.

And so I think the -- these are really important, so I am really applauding this. And I think we forget, being from community and urban and academic and well-resourced organizations, they don't have what we make basic assumptions for. So thank you for that.

CO-CHAIR MULHAUSEN: Jim, I think you're next.

MEMBER LETT: Thank you, the -- the one thing -- I am from a small state, from a small town -- one of the things I would ask is burden, burden, burden -- don't. You're talking about individual or very small numbers of doctor groups. Or, as pointed out, nurse practitioners, PAs out there, small hospitals, mom and pop nursing homes, which means they're really not going to have a lot of resources. The big groups will have coders and in some of the groups now even have attendants following physicians and nurse practitioners, checking off quality measures. Those resources are not there.

The other part about that is you will likely have the same providers going to all sites of care. So when you're thinking about office, hospital, post-acute -- it may be the same person doing all three. So the burden of reporting is going to be enormous. And also, CMS to their credit put out a great paper about what does the Medicare enrollee look like across the country? And one of the things that really struck me was that in the most unexpected places you will come up with remarkable ethnic immigrant populations -- even in very rural areas. So you may find some very interesting and -- what are they doing here questions come up.

CO-CHAIR MULHAUSEN: Liz?

MEMBER HALL: Thank you, I just wanted echo some support from a -- a prior comment around the opportunity for telehealth to increase access. But wanted to just mention consideration for the technical infrastructure that exists in the rural communities, particularly around broadband. We know that still continues to be a

challenge. And just to point out as well that recent opportunities at FCC has enabled through some of their broadband initiatives particularly for skilled nursing facilities. So there are increasing opportunities, but just to consider those infrastructure issues.

CO-CHAIR MULHAUSEN: Kim, you've had your -- whatever this -- name tag up for a while. Are -- did you still? You're done. So -- so since -- so what I am going to do is prioritize and we'll have Gerri go and since, Theresa, you've already spoken, we'll do you last and then we'll take a break. So, Gerri.

CO-CHAIR LAMB: Thank you. In listening to all the comments I was just kind of resonating with what Theresa was asking before in terms of how this work integrates with the other MAPs. And some of the issues that this MAP is going to be dealing with are really thorny issues for all the MAPs, related to do you go condition-specific? Or do you go population-based? Or the -- the issues related to the same providers

seeing people or multiple teams. So I would just encourage that group to really embrace the thorny issues so it can come back to all of us for that dialogue.

Because, you know, like Alan was saying, what keeps him up at night -- I have been on a lot of committees where we are really struggling with do we move down the condition-specific avenue? Or do we keep it general? Particularly in care coordination and in transitions of care. And if they can help really address that, then I think we can advance PAC Long-Term Care together rather than all these siloed efforts.

CO-CHAIR MULHAUSEN: And -- and Theresa, we're going to give you the final word. And then we'll take a ten-minute break.

MEMBER SCHMIDT: I will keep it quick. I just wanted to bring together a couple of the comments of the colleagues across the table. Alan, I think you're absolutely right that this does present unique challenges for providers like

Hospice, like home health, like home-based palliative care who provide care in the home. And transportation is paramount among those. Our hospices will travel hours to visit patients in rural areas.

In -- in Kim's neck of the woods Hospice of the Valley serves the -- the reservation. And they drive three hours to meet patients at a community store who have come down from the reservation. And they don't even make it all the way to their houses. And cell phone use -- technology is also a challenge in these communities. They'll call before they enter the service area, say hey, I am going in. I will call when I get back. If you don't hear from me, send somebody.

So these are all challenges for the providers in access in addition to the patients in access. And I think that -- I wonder if any of the measures and any of the work that you're doing might consider, are there risk adjustments that would be needed for current measures in

place in relation to rural? And I'm not -- I am honestly not sure if -- if any of that work has been done -- any of those numbers have been crunched.

MS. JOHNSON: And to answer your question, yes, risk adjustment definitely came up. One that came up, obviously, is distance. Although, even distance may not be quite the right risk adjuster. It might be more like time to whatever. So -- yes.

CO-CHAIR MULHAUSEN: All right, Karen, any other reflections or observations after all that?

MS. JOHNSON: I am excited. Thank you guys for all your input. I will bring this back at some point and let you know where we -- where we've landed.

CO-CHAIR MULHAUSEN: As an Iowan who used to drive hours to do in-home Hospice visits, I think it's a terrific initiative. So we're going to take ten minutes. The clock up there says -- let's just reconvene at ten after 11:00.

Okay?

(Whereupon, the above-entitled matter went off the record at 10:56 a.m. and resumed at 11:08 a.m.)

MS. O'ROURKE: All right, everyone, if we could have you rejoin us at the table? We have a few new Workgroup members who have joined us since Elisa did the disclosures.

So, we have Mary Ellen from HealthSouth and Frederick from Families USA. If you could just introduce yourselves and let us know if you have anything to disclose.

MEMBER ISASI: Hi there. My name's Fred Isasi. I'm the Executive Director at Families USA. We are one of the oldest organizations in the country that's been representing consumer interests in healthcare.

It's a joy to be here. I've worked on a lot of these sort of bodies before. And we are deeply interested in ensuring that the future direction of long-term care is serving the interests of consumers. And thanks for having

us.

MS. O'ROURKE: Thank you.

MEMBER ISASI: And I have no conflicts to disclose.

MS. O'ROURKE: Excellent. Thank you. Mary Ellen, are you on the line?

MEMBER DEBARDELEBEN: Yes, I am. My name is Mary Ellen Debardeleben. I'm the Director of Quality for HealthSouth. We have 128 inpatient rehabilitation hospitals in over 30 states, and almost 200 home health locations.

And we are very interested in quality measurement in the post-acute care space. And I'm grateful to be representing Dr. Charbonneau, our Chief Medical Officer, on this MAP Committee meeting today. And I have no conflicts to disclose.

MS. O'ROURKE: Excellent. Thank you. Thank you both, and welcome. So, I think with that I can turn it back to Paul and Gerri for our next conversation.

CO-CHAIR LAMB: Okay. We're going to

continue to talk about background. We've just gone through the Meaningful Measures, had an opportunity to hear about rural health.

We're going to move now into the IMPACT Act. And Stace Mandl and Tara McMullen are here with us to give us an overview. And just as we've been doing, let's continue the dialogue, the recommendations.

You know, we were just reflecting during the break, what a wonderful opportunity. We're usually so packed at these meetings reviewing measures to really have a sense of, how can we influence the field for the future?

So I think Paul and I feel really strongly, let's really maximize that opportunity to get, today, together. So, Tara, Stace, thank you.

MS. MANDL: So, thank you for having us here to present on the IMPACT Act and the updates. We have historically joined you to go through the quality measures. It's with a lot of enthusiasm that today we're going to actually

present on the standardized patient assessment data elements.

As you are probably aware, the IMPACT Act required not just quality measures that satisfied certain domains, but it also requires a standardization of patient assessment data elements.

So, we're going to give you sort of an update, a little bit of background, and a little bit of an update on this work.

So, the Improving Medicare Post-Acute Care Transformation Act of 2014, which we were very excited about -- we're still excited about; we're a little tired, but we are excited -- was passed by Congress in September of 2014 and signed into law in October of 2014.

And I think we were quick, fast, and in a hurry here at the MAP with our first of the evolution of measures to satisfy the IMPACT Act domains.

So, the IMPACT Act requires that long-term acute care hospitals and skilled nursing

facilities and home health agencies and inpatient rehab facilities all submit standardized patient assessment data using the assessment instruments that we already require that they submit data on into CMS.

And just to kind of orient you, the long-term acute care hospitals submit the long-term acute care data set, or the LCDS. And the skilled nursing facilities, as you are probably very aware, submit the MDS. The home health agencies submit the OASIS. And the inpatient rehab facilities submit the IRF-PAI.

But the law requires that these providers submit standardized assessment data for various purposes. One is to ensure quality care and improve outcomes. That's both in the quality measures that are associated with the IMPACT Act, but also with the standardized assessment data itself.

It allows for data element uniformity, which, sort of long story sort, really allows both written, verbal, and electronic

communication to be more feasible and easily understood to allow for the ability of quality comparisons, and the transmission of data across post-acute care settings. And, actually, into and out of other provider types.

To improve discharge planning, exchangeability of the data. To enable coordinated care during transitions of care, which I heard a lot about today. And then to inform payment models.

As you are probably aware, except for the LTACs, the other providers submit standardized assessment data not just for quality measure calculation, but for other purposes as well, including payment.

So, the Act requires, as I said, that they report the standardized data, patient assessment data, and standardized patient assessment data specifically on quality measures.

And then also other data sources can be used for the measures that pertain to resource use. And the other measures that you're probably

aware of, discharge to community, and the potentially preventable readmission measures, as well as the MSBP measure, those all are based on claims data.

But the data, in the law it requires specifically that the standardized patient assessment data be also made interoperable. And we're joined by our colleague, Liz Palena Hall from ONC. And to enable for the exchange of information using common standards and definitions. And that's actually specifically spelled out in the Act. And to facilitate care coordination and the improvement of Medicare beneficiary outcomes.

And it does spell out the exchange of information, but also to look at longitudinal outcomes. And that PAC assessment instruments be modified. The law requires that the assessment instruments be modified to include that standardized patient assessment data. And that will allow for the comparability of data.

So, the Act does not require that each

assessment instrument be wholly, exactly the same. And that was one sort of misunderstanding that we've spent several years, even time before the IMPACT Act passed.

We are aware that there are core data elements in the assessment instruments that are necessary for those specific provider types. For example, long-term acute care hospitals and home health agencies may have specific needs of their own.

But ultimately there's sort of this Venn diagram where the standardized data sits in the center. And actually, we're working closely together with our partners and Medicaid with their work in public community-based services and long-term services and support to also apply standardized assessment data there. Because it doesn't really do us much good if -- I should actually say beneficiaries -- if the information is only sort of exchangeable and usable and uniform up until a point and ultimately they go on to their homes.

But the IMPACT Act, and I think you've probably seen this slide before, does enable us to sort of crack the code in three very complex areas.

One is strengthening person and family engagement as partners in their care. Promoting effective communication and coordination of care. And promoting effective prevention and treatment of chronic disease.

And that's what having that standardized assessment data that can be used across provider types, with measures that look at sort of long-term outcomes, and being able to really look at long-term outcomes, and having data that's usable in realtime, can provide for informing clinical care, decision support, care planning, and so on and so forth.

So, these are very unique, a little bit more difficult areas to address with quality measures and use of data. And so these are some of the areas that we think that the IMPACT Act helps to address.

So, the IMPACT Act specifically requires that the assessment instruments be modified by particular dates to include data elements on the following five categories: functional status; cognitive function and mental status; special services, treatments and interventions; medical conditions and comorbidities, impairments; and other categories as required by the Secretary.

Now, I'm a nurse by background. I can tell you that this is all very classic nursing healthcare types of categories. There's nothing arbitrary or odd about any of these.

If you're not familiar with what our assessment instruments look like, this is sort of a sample of a functional status question and response codes where the assessor is looking at the individual's usual performance related to functional mobility.

The assessment questions are on the right-hand side. The response codes that are allowable are on the left. And that data can be

used by the provider in realtime. And it's also used by CMS.

In realtime, the assessment information -- and those of you who are familiar with how this is done, particularly in home health agencies and in nursing facilities, is that they use the data for care planning. And we'll take that a step further: hopefully for clinical decision support. Because as we saw, those are categories that are also already in existence within the assessment instruments, to some extent. They're just not standardized across them.

So, the standardized data can really support local care planning and decision support, quality improvement. It's used by CMS for payments, for the calculation of quality measures. And now, sort of the gift of the IMPACT Act is to also support care transitions.

And one unique opportunity that exists with post-acute care is that the quality measure data is provided, we can calculate the data on

our end. But also, the reports that we provide to the providers, they can run on demand by them.

So, in realtime, or in very close to realtime, with I think a week or so of the data being submitted, we work with our support contractor to develop the technical requirements so that they can run and generate their own quality improvement reports by looking at the quality measure calculation at the facility level, and actually also at the patient level on the assessment quality measures.

So, really, turning the tide and looking at quality improvement is a joint effort, right? And we know, you know, that the quality measures, the assessment instruments, they can only drive quality improvement just so far. But the standardized assessment data, and really shining a light on specific types of categories, is a part of the solution.

If you think of an individual who has severe functional and cognitive impairments, let's say they were in a motor vehicle accident.

And the assessment instrument is capturing their functional cognitive abilities. And then the treatments and interventions that are used, let's say they're on a ventilator, they're receiving tube feeding. They are, you know, requiring suctioning or oxygen. Those kinds of things can be captured in a uniform way, which most facilities do within the facility already.

And then you look at the quality of care by the provider. The patient services and clinical care, their use of not only the standardized assessment data, but also the rest of the medical record for clinical decision support, and their care planning, and then communications and continuity.

And all of that taken together will help inform the outcome and drive the outcomes that that individual has.

So, we've done a lot of work in this space over the last, I guess, couple of years in looking at standardized assessment data elements. As you're aware, we went forward with proposals.

We heard the public comments loud and clear, that it was too much, too fast. We understand.

And we are back, you know, in the field working. And really working through a lot of consensus work, as well as the testing. It's all really been an important aspect of this work.

And with that, I'm going to turn it over to Tara to describe and provide an update on that work.

DR. MCMULLEN: Yeah, just focusing on this slide for a second. So, I know many of you in here are well, very knowledgeable about the Post-Acute Care Payment Reform Demonstration, the PAC-PRD. And the PAC-PRD is really the paradigm to everything we're doing now with the data element standardization work.

And one thing I like about this slide a lot is, what the PAC-PRD brought CMS was a greater understanding that a data element is very powerful, and that it could tell you about acuity, severity, illness, and characteristic.

So, if you're looking at the clinical

characteristic of a person, you want to look at resource intensity. You want to track their trajectory across care settings. You want to see case mix. You want to look at if that item's useful for quality purposes in the risk adjustment model, or for a quality measure. That certain items are useful in that way when tested, proven reliable and valid. And that was PAC-PRD.

And as you know, the care tool was built from that testing and from that knowledge. And from there, we have this work. And it is the standardized data element assessment work under the IMPACT Act.

So, specifically under the IMPACT Act, Section 2A, the Act mandates that CMS develop standardized data assessment elements. And these are in the categories that Stace delineated: function; self-care and mobility, as an example.

Cognitive function; for example, expressing and understanding ideas, mental status. And then there's depression and dementia. So, mental health is nested in there.

Special services, treatments and interventions. For example, need for a ventilator, chemotherapy, and nutritional items. We heard nutrition earlier.

Medical conditions and comorbidities. For example, pressure ulcers. We heard that link, pressure ulcers and malnutrition, diabetes, heart failure.

And then impairments. So, you're looking at the ability to see, hear, swallow, sensory, moving above and beyond.

So, CMS, with our colleagues from the RAND Corporation, moved a couple of years ago now to begin to assess candidate items for standardization purposes. And we have moved in this selection and this exploration in a phased approach.

So, as you see here, we conducted the first phase, which was information gathering, through 2015 into 2016. We piloted our data elements. And as you know, and I'll touch on, within that time we also had a rule proposal.

And we called that piloting Alpha 1 and Alpha 2.

And we are now in the next phase, and that is the national testing. And that's what I'm going to focus a lot of this discussion on today, to give you an update and to gather your input.

Sorry, I'm following along, because since we had these slides last week, I have all sorts of updates. Because we're actually in the field right now and it's like daily updates. But here is a basic graphic -- and we will provide these slides -- of basically the general timeline. And on this slide we really break it down.

What we're trying to delineate here is that, from the start of this project, we have embarked on a robust process of consensus vetting, public comment, technical expert panel processes, focus groups, into testing, into developing and piloting from de novo work, to looking at work that CMS already had done on data elements, such as the PAC-PRD work.

So, what we're showing here is, going into 2018, we're about to hit a point where there is a lot of activities going on. And I'm going to discuss some of these activities.

So, again, these are the categories which are outlined in IMPACT Act, Section 2A. So, in our first phase and into our second phase, CMS said, well, okay, how do we get to a point where we know what are the best candidate items? How do we know what are best in class?

As you know, individuals are not the same. Older adults are not the same for each setting. And care services in each setting vary, right. So, what do we do?

So, this slide shows you that CMS, with RAND Corporation, went on a fact finding mission. We started with developing an organizational framework, which I won't discuss today, but if you have questions I'm happy to speak to.

But this framework kind of set the paradigm for us in how we would go about

selecting candidate items. We did an environment scan, a literature review, of all the PAC settings. And really beyond the PAC settings. The universality of items and information, and things like that.

We had focus groups. We solicited for and conducted -- RAND conducted a technical expert panel. And I'd like to thank Dr. Deb Saliba for her work on that.

We had clinical expert advisor input. And we continue to have that input, many clinical and expert advisors on each domain. And we consulted within CMS, across HHS, with our sister agencies, on what items are useful, say, for the idea of care coordination, interoperability. Where do we need to target? Where do we need to go? What are the gaps? We know there are many gaps.

So we developed this list of candidate data elements. And kind of this paradigm guided us in our fact finding mission in choosing items to test.

We focused in on an item's potential for improving quality. It's very important to maintain that person-centeredness. The validity, and the reliability of the item. Going into the feasibility of the item for use in PAC settings, and really for the intent of standardization. And the utility of that item for describing case mix. And that's very, very important if you're talking about things such as payment modeling.

So, as we were going into this work in more depth and we were in the pilot testing, what we noticed is, now we have two tracks of work.

Track 1 is data elements that we were assessing, that were tested in prior efforts, such as the Payment Reform Demonstration, the PAC-PRD. And Track 2 encompassed new items that we were using for feasibility testing.

So, you see here, Track 1 was PAC-PRD. We were looking at items that were previously tested, and chosen, and proven to be reliable and valid in PAC settings, sensory impairments, items and special services and treatments, impairments

and interventions, cognitive function and mental status.

Track 2 encompassed de novo work, new items that we reviewed and assessed from an environmental scan. Items that were taken from public comments that we received from many folks in this room and beyond, our stakeholders.

And that feasibility testing really focused on a lot of items in cognition, looking at executive functioning, pain, continence, care preferences, and medication reconciliation.

So, I'm going to touch a bit on Track 1, which was the work that was taken from the PAC-PRD. So, there were many items that we put forward in a rule proposal in the Fiscal Year and Calendar Year 2018 proposed rules.

Those items run the gamut of the domains within the IMPACT Act. And beyond the domains of functional status and pressure injury, or ulcer, we chose not to finalize items that were in the following domains: cognitive function and mental status; special services, treatments

and interventions; impairments.

And the reason that we chose not to adopt those proposals is, as Stace delineated before, the stakeholders, and everyone who really read into the rule, caregivers, real people, were saying, hey, CMS, this is too much too soon. It's good that the items are reliable. It's good that you found them valid. But this is a lot. These items are a lot. They're a lot for our systems. We need to think this through.

As you see in bullet 2, we need to enable greater recovery for providers between major releases. As you know, we have release every two years in our PAC settings. We need additional testing on items, because if these items are going to be the gold standard we want to prove that there's a gold standard. And CMS agrees with that.

And that we need more time to build the consensus, you know, the collaboration to ensure that all parties, including CMS, are onboard with this so that we can move forward in

the collaborative effort.

So, CMS chose not to finalize our proposal. And in moving forward and not adopting what was proposed we said, okay, let's go back to the drawing board and let's think through, for our national testing, what items we can take that might be useful in all PAC settings. And let's go out and work with the stakeholder community.

So, Track 2, Status 2, was occurring at the same time as that proposal. And we were looking at elements in Alpha 1 and Alpha 2. And there are elements from that pilot test that now we're taking into our national test.

And basically what we learned, or what we gleaned from that pilot test, is that certain elements performed well, but we need to do additional testing. They may be feasible, but we're not exactly sure that they're 100 percent reliable or valid, or their use can be 100 percent valid in all PAC settings.

We received qualitative feedback in many focus groups and interviews saying we need

improved training and instructions on the items. I know what this item means, but when I go and I have my gold standard nurse, you know, collect this item, she may not know, or he may not know what that means. So, we're not sure if the inter-rater reliability is of a standard that CMS would want to move forward with this item.

And that there is just other information that was problematic. Some items were overly burdensome. We took that to heart. And in our new initiative looking at Meaningful Measurement and measures and patients over paperwork, we are now in our current state. And that's the next step. This is the national test.

So, in our national test we like to point out that we went back to the drawing board. And we thought, okay, how do we get to the ideal state of what could be "best in class"? And we zeroed in on candidate items and a few facets. We're now looking at the timing of assessments, and how those items fit into that timing, so that if we're collecting on an assessment we're

ensuring that we're collecting for an item in the least burdensome way, but in the most effective and valuable way, that it's feasible.

We're focusing in on data elements that are key to the overall assessment of a person, such as malnutrition. We heard that earlier. We're looking at nutritional status. We're looking at items for medication reconciliation. I like to say, items that help us tell a story, items that are meaningful, items that are useful in that clinical assessment.

We're looking at data elements that are useful not just for standardization, but for quality measurement, that detail clinical complexity, that look at patient characteristic. Again, that tell that entire story. Items that can be used and reused many times, not just by CMS, but to the entire world in our data element library.

At this time, I'd like to note that we're currently testing items for the sake of standardization purposes. But we want items that

are universal, if there were such a thing. And we believe that there will be such a thing.

So, here we are in the national beta test. So, the national beta test begins now. We're preparing for it. We're training. We're educating our gold standard nurses who are in the field.

We'll be in the field until May of 2018. We are looking at a sampling of 14 geographic and metropolitan areas. These were randomly selected. And I'm sorry, we have a really great graphic that shows where we are. I like to show it. I didn't put it in here and I'm kicking myself for that now. But it's really great. And it's online.

There are eligible providers. We invited them to participate. Participation is voluntary.

This slide has been updated since we finalized this last week. At this point in time, today, we have successfully recruited 172 agencies and facilities. Our goal is to recruit

an N of 210. So, 210 facilities and agencies.

We are in the last phase of conducting recruitment across all markets. And this is taking place now to offset early dropouts. So, as we see here -- and I'm sorry, this slide has also been updated. The target number of patients per facility and agency, you have that at 30 for LTACHs, and a 30 for LTCHs, 30 for IRFs, 25 and 25 for home health agencies. These are targeted assessments so that we can reach a level above and beyond generalized ability for data outcomes.

So, we will be in these markets, in these facilities and agencies collecting data with our gold standard nurses electronically on handheld tablets. So, folks, we can look at the timing of assessments, and the usability and feasibility of collection of data through multiple modes.

The protocol includes patient interviews, patient observation, and record review items. Testing includes admission and discharge assessment protocols for assessing

communicative patients and residents. And we also have a protocol for patients and residents who are unable or unwilling to communicate.

So, we have three different protocols, one at admission, one at discharge, and I think we did a knowing communicative -- I forget how it's listed or labeled online. But we have one for unwilling or unable to communicate.

I'd like to say that these protocols are now posted on our CMS website, on our IMPACT Act web page, in an effort to be 100 percent transparent in what we're testing, so that we can begin this dialogue with everyone, the outside world, our stakeholders.

And if we're going down the right road in terms of our testing, our methodology, our mode for collection of the items that we're assessing.

Also, and we announced this yesterday on our special open door forum. We are walking into a robust consensus vetting process now for 2018.

We have a three to four pronged approach for reaching out to stakeholders, caregivers, family members, real people in the community, real people in these facilities and agencies.

We are going to be speaking at conferences, holding webinars and focus groups. And these will be targeted on specific populations. We're calling them special populations.

But we want to hear from, like for example, representatives of pediatric organizations, so we can get that input for future efforts in testing.

We are talking with our beta assessors, or the folks who are testing these items in the field, to get their feedback. We're conducting follow-up interviews.

And in October of 2018 CMS will be holding, we call it a forum or a conference at CMS to talk about the results that we're finding in the field. That forum or conference is open

to anyone who would like to attend. And we hope to have that streaming via webinar.

So, again, what I'm calling gold standard nurses, our research nurses will also conduct repeat assessments on subsets of patients to identify optimal look backs. So, that's the timing of assessments.

We heard this in our public comment. We've heard it for many years. And we've come to a point where we're able to now test what is an optimal look back, what is an optimal time to be able to collect, so that we're able to collect the most reliable information on the person in our facility and agency settings.

The next slide shows you the domains in which we're focusing on for the beta assessment. You'll see the domains align with the IMPACT Act, but we're going a little bit above and beyond.

We're looking at data elements that fit in the domains of cognitive status, mental status, pain, impairments. Special services,

treatments and interventions, including nutritional approaches, care preferences. We're focusing in on PROMIS, the PROMIS item set. And items for medication reconciliation.

And the next couple of slides, and this will end the presentation on this data element work, and love to hear your thoughts. The next couple of slides give you a qualitative look on what we're collecting in the consideration of the beta test.

The protocols are online. I don't know if there's internet access via this. But if you go online on your computers and you go to the IMPACT Act web page, and you go to the tab National Beta Testing, you could pull of the protocols and you can see how we are testing those items.

Some items are on a one, three, five, seven day look-back timing assessment. Some items are split into two different subsets of collection, we're doing a split half reliability testing. So there's different processes and

different means for different items. And there's a whole line of thinking behind that approach stemming from our Alpha 1 and Alpha 2 testing. And I'd be happy to discuss that.

But as you see here, we have data elements under the mode of expression and understanding. We have the bins, we have the CAM. We have the behavioral signs and symptoms items, staff assessment for mental status, one of my favorites. PHQ-2 to PHQ-9, that's a gateway, PROMIS depression, PROMIS anxiety, PHQ-9 observational. That's the staff assessment mode.

We have items for pain interview, pain presence, severity, effect on sleep, interference with therapy and non-therapy related activities and related staff assessment on pain or distress.

Ability to see, hear, swallow, continence, patient/resident perceived problems of such, continence appliance use, frequency of events. Service and treatments for cancer, respiratory, or other nutritional approaches, IV or feeding tube diet.

Care preferences, decisionmaking preferences, designated healthcare agent. We have PROMIS Global Health. That's the PROMIS 10 I'll discuss in a second. It's one of my favorites. Medication reconciliation. And that's it. I say that's it. That's a whole world of work. That's it.

And, you know, like I said, based on the item we are collecting by different -- you know, it's the same item but some of the items may have been altered based on what we found in our cognitive interview. And again, based on the timing of assessment.

So, happy to answer any questions. And thank you for your time.

MEMBER LEVITT: I just need to say one thing. First of all, I need to publicly thank Stace and Tara. Because it's been three years. I remember watching the bill. We all watched it trying to be passed. And we thought the vote was going to go down but was just a voice thing, just saying yea.

And literally, like, the next day we were starting to think about this and how we were going to make it work and make it start right. And they've carried it for these three years, and continue to carry it. And, you know, it's been extraordinary.

And also, I know I've said this before, I want to thank you. And "you" is the post-acute care community, which I still feel part of, since that was my life.

When Congress asked for comments initially as to how to improve post-acute care, it was a universal, "we need to have this type of standardized assessment." That was the message they got back from you.

And when Congress decided to do this, it's being done first with us. You know, this doesn't stop with our patients when they're in doctors' offices, or in hospitals, particularly hospitals that have all the resources that a lot of times PAC settings don't necessarily have.

And yet we are the ones who are

carrying the ball on this. And, sure, there, this is a "we," because it is a partnership. And we've got to look at, you know, the burden of trying to do this, to get this transition, to keep all the other things that this is important for besides quality measures. To be able to be better. To show the importance of the resource uses that we need to effectively manage our care planning and hopefully one day expand this beyond our settings because the other areas will see how important this is. And this is just the start.

And so, thank you. There's going to be a lot more to come on this. And we really appreciate the efforts you've done.

CO-CHAIR MULHAUSEN: Jim.

MEMBER LETT: Oh, thank you. Could I ask a couple of process questions about this? I don't have any problems with seeking for the right data elements and I love the fact that we will now be able to compare apples to apples across the post-acute continuum.

My question is about the data elements

that you all have spoken about here. Did you pull these from existing assessment instruments across the post-acute continuum that are -- these are questions that are currently in those instruments? Or you went outside those instruments in order to gather this data?

That's my first question. I have a couple.

DR. MCMULLEN: Yes. Hi. That's a really good question. I don't know if I have to say my name. I did two years ago for transcribing. But it's Tara. Yes, that's a very good question. I'm sorry I left out that detail. It's very important.

For the beta test it's a mixture of items. Some of them are de novo, you know, from scratch development. Some of the items, you know, medication reconciliation, are new items.

The PROMIS items, for example, are not items that are used by CMS in our repository or data item bank for post-acute care. Those are developed and held with our sister agency, NIH.

So we're testing out what has been developed from scratch by NIH and their contractors.

And then some of the items, such as the pain items, they're mixed. Some of them are pain items that have been updated and revised based on what we know from their current use.

So, it just depends on the item. And let me go back. I'm sorry about this. I should have detailed this. I skipped over the middle column. But you'll see a lot of the trajectory for development of the item, based on where they came from. And I could speak to each one, if you're interested.

We also have this information online, where we talk about this item's existing, this item's new, this item's changing because it's topped out. The item level testing has shown us that it's no longer functional in the way that it should be, things like that.

So, it's a mix. We were shooting to expand upon what we have to see what else is needed, because there are gaps.

MEMBER LETT: My question goes to burden. What I'm hearing is that you will find data elements outside of the current assessment instruments, which means we will have to expand the current instrument for each site of post-acute care.

Are you going to decrease any elements within those instruments so that we can decrease the burden of reporting? Would be one of my questions. Because that is a concern. We laughingly call the minimum data set in long-term care, we worry you'll come up with a maximum data set. And that keeps us up at night. So I would like us to think about burden as we do this.

And you're going to then have the same set of questions or similar questions across all four instruments, post-acute-care instruments? You'll have a core dataset, and it will be the same questions across all four so they are reproduced all across those sites?

MS. MANDL: This is Stace Mandl. So, if I could just jump in. So, I think you raise

questions that we have dealt with since the beginning. And if you're familiar with the MDS, some of the questions, you know, assessment areas that Tara touched on should look familiar.

When this work began, we began also with some basic principles. That we look at burden, and we also look at clinical relevance.

And so I think the PhQ is an excellent example of an assessment that's used not only in nursing facilities, but also in physician practices and hospital practices. But really looking at sort of guiding principles around clinical relevance. You know, what would be assessments that would be important or already done?

We certainly looked at what already in sort of the wheelhouse of the assessment instruments, beginning with the MDS and looking at the assessment questions that related to interventions, you know, or treatments.

And as a clinician, you know, looking across all of the assessment instruments, what's

relevant in transitions in care? Well, I need to know if they're on a vent. If that information's supposed to be made interoperable, it's important to know whether they have, you know, a central line, if they are on oxygen, if they're being suctioned. You know, those basic clinical care to help sort of tell the story quickly.

And those are consistent with some of the state-mandated transitions in care documents that are required as well. So, we sort of looked at all of this taken together, but with the charge of knowing that the information needs to be meaningful to other providers, you know, back and forth for those transitions in care.

MEMBER LETT: Okay.

DR. MCMULLEN: I think, taking from Dr. Levitt's work with the OASIS and the team there, our contractors and PAC associates, they've done a nice job of looking at that assessment instrument for home health agencies, and saying, where do we need to cut? What is most useful for our population? They are really

populations of people.

I think this sets the tone for what will happen in post-acute care. It has to. We can't keep adding, because what we know is, we have individuals who are more complex, and there are more of these individuals.

And we don't have more physicians. You brought up workforce shortage. So, I mean, I think ultimately, yeah, we will have to look at what's useful, what's not, then cut.

MEMBER LEVITT: Thank you, Tara. And just in the example in home health. So, we removed measures two years ago. And then it gave us an opportunity to really look at the OASIS, and work with our partners in the agency, because the OASIS is not just used by us. It's used by survey and certification groups for certain needs. It's used by Centers for Medicare for payment. It's used by the home health value-based purchasing program.

So, all these needs on our end for the instrument. So, looking at it item by item and

figuring out what we can remove, because we want to be able to add items as well. But we were able to. I mean, it took a lot of work. We removed over, I'd say, probably two million hours worth of time. It sounds like a lot, but I know there are lots of hours that a lot of agencies.

But it's something, you know, it's a model that we'll continue to do, both in home health and in the other programs.

And one thing, I didn't mention this before, I have to say hospice, you know, separately we have been looking at and assessment instrument too, in hospice that's called the HEART. And, again, it's separate from all of this. But, again, you know, this idea of developing assessment items, standardizing it, really needs to be done, both for a statutory reason, and then really for all other clinical reasons that we know.

DR. MCMULLEN: And you had one more question, and that was the use of the item. The items that we're testing, we'll be testing in the

four PAC settings that are, you know, delineated by the IMPACT Act.

So, we love hospice. But the IMPACT Act said home health, IRFs, LTACHs, SNFs. We're testing the same item in the same manner with the same instructions to be used in the same way across -- to analytically be able to make associations.

And so while that item may be used differently, say in a quality measure, based on the model, you know, the model that supersedes that or balances that out, it will be the same item. That's the intent, that is.

MEMBER LETT: Okay. Thank you. Just one more comment, if I may. I would encourage the thought process to move away from medication reconciliation, because I think that's become a checklist item. "Did you do med rec?" "Oh, yeah, yeah, we did." To a concept of a correct medication list.

So, thanks for your indulgence. Appreciate it. And you all from CMS, appreciate

it.

CO-CHAIR MULHAUSEN: So, we'll take one more reflection from Gene on this particular topic. And then I want to engage you around the agenda management.

MEMBER NUCCIO: Thanks. Real quick, and I will look at the protocol, but one feature of the items is a goal box or goal component. And I was wondering what your vision was for using that, perhaps to capture something about patient preference, which is one of your items.

And, second, in the protocol you mentioned that you were doing RN expert gold standard nurses and you were doing nurse/nurse assessment. Were you thinking at all of including PTs in that assessment process?

DR. MCMULLEN: So, in the collection of the items, CMS does not dictate who can collect items. They just need to be clinicians that are licensed.

And what we were building off, for the methodology, we were building off the Post-Acute

Payment Care Payment Reform Demonstration and the MDS 3.0. I keep pointing to Deb Saliba. This is all her down there.

But what we found was that testing for even quality measure reliability by gold standard nurses is a reliable method to be able to retrieve results that are usable and feasible for CMS. So, we went along that method, knowing that the nurse will be with that person or that resident most of the time.

I don't think that we're limited in who we can test for collecting in the future. And I think that we welcome looking at other individuals who are in different professions for that reason.

And one thing I do want to add is, in the RAND work, we did speak to many professions about the use of the item PTs, OTs. We have them as subject matter experts in the item development work. We have geriatricians, internists, you name it. And it doesn't even stop there.

So, we're trying to run the gamut of

who will be assessing, who's using this item? And we also focus in on caregivers, their proxies, those types of individuals, so that we're hearing everyone's consensus. We're attempting to gain a consensus on those items.

Goals are very important to us, obviously. We have Section GG, functional abilities and goals. And one of the main highlights of that section is the goals column. We love that.

For the care preference items, we are focusing in on decisionmaking. It was in an effort to be able to illuminate what items could be most useful in the ocean of care preferences. I mean, there's so much you can focus on. And we know that we're building from work that's already in our assessment instruments.

The goals items, I think we didn't focus specifically on goals. But the intent always of the assessment instrument is to have items and assessment that's built off the goals, the wants and needs of the person.

I mean, that's our overall intent always. And I hope that answers. I think Stace wants to add a little bit.

MS. MANDL: I was just going to say that the consensus work doesn't involve, you know, all of the various specialties. But also that in the PAC-PRD, I believe that the testing for function also included physical therapy, so OTs and PTs. So, just a little background on that.

MEMBER NUCCIO: Yes, thanks. We should chat about some data that I have differences between the things, which I'm sure you're aware of. Okay.

CO-CHAIR MULHAUSEN: Okay. So, we've covered a lot. It's been a lot of terrific effort. We're running about an hour behind. And I want to discuss time management with you. And there are a couple of things that I'd like to propose at this point around the agenda.

So, one is a working lunch, where we would take a very short break, just to get some

food, a bio-break, come back, reconvene, and keep moving. Is there any disagreement with that?

And we would introduce that into the agenda after the update on the PROMIS tool that we're about to embark on. Any problem with that? Okay.

And then the other thing I'd like to propose is that we keep the discussion around the PROMIS tool update to 30 minutes. And if we can't achieve that just in the presentation, then perhaps there would be opportunity to discuss with the CMS team offline questions you have.

So, is everybody okay with that? Okay. Terrific. So, the next item on the agenda will be Stace and Tara talking about the PROMIS tool.

DR. MCMULLEN: Okay. I've got 30 minutes. I can do this. I'll get this down to ten or 15. Okay. I was going to give you some findings from what we've been doing in PROMIS. There's two discussions here.

Our contractor, Abt Associates, had a

pilot looking at the PROMIS Global 10 in home health agencies. And we found some really good work from that with their efforts. We also have a PROMIS that's going into our national test with RAND that I just discussed.

Behind both of those pieces of work I was going to talk about the findings that we found from our technical expert panel, from our public comment periods, and from testing.

I'm going to limit that. If you guys have questions, or if you'd like me to present at a time when we have more time, I can do that. So, I'm going to go through this. And I hope that this is comprehensive enough for today.

So, I'm going to start with the current state of PROMIS. And that's in our RAND national test work. So, building back to, I believe, last year -- I was on maternity leave, so I think that was last year, right, Alan? I don't remember.

We had our colleagues from NIH come in and give some background about when a new

collaboration at CMS and NIH and really the FDA were embarking on. And that's the use of PROMIS across our quality reporting programs. And the focus of this work started in post-acute care. And there are many reasons for that. As you know well by now, post-acute care, we use instruments, their surveys. Looking at item use and the collection of items for feasibility purposes is a good reality. So we said, let's bring PROMIS in here and let's see what we can do.

So, we were looking at the following domains for the use of collecting PROMs -- or PROMIS, and making, you know, PROMs or PROM-QMs impact in the following domains: cognitive function, anxiety, physical function, mobility, fatigue, sleep disturbance, social role functioning, depression, and pain.

At this point I was going to give you some background, a lot of results that we found, but moving into the next slide. So, quickly, we held a technical expert panel and a public comment period. And we also had some survey

development go out for this PROMIS work.

First, our technical expert panel was held in January 2017. And we assessed the idea of having PROMIS items, PROMs, to develop PROM-QMs for cognitive function, anxiety, PROMIS quality of life profile score, a general one.

And then in November and December of 2016 we solicited feedback on cognitive function, anxiety, physical function, mobility, fatigue, and sleep disturbance.

Overall, there was a lot of discussion. And I guess mixed discussion. Quickly, a lot of people are concerned about burden, about item collection and burden. A lot of people were concerned about difficulty for patients to accurately self-report some of the items, say, for function or cognition.

A lot of individuals were thinking that profiles or protocols such as anxiety are very important, but some of the items aren't suitable for PAC populations.

People also raised concerns about

redundancy and whether items can really be seen as patient-centered or person-centered care. Or whether the items would be useful guiding care.

From our technical expert panel we said, okay, this was really good input. We got mixed results. Let's go solicit some feedback from individuals on these PROMIS protocols and see what we find.

We sent to 285 providers and 61 consumers a list of the PROMIS items. We asked these providers and consumers to indicate whether they believe the items, the PROMIS items, were suitable or not suitable across PAC settings. We asked them to provide written comment, just their overall thoughts.

We used these results to reduce the full item bank of PROMIS items for beta testing. And what we found was that agreement between stakeholders was varied, but there were a few areas that people agreed upon that PROMIS was useful.

And at that time CMS was also

assessing for burden. And CMS, with the stakeholder comments, said let's focus in on the key areas. And this is where we are now, PROMIS in the national beta test.

So, as I just discussed with this work that we're in now through May of 2018, CMS, with our colleagues from RAND, are assessing the usefulness overall, reliability, and validity of the -- well, really, the usefulness and efficiency of the PROMIS Global 10, the PROMIS Depression, and the PROMIS Anxiety protocols for use for standardization in post-acute care settings.

So, there are some caveats to this. And I'm going to explain this right here. But for PROMIS Global 10 and PROMIS Depression and Anxiety we have two versions of those protocols that we're assessing to look at the specific timing of assessments.

And for specifically Global 10, we looked at the items, how they were being asked. And through cognitive interviews we found that we

had to actually reformat some of the items, not to take away from the concept of the item, but the usefulness of the item, how it's being asked and if the person would be able to understand what's being asked of them.

So, again, these protocols are online. We've posted them if you want to take a look. But half of the national sample of assessment protocols for our national testing will be Global 10 collected at three days. And that's a modified version. And the other half will be Global 10 collected in the version that was finalized by NIH at the seven day timeframe.

The same for Depression and Anxiety. Half of our sample of assessment protocols will be collected in the three-day timeframe. And the other half will be asked over the past seven days for mood.

Again, I'd like to remind everyone that today we have recruited 172 facilities and agencies. Again, our goal is 210. And we're looking at a target of 20 or 30 individuals from

each setting. So, we're doing a split half reliability test there.

The second part of the discussion's on the Abt work. So, preceding this work was work that we did in the home health agency setting. And that's with the work of the OASIS. And, really, I'd like to think that this is a proof of concept for what we did with our RAND colleagues, and now in our national beta sample.

So, when NIH and CMS met about a year and a half, two years ago, CMS turned to our colleagues in our home health setting and said, can we conduct a pilot where we're looking at Global 10? Let's see how feasible it is in a home health agency setting.

And this is what we have here. We conducted a small pilot. We looked at 12 Medicare-certified home health agencies, with a total N of 213 enrolled. We looked at Global 10, and 56 individuals completed the PROMIS survey on both start and resumption of care.

We have a lot of robust data from this

pilot that helped inform where we are in the national test now. But overall we found that patient-reported outcomes PROs are feasible to collect among intact home health patients. And that clinicians in these settings appreciated the value of the patient self-reporting their status overall. So, that's really good.

The sample of patients reported worse overall physical and mental health in comparison to the U.S. reference population. And Gene, he was a part of this work. So, thank you, Gene. And this falls in line with what we know. Because we know home health patients have more chronic conditions and worse functional status than those individuals who are not receiving home health care. So, this finding we thought was very reliable.

Additional testing in home health is needed and warranted. And that's why we're in the national test now, to go back into home health and test the revised and the stable PROMIS 10 -- stable's not statistical, but the PROMIS 10

that was originally developed.

We want to take into consideration participation, how that could be achieved and integrated for cognitively impaired patients. And we're doing that.

We did assess for feasibility. Clinicians were evenly divided pertaining to feasibility in concluding that their patients did or did not find the survey difficult or confusing. So, it was an important finding, and we found that in our data element standardization work with RAND as well.

Some clinicians reported patients found the response scale, the seven point response scale in Global 10, confusing. Some clinicians reported patients had difficulty distinguishing between some items, like overall health and physical health.

However, just as many clinicians reported that their patients had no difficulty completing the survey, the Global 10. And that they didn't have any questions. They found it

useful.

So, overall, these findings were wonderful. And thank you to our colleagues at the Abt team, and our CMS home health team. These colleagues built and solidified why we're in the field now testing Global 10 in the hundreds of residents, patients that we're about to test that on.

I think I got that down to 11 minutes. I was a doctoral student at one time. There's not many times you can talk to your stars in your field.

CO-CHAIR LAMB: Heather, go ahead.

MEMBER SMITH: So, thank you so much for presenting this information. The American Physical Therapy Association actually has been strongly encouraging our providers across all settings to use this tool. Because, for us, to be able to look at patient function really across the care continuum is critically important. And we also have seen strong adoption with other care providers.

So, we really think that this is potentially a tool that may harmonize the discussion around a lot of the domains that are really critically important to our patients.

So, just thank you for pursing this and starting to go down this road, because I think it will be critically helpful in the future.

Just a couple of thoughts. You know, again, I think in linking our patients across the care continuum, getting to a place where we can at least start to incorporate some of these items, would be really helpful. And I think just sharing that as we move forward and looking how we might use that in other quality reporting programs across CMS would be really helpful.

The other thing I would say, I mean, obviously there are definitely some limitations to these tools because they are patient self-report. But, you know, I'm always hesitant to say, oh, we shouldn't use it. I think we should try to use it.

One thing I think we might be able to balance this out with, certainly from our standpoint in looking at function, are measures of performance. So, also looking at something like a six minute walk test, for instance, to see how a patient self-report might line up with actual walking abilities.

That is something that doesn't exist, really, in a standardized fashion in any of the quality reporting programs. But it's something that we're starting to think about, you know, both just to lend credibility to, you know, what's the patient's perception and what's truly happening, as opposed to just having either the clinician or the patient self-report.

And because there are normative standards for some of those tests, again, I think that this would be something else that might go hand-in-hand with some of the existing measures.

And, you know, I hate to suggest additional measures, because I recognize there's always a component of burden, but in really

trying to paint that full picture, I do think some of those performance measures would also cross multiple care settings as we're trying to get a full picture of our patients. So, thank you so much for your work in this area.

CO-CHAIR LAMB: Theresa.

MEMBER SCHMIDT: Just a quick question. Have you given any thought, or has any work been done, about the applicability of the PROMIS tool for caregivers or families?

DR. MCMULLEN: Yeah, that's a very good question. We have given that thought. I hate to mix quality work that I'm involved in. But in our quality measure work that I'm also involved in under the IMPACT Act, specifically in our transfer of health information quality measure work, we are bringing in caregivers, patients, families, talking about the applicability of that and that sort of metric.

With PROMIS we have discussed patients, family, caregivers. And it's definitely a future direction that we would want

to explore. At this time, just bringing in the person's voice, I think, is the focus. We can't state how important that is.

Plus, the development of our PROM-QM is something, I mean, I'm very interested in. It's something that we do not have in post-acute care. And across HHS, committees are talking about the feasibility of developing a PROM-QM that could be used across settings.

So, in the future I guarantee there will probably be a patient, family, proxy, caregiver voice brought into something. I don't see how you couldn't do that.

MEMBER SCHMIDT: Just to be clear, I wasn't referring to a proxy or a surrogate voice. I was referring to capturing health outcomes for caregivers and families.

CO-CHAIR LAMB: Pam.

MEMBER ROBERTS: I also applaud your work in starting to look at measures across the continuum with PROMIS items. And I echo Heather's comments about looking at the PROs with

performance measures.

In addition, are you looking at, especially with some of the PROMIS measures, in individuals that have communication and cognitive problems that may not be able to do it in one setting, but maybe further down the line they will be able to do it, and being able to capture that?

DR. MCMULLEN: Yeah, that was the intent, to add it into the protocols for the four settings, is to see any type of variation in that coding and collection.

So, if you look at the protocol for the non communicative folks, and that's applied to all four. And right now this is just for the four PAC settings. So I can't talk to home, community-based, or acute.

The point is to be able to see if there is any variation, if there's a change, and when that marked change occurred in the services applied to that person.

MEMBER ROBERTS: My understanding of

the non-communicative one is different than when you wouldn't do it at all but there are some people that you can get some of the information, but you won't be able to get all of it. And that's kind of gap that's not captured.

DR. MCMULLEN: Right. We agree. And in that protocol we knew that there might be some limitations. We added in folks who were unwilling. But we still understand that we might have some dropout there. And within that, I think that's a significant finding. And I think we've just got to fill that out. But we understand that. We concur.

CO-CHAIR LAMB: Tara, I have a question about the development of it. When you were talking about the consensus development, we've been talking this morning about multiple stakeholder groups, and I think the question about the alignment between those groups.

So, my understanding of what you said with PROMIS is that there was a process that consumers identified what was important, and

stakeholders did, and there was an attempt to look at the intersection of that.

Did you have any impressions? Were there, you know, substantive differences between what consumers and patients thought was important and providers, and how that played into it if there weren't intersections?

DR. MCMULLEN: Yeah. So, what I was going to detail in that work was, between the consumers and the stakeholders, we asked them to organize from the protocols what items were most useful to them.

I'd have to go back in and work with our RAND team on this, but we believe that there were consistent ideas. Like, for example, I was going to talk to the most preferred item between all the folks that we assessed or asked them to give their input was, "I had difficulty sleeping." The second preferred was, "I felt worried." And this was for anxiety.

And so I believe that was a universal agreement for the most part. But I'd have to go

look into that. Yeah, I would have to figure out what weighed heavily on that. I'm looking through my feedback.

Overall, what we found in the PROMIS work was dependent on who you talked to. There weren't consistencies. There wasn't an overall "we have to do this," other than "we have to assess and have patient-reported outcomes assessed." But between the protocols there wasn't a consistent response. So, we relied on the cognitive testing for that.

CO-CHAIR LAMB: Well, I was just going to also echo what Heather was saying, is the importance of aligning those different assessments.

And the, obviously, the link to outcomes, which is, if there is a divergence, how do we understand if a patient feels something is critically important, but it's not in alignment with how the professional is evaluating it? What difference does it make? Because it may make a huge difference in terms of what I believe is

important, either as an individual, or what Theresa was saying, is a family member may have huge insights into the outcomes.

I'm really struck, in the latest report of the National Quality Strategy, that the care coordination changes are lagging behind the other key priority areas. And I'm wondering if understanding this difference may give us some insights into why they're lagging.

DR. MCMULLEN: I would imagine that, the outcome of testing in beta, we would be able to make some of those links. And we should be able to make some of those links. I mean, we're going into the field collecting on multitudes of individuals.

Ultimately, I think everything you said is very important. We're just not to the point yet where we can make those associations. But we agree with you. And that's why we're moving forward with looking at PROMIS.

CO-CHAIR LAMB: Any other comments, recommendations? Alan.

MEMBER LEVITT: Yeah. Just one. This is a great discussion. It's the reason we're all here. And we need to hear these ideas about, you know, where this should go, continue to go.

This is step one, you know. We're trying to do this. And once again, who's doing it? It's post-acute care. We're doing this. And we need to build on this.

So, please, you know, we're going to give you answers sometimes where we're not doing that. But it's we're not doing that yet. But the "yet" is going to be, you know, based on the partnership that we have together. So, thank you very much.

CO-CHAIR LAMB: Ready for lunch? How long should we take, Paul? Ten minutes, 15, to get the food?

CO-CHAIR MULHAUSEN: That would need, I think, at least 15.

CO-CHAIR LAMB: Take 15. And then we'll regroup. At 12:35 we'll regroup.

(Whereupon, the above-entitled matter

went off the record at 12:18 p.m. and resumed at 12:40 p.m.)

CO-CHAIR MULHAUSEN: All right. If we get everybody to bring their lunch to the table, so that they're present at the table, then we can move on to the next agenda item.

I think we probably have a quorum at the table, so we're going to just launch right into our next agenda item that Erin is going to lead us through.

MS. O'ROURKE: Excellent. Thank you.

So, this is actually something we've already begun touching on this morning, and I think we can continue to weave these themes throughout our conversations throughout the afternoon. So, I do want to acknowledge that points that have already been made and that we will have an opportunity to continue this conversation.

We did want to briefly have a conversation about some of the specific challenges that post-acute providers may face

when trying to participate in the Merit-Based Incentive Payment System. Just to make sure we're all on the same page, I have a few very brief overview slides, so that everyone's aware of what the program is.

It was created by MACRA in 2015. It required CMS to implement an incentive payment, now referred to as the Quality Payment Program, that has two participation checks, the MIPS program as well as the Advanced Alternative Payment Models.

MIPS combined four legacy programs into a single program, PQRS, the Value-Based Payment Modifier, as well as the Medicare EHR Incentive Program for Eligible Professionals.

MIPS is comprised of four performance categories for 2018, quality, cost, improvement activities, and advancing care information. So, this program addresses physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists.

There was a change to the low-volume threshold in 2018. It includes MIPS-eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges and providing care for more than 200 Medicare patients a year.

So, with that, I want to introduce Dr. Ted Long from CMS to say a few words and, then, turn it back to our Workgroup for thinking a little bit about if there's any MIPS-specific gaps you want to highlight or any feedback we should pass along to the Clinician Workgroup and Coordinating Committee.

MR. LONG: So, first off, thank you, everybody, for taking a few minutes to talk about this today. We've been excited to come in and talk to you all about MIPS, in particular, because there are a few key areas where we would really love to hear your insight and feedback. So, I will be very brief, because I was excited to hear from you. So, I will not belabor the point.

But I just wanted to lay out three

sort of key areas that we see that we would love to your feedback on, just to sort of set the stage for the conversation today. Don't feel limited to these three. Just consider this is a place to start, and then, wherever the conversation goes, we would love to hear, because wherever you think it should go is the most important direction.

Three of the areas we think about are, first, we have measures in the MIPS program. There are measures in the post-acute care and long-term care setting. Do we have the right measures in the MIPS program and, if we don't, what would your suggestion be about how we could get there?

Second, in the post-acute care and long-term care setting you do have measures that are important to patients, family members, caregivers, and clinicians in those settings, but oftentimes those measures are not currently specified for use on the individual clinician level or for how we could otherwise use them in

the MIPS program.

We would love any insider thoughts into the priority you would give to the idea of respecifying measures, taking what you think is of highest priority and most important in the long-term care and post-acute care setting, and potentially bridging them over to MIPS, and how that would look. What would go into that and how we might deal with some of the thorny issues such as attribution. If we have a clinician that sees patients at multiple different facilities, how do we approach that?

And then, finally, we were fortunate to have several public comments in our proposed rule this last year for the MIPS program, but a new concept called facility-based MIPS Score. In a nutshell, what this is, facility-based scoring is where the MIPS program would take a facility program score and translate that into what the clinician or group score would be for the MIPS program.

To give an example, we laid out what

could be a proposed plan for thinking about this on the hospital side. We, then, received a lot of comments back about the priority for thinking about this and some initial thoughts on how this could look on the post-acute care and long-term care side.

But I was curious, we are curious, if (a) this sounds like something that we should be pursuing and thinking about, and (b), if so, what are your thoughts on how we could begin to approach that?

So, I know my three areas here are pretty broad, pretty open-ended. Please, again, don't feel restricted to these, but, overall, we're looking forward to hearing your thoughts and feedback today. So, thank you.

One more comment and, then, I'll turn it over to you all. In terms of other upcoming activities, milestones, and timelines we have at CMS, our rulemaking cycle will, again, start this next spring. That is where we can begin to include some of the ideas we may be discussing

today. That would be an important milestone.

Another important milestone is that we have put out, or we will put out, we have put out a forecast and we will be putting out a funding opportunity announcement soon where we want to lay out an opportunity to collaborate with cooperative agreements for future measure development. So, we just wanted to put that on people's radar as well.

With that, thank you. Looking forward to the discussion. I will be quiet.

(Laughter.)

CO-CHAIR LAMB: Thank you for inviting the feedback, and thank you so much for being here today. I know we were all excited about having this dialog.

Heather?

MEMBER SMITH: As currently a non-MIPS-eligible participant, I figured I would just start it off. As you know, physical therapists are not part of the program currently. We hope that we are included in 2019, because, obviously,

at this point in time, for a number of reasons, we think it sends a terrible message to our providers about not moving forward with value. And I think it doesn't create a full picture of what's going on with the care team to have certain providers being withheld from the program.

I do want to point out some concerns that we have, and we did express these in comments, about our post-acute care providers. Physical therapists independently bill in private practice. However, we do not independently bill in Medicare Part B facility settings. And so, even if we were to be added to the program, if it was carried out as the old PQRS program was, we essentially would not be able to participate because of the fact we don't independently bill in the Part B post-acute care settings and other facility Part B settings.

We would strongly encourage you to think about how you might be able to apply the facility scoring to our providers and potentially

create opportunities for them to participate as groups. We do believe that this would allow CMS to include our providers in this program. And as we discussed, obviously, in the last section, I think measures of function would be easy potentially to start to think about across the care continuum. Certainly, some of the measures for the post-acute care settings moving into traditional outpatient spaces, where patients are independent, I think would be a great area to look at for function and really meaningful to our patients as well.

We're happy to have more detailed discussions about that, and certainly, we will be proactively going to the agency to discuss that in the next couple of months. But I just wanted to put those comments forward for consideration.

Thank you.

MR. LONG: Yes. No, those are all very important comments and points. Thank you. Yes, this is exactly the type of feedback we would love to hear. So, thank you.

CO-CHAIR LAMB: Caroline?

MEMBER FIFE: Yes, Caroline Fife.

So, one of the challenges -- I am the Executive Director of a QCDR -- one of the challenges that we discussed before you got here this morning is that, under MIPS, as you know, physicians pick any measures that they wish to select and they're monetarily incentivized to pick their highest-scoring measures, which may or may not be a natural fact relevant to their practice.

So, as a result, even if you have the perfect group of measures, as long as I can pick the measures that I've scored the best at, I can select the measures where my nurses have effectively done all of the work for me, and I have participated really not at all in the actual work involved. And if I have a really good EHR and a fantastic staff, then I can do very well on those measures, and you will actually know nothing about me and it will be irrelevant.

Unless that changes, I really think

this is a fool's errand. And one can talk about all the ways in which that could be made to change, but I just don't see a fix.

The thing I am curious to know is whether there is any interest in using the non-MIPS measures, the QCDR measures as a way to either pilot some things or to help us get out of the silos of care, because I can see that as an opportunity in post-acute care.

I keep waiting to get kicked off this panel, and they didn't do it after the last meeting and that really surprised me.

(Laughter.)

I'm pretty sure that I didn't get kicked off this one. But the reason is that I'm not really a post-acute expert.

But, when I think about the way in which quality is focused in these sites of care, it's focused on the facility and not really the doc in the facility. And I don't mean to -- I realize that nurse practitioners and other practitioners are there, but it just feels that

there is no window on this other really important individual who has a lot to do with what happens to that patient. And that just worsens the siloing of care, which we already realize is a problem.

And somehow that concept that our way of looking at quality is where your body is, and not who you are or what the matter is with you, just there's something that, I just rebel at the idea that that's what quality is.

If I have had a stroke, then why are you measuring something different when I'm in the hospital than when I'm in rehab, or when the home nurse comes to see me once I get home? I mean, I still just had a stroke. But they're completely unrelated things that people are looking at. It just doesn't make sense to me. I'm a simple girl. I get that.

So, it seems to me the only way to get out of that might be non-MIPS measures that are focused on the provider and the care that he or she is giving. It is just a silly idea, but it

might work.

And the other advantage of that is that you can pilot some things because you have more flexibility. Because of the things that seems apparent to me in looking at the process we go through is that it is really long and really challenging. In some cases, by the time we get something all the way through to the end, it's already obsolete and you have to start over again, which was one of the impetuses for the QCDR.

The other question that I have has to do with barriers, which always gets back to technology. So, I was kind of wanting to ask Liz about this later. But, you know, we're looking at smart apps using buyer technology, and that could break down so many silos. It's been on my mind all day long. So, I don't know if that is another area.

I mean, we know that we have high hopes for that, although, given the data blocking that we've been coping with all along, I know

that it's just going to be another head-banging thing; I know. I just need to get a Prozac salt lick out and just keep using it, because it's going to be horrible, just like it has always been. But maybe something wonderful will happen and technology can help us get past that. So, I hope that will be an opportunity, too.

And then, virtual groups, I don't know what your thoughts are or whether that offers another opportunity for us to better target measures at who you want to look at.

MR. LONG: Yes, those are all, I think, great points. And there's two, at least two, sort of foundational questions that you're sort of alluding to there. If everyone is okay with those, I was hoping I could actually ask you maybe for a few more of your thoughts on two of these things.

One is the tension between allowing clinicians to pick what they feel is most important to the care that they deliver, with the tradeoff there being that they might pick based

on other criteria that they may have as well. And that's one of the questions I had for you, if you have any thoughts about how to get around that, maybe specifically with respect to the post-acute care and long-term care setting.

Then, the other foundational, I think, issue is facility-based scoring, you are saying a few words about that. Now that would not give clinicians the same choice. It was be a yes/no. So, that is a little different than the issues that you brought up with the choice of a variety of measures.

But I was wondering if you could comment maybe on that sort of interplay between choice, options there to ensure we're getting where we all want to go, which is the most important areas for the patients, and how that might pertain to facility-based scoring.

MEMBER FIFE: So, I hope this is going to answer your question. One of the barriers that we currently have is we have a lot of physicians who go -- and my nurse practitioner

and her colleagues are always frustrated when I say "physicians," but I don't denigrate them. I elevate them.

But we have a lot of advanced practitioners who go multiple places. What happens is, if your amount of practice is less than 51 percent at any one particular place, you end up not reporting anywhere, because of the weirdness of the math. So, you end up being exempt from all quality reporting because your care is fragmented, and that seems like the very person you should be capturing.

So, it seems to me that the answer should be you report quality wherever you are and stop worrying about whether we have the sum total or whether it's more than 51 percent. So, I think that's a problem. We just have to say, we'll take it wherever you give it, and that it will be appropriate to the site of care. And then, we figure out what's appropriate.

I don't do long-term care. So, I probably shouldn't speak to that. But, if there

is a measure that we feel is both relevant to the physician and the facility, terrific; we'll take that. If, then, you're in the hospital setting, and it doesn't work that way in the hospital, then we take what's relevant to you there. Maybe that's just pain management. And then, when you're in your office, maybe it's something different. Maybe it's still pain management; maybe it has to do with use of high-risk medications in the elderly.

But whatever is fair for that site or that patient population should be fair in that setting. I just don't see why that is so hard, because there is a different mechanisms of submission unless we figure out, through technology, something that is more simple.

So, I don't know if that answered your question, but it just seems like it is always appropriate to your environment because we adjust to the purpose of our being there when we walk through the door.

MR. LONG: Yes. No, it gets back to

the fundamental point that we want to capture what's most important to the patient in different settings, but the patient is the same patient across settings.

It's obviously a challenge for us from a measurement standpoint, but I think it is a very worthy thing to raise and something we think a lot about, too. So, that is a very well-taken point.

MEMBER FIFE: I tax ID number isn't changing. So, it's a problem if you're from a group, and that is another issue that is really challenging in academics.

MR. LONG: Right.

MEMBER FIFE: Because when the university decides they're going to report everybody at the entire medical school under one tax ID number, then, you know, they're going to use BMI, smoking cessation, and blood pressure measurement. And you know the orthopedic surgeons are totally focused on blood pressure measurement, just saying.

CO-CHAIR LAMB: Okay. So, we've got three more folks. What we would ask is, please make your comment. And, then, Ted, if we could make the comments first and, then, kind of deal with it as a group, so that we can kind of have a round robin going on?

Pam, I think you were next.

MEMBER ROBERTS: I mean, I totally agree with Heather. I'm starting to look at, for therapies, PT, OT, and speech, being able to have individual measures at the PAC providers and, also, being able to carry those measures, because many times therapists work in multiple settings, and not just one setting. And then, kind of tying this back into the IMPACT Act discussion that we just had, where those are much more global measures.

But, if you really want to understand how do you improve quality at the facility level, if you could at, maybe via MIPS -- and this is just throwing it out -- what are some of the inputs that go in there? Then, the facility

could actually figure out where there is quality. But, right now, it is granular, which is the first step of being able to go across settings, but the next step would be able to get into like where the variety is. What is driving care and what is improving it? Maybe by having MIPS at the individual provider levels in post-acute care would help.

CO-CHAIR LAMB: Deb?

MEMBER SALIBA: Yes, I think during this initial transition period, I am comfortable, and in fact, think that it's a good idea, to allow providers to have some choice of the measures that they're being measured by, with the goal to perhaps move to your more ideal state of some of the more universal measures.

But I think we have a lot to learn about how these are going to work and how they're going to roll out. And having that opportunity to see which measures are being selected, how they perform, and getting provider buy-in, which particularly for smaller practices is going to be

an issue. I think in the larger practices where they've got smart people doing the analytics and picking out the measures, less of an issue. Still an issue. So, I'm comfortable with letting there be some selection process.

The other is I am uncomfortable with sort of the forced distribution measures. The fact that there have to be defined winners and losers on every measure, no matter how close they are to each other in performance, I know it's difficult, but it might be nice to come up with some kind of established benchmarks or performance levels that we consider, as we're looking at these measures, based on data for what can be achieved in best practice, to help with that. So that we're not deciding between people, ranking one person high and one person low with our organization with only a two-percentage-point difference, you know, between them.

CO-CHAIR LAMB: I'm not able to see the name tag down there. Frederick? Is it Frederick? Please.

MEMBER ISASI: So, just a couple of thoughts, and these are global, I think beyond the questions you're asking here. I just want to contribute a little bit to this, and really associate myself with, I think it was Caroline's comments earlier.

I come from doing a lot of work around post-acute care and long-term care for the governors at the National Governors Association and with a lot of their state leaders. And I was really struck by the measures that we were trying to develop that really had an impact, which often around behavioral health integration. It was often about social determinants, including things like transportation and housing and stability, things like that.

Now it's for a subset of vulnerable populations, but the outcomes that these types of needs drive are pretty astronomical. They usually represent the top 5 percent of spend within a governor's state Medicaid program, something like that. So, they're associated with

very, very high spend.

And then, the third point I was going to make was on data exchange. One of the biggest obstacles for clinicians, just being these kinds of measures, is data blocking and the inability to really get data flowing. I think if we aren't a lot more deliberate about trying to understand and quantify the amount of data and the quality of data being exchanged by the providers, we're missing the opportunity to try to have providers solve the problem with us.

And then, the last thing I was going to say was, this notion that clinicians get to choose their measures is pretty crazy. If the idea is you want to allow clinicians to select measures they think that have the greatest impact on the quality of care that they're providing, it seems like you're just taking a cookie jar and just opening it up and saying, "Take whatever you want." Versus, you know, here's the set of measures that would be most responsive within your specialty or within your focus area; pick

five of seven, or whatever. It's giving them a menu. Or the diagnosis you're treating, yes.

But, if your end game here is to allow clinicians to be able to help guide the measures that are being emphasized, it seems like it's the tail wagging the dog if you're just saying, "Pick whatever you want." Right?

CO-CHAIR LAMB: Raj?

MEMBER MAHAJAN: Thank you.

And most of the people have heard me talk about this for several years now, and I am so happy that you came here and, as the practitioners in post-acute/long-term care for several years, we have said that current measures, although 50, 49 of them from the MIPS set apply to place of service and nursing homes, but when you break it down, really none of them are as meaningful as they should be.

So, we do have a quality measurement or Quality Measures Subcommittee as part of the big policy committee AMDA that has been looking at, okay, you're complaining all the time it

doesn't make sense. Then, what do you think makes sense? So, we do have a good 20 areas that we have identified that could be possibly good areas to develop measures.

And I just want to just comment that earlier this week I had my two fellows at the nursing home look at assessment plans and care plans, physician notes, assessment plans, and care plans from the MDS. And 80 percent of assessment plans and the physician notes had nothing in common with care plan at the nursing home. These are over 10 charts at a real institution just a couple of days ago.

And so, that is the problem. The facility has its own plan, and the physicians are thinking they're doing care, but they have their own plan on CHF management and all that. That might not really be that important for either the short-term or the long-term care plan.

Then, in the end, I will say that, while our group has looked at what things are out there, very strikingly, the measures that are

being looked at under IMPACT, most of them have a very high physician impact on their involvement. I think it should be looked at as an add-on to the work that is being done under IMPACT or additional work that the measures -- so, you're aligning all post-acute levels, but you can also align physicians' network in there. And they could all commonly report on these measures.

And so, as I said, most of the measures, as we looked last in IMPACT, are physician attributable. And if that is not a possibility, where just like hospitals, facility measures being used by docs -- I know there are a lot of logistical nightmares to where you live, what facility you use. And can people only use the good facilities and not bad? So, all those things are there.

But I think it is definitely worth officially looking at whether this can work. And I strongly think it can work. If it is not going to be facilities measures as in use MDS to report, those measures could be looked at,

validity, within the physician space and long-term care.

CO-CHAIR MULHAUSEN: So, one of the areas of confusion that -- I actually don't know the truth here -- that I have encountered in my own work with colleagues has been whether or not in the domain of practice improvement, whether improvement activities that one is engaged with in long-term care could apply to the practice improvement category.

So, the one that we've had a special interest in, because in part of my work I promote antimicrobial stewardship -- it's required by the SNFs. A lot of physician involvement is what we're promoting. And we've always struggled with the answer to the question, well, if I participate in the long-term care antimicrobial stewardship initiatives, can I count that? And at the level of asking CMS, it just ends up being confusing.

MR. LONG: Okay. So, I'll be very brief here, but I just want to say again thank

you, everybody, for your comments. I want to highlight a few summary notes that I was taking here from what people were saying, just to make sure I'm taking the right things away. And then, I'll answer your questions.

Pam, to your point, we need to look at PT and OT and their inclusion in the MIPS program. Definitely hear that and it's well-taken.

Deb, to your point, we have thought about the role of achievement points in the MIPS program, in addition to how we do benchmarking. But your emphasis on it here is very helpful to hear. So, thank you.

Frederick, we hear you on information block -- and everybody -- information blocking. We recognize it's definitely a problem.

Also, Frederick, one of the points you made which is interesting to me, and maybe if we get more feedback on this moving forward, is the idea of putting measures together in sets. So, it's a challenge with post-acute and long-term

care because it's a setting that we're talking about here. Whereas, for different specialties, we have created sets.

If you want to take a look at our website to see how this might work for the post-acute care and long-term care setting? For example, orthopedic surgery is a set. So, if you're an orthopedic surgeon, you go to your set and you see which measures apply to the type of surgery you do. So, if you're an orthopedic hand surgeon, the spine measures will not apply. That's where the choice comes in. It's in terms of designating really what's within the scope of your clinical practice.

I think it is a challenge to translate that to the post-acute care and long-term care setting, but I think we would be interested to explore that further. So, your point is well-taken on that, too.

Raj, looking at how the IMPACT measures could be taken over to the MIPS program, the concept behind that, with the attribution

currently to finish this, is very well-taken. It's time we talk about it. No, I agree with that. That's very important.

And, Paul, the improvement activity, so the answer is, absolutely, yes, the improvement activities do apply. Now the caveat to that is the improvement activities in the description of them sometimes have requirements that require the action to be done in a certain way or with a certain protocol.

I could tell you that antimicrobial stewardship not only has -- there is one, at least one improvement activity that is specific to that, but there's others that actually apply under that as well. So, the activity you're doing, the Act should have been met in a couple of different ways.

I found it's easiest to take it offline, and I would be happy to share my email with you and to answer that more specifically for you.

CO-CHAIR MULHAUSEN: It's very useful

to know, though, that improvement activities and long-term care can be applied in the practice improvement.

MR. LONG: Yes.

DR. YONG: Can I ask you why there's that? I mean, why would you think of getting it?

CO-CHAIR MULHAUSEN: Well, simply because everything has, to date, seemed very focused on ambulatory care. And I think many clinicians who are dedicated to long-term care have felt left out.

So, just a reflection on feeling left out. Before Telligen became the call center for QPP, so I'll confess to that, but this happened before.

(Laughter.)

I don't know what would happen if I called now. But, when I called the call center and said, you know, "So, if I'm in a nursing home and my practice is in a nursing home...," and the answer I kept getting back was, "No, nursing home work doesn't apply because the site-of-care

sub -- whatever -- code. Right? And at the time, I could have told you that more articulately.

And that message came over and over and over again. I even said to them once, I said, "That makes no sense to me. Are you sure that's correct?" But their argument was, well, it's not Part B. And I go, "Well, to my knowledge, everything I did over the course of my career in non-post-acute care settings was all Part B." And so, that created the confusion for me. Does that make sense?

MEMBER FIFE: Sorry. The other clarification was that most of this data is being collected from a specific type of, usually, EHR. And so, the entity that did the reporting had to attest that you had at least 51 percent of the data of that provider, if you were going to do their reporting for them.

So, if you were a PQRI, PQRS, or a MIPS-reporting registry, and you couldn't say, "Yes, I have 51 percent of their data," then it

wasn't applicable. And since most of us are attesting for their IAs as well as their MIPS on quality reporting, then you wouldn't attest to any IA activity that didn't happen in their office, where their EHR was. And so, if they were doing that in some other site of care, we wouldn't be attesting.

MEMBER MAHAJAN: And just to add onto that is a lot of times, for example, two of the big items right now that are high impact are either anticoagulation management or glycemic control. So, if there is a QAPI put together by the facility, it is an IA for the facility. It is housed in the facility EHR. And it is done for everybody that practices there.

So, although it makes sense if your patients are there and you are using that protocol for either anticoagulation or for glycemic management, and, yes, you are, but, I mean, you can attest to that. But I know a lot of people who attested to the incentive money and got their payment back after it was audited and

found out that it wasn't appropriate.

So, there is that fear that, if you use a protocol developed by the facility to attest to a physician-level intervention, it might not fly at an audit.

MR. LONG: Yes, I will add, this actually is really helpful feedback for us to hear because these are things we can really help to clarify.

If there are questions, we do have a way to answer, through our current service center, questions about which type of activities would qualify for improvement activities for clinicians as well. So, I would encourage you, and we can share that information, too. So, we do want this to be as clear as possible, and it sounds like there are ways for that.

CO-CHAIR LAMB: Thank you.

And in our ensuing discussions today, we're going to be talking about gap areas. So, we're hoping that we can also share that with you in terms of what may be relevant for looking at

MIPS in the post-acute/long-term care.

So, thank you so much for coming.

MR. LONG: Thank you all very much.

MEMBER FIFE: Do you dare leave your contact information?

(Laughter.)

Or do you want to like get out fast?

(Laughter.)

MR. LONG: It's alan.levitt -- no, I'm just kidding.

(Laughter.)

No, actually, I will be happy to be in touch. It's theodore, T-H-E-O-D-O-R-E, dot, long, L-O-N-G, @cms.hhs.gov. And we can share that, too. But I would be very happy to be in touch.

MEMBER FIFE: Okay. You'll be sorry.

(Laughter.)

MEMBER LEVITT: If I can just make a comment on the alan.levitt -- (laughter) -- no. No, it actually is true. Because last year we were sitting next to each other, Raj, Ash, and I.

We were talking about this. And when I left the meeting, I gave each other an email, so they could start talking about this and working.

And much like the feedback loop where you would tell the message back to us at CMS, it was we want to hear more about these measures. We have issues and questions about them. Please, when you can have some answers to them, bring them back. So, what you talk about here, we're listening too, and please continue to do that.

Alan.levitt@cms.hhs.gov.

(Laughter.)

CO-CHAIR LAMB: Thank you, Alan.

We're going to move into pre-rulemaking now, and Jean-Luc is going to lead us through that.

MR. TILLY: Great. Thanks, Gerri.

So, as many of you know who have been returning to this for a few different years, we have a three-step approach to pre-rulemaking. So, we'll start with a kind of program overview, so you'll hear about each of the different

programs in turn. We'll review the current measures in that program. And then, we'll take some time to look, in our case this year, at the one measure under consideration, kind of talk about how that would add to the program measure set, review the staff preliminary analysis, and then, vote on that measure. For the programs where we don't have a measure, we'll just kind of concentrate on that gaps discussion.

To evaluate a measure under consideration, essentially, we do have to reach a decision on every measure, which feels pretty attainable this round. The decision categories are standardized for consistency across the Workgroups. So, we're all kind of voting on the same things and giving CMS the same standardized feedback.

In addition to the vote that you take, we will be summarizing the conversation as a kind of statement of the Workgroup's rationale. That can help CMS understand the context that surrounds the voting decision.

In previous years you'll remember we used a kind of consent calendar voting process where we looked at the staff's full analysis, gave the Workgroup members a chance to pull measures off the consent calendar and discuss those. Given our unique situation, this round I think we'll just pull the measure and give everyone a chance to talk about it. You know, we haven't assigned any lead discussants. So, we'll just kind of open the floor for conversation there and allow the Co-Chairs to summarize that conversation, advance a motion, and then, vote on that motion.

When you're taking a look at the preliminary analysis today, hopefully, not for the first time, but we will see that, basically, our goal is to give a kind of succinct profile of the measure we're talking about, and this goes to the core queue for the SNF therapy.

We've given it a verdict and a little bit of justification around that verdict. We've walked through the criteria. So, you will have a

chance to kind of see our reasoning there, ask us questions about that, and discuss.

So, the MAP measure selection criteria, there are seven. They have to do with a kind of logical sequencing from looking at, you know, how well does the measure fit into the program set? How responsive is it to our standards for scientific acceptability? Does it help the measure set have the right set of measure types? Is it responsive to some of these more emerging demands? And does it reflect our emphasis on person- and family-centered care? And does the program measure set promote parsimony and alignment?

So, we'll talk, then, just really quickly about the four decision categories you'll be choosing from today for that one measure under consideration.

Support is pretty simple. That's just that the measure meets all of the criteria in the algorithm. If the measure is in use, it's that there haven't been any kind of unintended

consequences identified.

Conditional support is close. So, the measure meets most of the criteria, but maybe there are one or two things that should be either tweaked or in some other way revisited. Typically, that means submitting the measure for NQF endorsement, to have that kind of deeper dive on the scientific acceptabilities on the different properties.

Refine it and resubmit it is a little bit more complicated. In a second, I'll turn it over to Erin to go into exactly what that means. But that's like a conditional support for rulemaking, but what we're thinking there is, are there really more substantial modifications that need to be made? And ideally, the measure would come back to the PAC/LTC Workgroup to have a kind of second crack at evaluating that measure and offering a decision.

Do not support means that, broadly speaking, the measure really doesn't meet the measure selection criteria that the MAP has

agreed on.

And so, with that, I think I'll just turn it over to Erin to talk through the refine and resubmit.

MS. O'ROURKE: Absolutely, and I don't want to belabor this because I know we're short on time, and our one measure is fully developed and NQF-endorsed.

But, in the interest of being consistent across the Workgroup, and because this concern was raised during your fall web meeting, we just wanted to follow up with some guidance on the refine and resubmit category.

The Coordinating Committee created this category, as Jean-Luc was saying, with the intent that a MUC that received this designation would be brought back to MAP before it was implemented. However, the Secretary of HHS does have statutory authority to propose a measure after considering MAP's recommendations.

This year we implemented the feedback-loop process that you heard during your fall web

meeting as a way to bring you that feedback, perhaps not through the formal pre-rulemaking process, but to keep you all in the loop about how measure stewards and developers had acted on some of the Workgroup's input on prior MUC lists.

However, given some of the concerns we've heard from this Workgroup, as well as the similar theme arose at the Clinician and Hospital Workgroups' meeting, we are going to ask the Coordinating Committee to review this decision at their January meeting.

Next slide.

So, we did start to discuss this issue during the November 30th meeting of the Coordinating Committee. They reiterated their intent was to support a concept of a measure, but recognized there may be a potentially significant issue that should be addressed before implementation. Ultimately, they suggested for this year using this category judiciously, recommended that you use this decision when a measure may need a substantive change.

The Committee also reiterated if Workgroups could please clarify any suggested refinements. This is feedback we've heard from the measure stewards and developers that it's challenging to make your changes when it's not clear what they are.

I also just wanted to talk a little bit about how the Clinician Group used this yesterday. They actually really saw the conditional support as a way to address some of the potential fuzziness with this category, and they identified a few measures that they would tweaked before they're implemented. So, they named some very specific conditions, provided that guidance to CMS, also to the NQF standing committees when a measure was not endorsed on specific areas where they wanted the standing committee to weigh-in and perhaps evaluate the evidence or some of the underlying scientific merits of the measure.

NQF does capture all of MAP's feedback on unendorsed measures and bring that to the

standing committee when they come in for their endorsement reviews. So, we do try to be the conduit of information and make sure that the standing committee knows any concerns the MAP committees may have raised with a measure and give them that guidance on where you all would like them to look and some areas of focus.

You also do have the option of doing this refine and resubmit, but I did just want to caveat that there is no requirement for the measure to come back before you on the MUC list. So, that is a distinction we do want to note to you all.

So, I think, with that, I did just want to ask Pierre if you wanted to share anything about how CMS operationalizes this or any thoughts.

DR. YONG: Yes, thank you, Erin.

And I think we certainly value all the input. And a lot of what the value is, is captured not just on the actual recommendation, like whether it's support, conditional support,

refine and resubmit, or do not support, but a lot of the sort of contextual comments that you provide as part of that discussion to arrive at that decision, which is captured in the reports that NQF puts forward from the MAP.

And so, we all are here for a particular reason all day, right? This is really to listen intently about the comments and thoughts that you have about the particular measures.

I did want to also echo Erin's comments that I think what worked really well at the Hospital, at the Clinician Workgroup -- excuse me -- yesterday was this sort of tweak about how they use the refine and resubmit. They did use it very sparingly, and they saw a way to use the conditional support to really incorporate some of the sort of concerns or issues that they raise as a way to sort of minimize the use of refine and resubmit in their voting process.

MS. O'ROURKE: And we did open this for conversation yesterday for input on this

category. In the interest of time, and that we're rapidly falling farther behind schedule, if you have feedback, or for those of you that have served on years past, please email me or give me a call offline and I'd be happy to hear it. We are collecting input from the Workgroups to bring this to the Coordinating Committee in January. I don't want to stand between you and your flights home, and we do still have some work to do. But, please, reach out if you have concerns or any feedback you want to share.

And I think, with that, I am actually back on to just walk you through the voting process.

Miranda, if you could skip forward a bit?

I'm going to try to go through these quickly, so we can get to the main event, if you will.

Just a few key voting principles to remind everyone. You've defined consensus as a 60-percent threshold. So, we need greater than

60 percent of participants.

Every measure under consideration will receive a decision, either individually or as part of a slate of measures. We do ask that the Workgroup comes to a decision on every measure under consideration. In the past, we had what we called split decisions where we couldn't get to consensus at the Workgroup level and the decision was left to the Coordinating Committee. They pushed back that they don't have the depth of expertise in the subject matter area that the Workgroups have. So, they asked that you push forward and try to send them a decision on every measure.

Next slide.

So, we will provide an overview of the process to establish consensus through voting. We'll go over some introductory presentations on the program and how it works. We do have a discussion guide for you all. It's the electronic file. You'll see the preliminary analysis as well as the early public comments

received. We also have a brief, little snippet explaining the program for your reference.

We've put every measure under consideration, our one that was a lift this year, through this preliminary analysis, based on the algorithm approved by the Coordinating Committee. And that serves as how we got to this initial decision about support, do not support, so on and so forth.

Next slide.

So, the first step, we'll present you a consent calendar. You'll have a group of one this year. So, a bit of a formality. We can move on.

Our next slide.

The process still is a consent calendar. Right now, the measure received a decision of support.

Jim, I believe you sent some early comments. I don't know if you wanted that to act as a formal poll. But, if anyone wants to have conversation on this measure, we ask that you

pull it off the consent calendar and open the floor for discussion. You could potentially disagree with our preliminary analysis or have some new information. You might also want to ask some clarifying questions of either CMS or the measure developer.

So, once we know which measures we want to pull off the consent calendar, the Co-Chairs will ask if there's any objection to accepting the preliminary analysis and recommendation of anything that remains on the consent calendar. If you do not remove the measure from the consent calendar, the associated recommendation will be accepted without a discussion.

Next slide.

So, if a measure is pulled, we open for discussion. There's a lot of words on this slide to go through the process. We don't perhaps need to be quite as formal, since you only have one measure and we didn't assign anyone to serve as our lead discussant, because we

really wanted everyone to feel free to jump in. So, if you would like to make a motion, we will open for discussion.

Next slide.

After that, I will tally the votes. We're looking for greater than 60 percent of a vote to get to consensus. Just to clarify, we are doing hand voting, right? We're having a little technical difficulty with the clickers that we've used in the past. So, the Chairs will ask you to just raise your hands. Folks on the phone, please just speak up with your vote.

We do discourage abstentions. But, if you do abstain, you will not be counted in the denominator.

Next slide.

We will open for public comment before we start committee discussion. We've also incorporated input that the public provided prior to your meeting into your discussion guide for your review. We'll also have a global public comment at the end of the day, as well as a

public comment period on the Workgroup recommendations prior to the recommendations being reviewed and finalized by the Coordinating Committee.

Next slide.

So, I'll go through this at the end, because I know we're short on time.

Next slide.

With that, why don't we jump into it? Our one measure under consideration is for the Skilled Nursing Facility Quality Reporting Program.

Dr. Gifford, if you wouldn't mind coming to the table as well?

MEMBER LEVITT: And the measure developers step forward.

MS. O'ROURKE: Sorry, while we're all getting to the table, John just let me know we have another new member who has joined us on the phone.

Amy, could you introduce yourself and let us know if you have any disclosures of

interest?

MEMBER GOTWALS: Hi. Amy Gotwals, standing in for Sandy Markwood, with the National Association of Area Agencies on Aging.

And, no, I have no conflicts to disclose.

MS. O'ROURKE: Excellent.

So, just a quick overview of the program. We did go through this in November. This is the SNF Quality Reporting Program. It involves a penalty for failure to report.

Facilities that submit data under the SNF PPS are required to participate in this program, excluding units that are affiliated with critical access hospitals.

Data sources include Medicare fee-for-service claims as well as the minimum dataset assessment data.

Next slide.

This is another slide from the fall meeting just highlighting what's currently in the program. You have this information in your

meeting materials in case you want to reference.

Next slide.

Again, here it shows some of the high-priority domains that CMS has put forward in previous years and how they've addressed it. In particular, highlighting the need for measures of functional status, they added some measures through the rulemaking process this year to address that domain.

Making care safer, in particular, a measure modifying the current pressure ulcer measure. Again, another change that was implemented through this year's rulemaking.

And then, an outstanding potential high-priority need of measures assessing timely transfer of information.

Next slide.

Some previous gaps that the Workgroup has identified include experience of care, the efficacy of transfers as well as transfer of information between clinicians.

Next slide.

With that, why don't we open for public comment on the SNF QPR and the measure under consideration?

OPERATOR: Okay. If you would like to make specific comments, please press *, then the number 1.

(Pause.)

And there are no public comments at this time.

MS. O'ROURKE: And it looks like no one in the room.

So, with that, we can move on to our consent calendar. So, we have one measure under consideration for this SNF QRP. It's MUC17-258, the CoreQ short-stay discharge measure.

If you see your discussion guide, the current preliminary analysis decision is a support for rulemaking.

So, we can open it up for the committee if you want to pull the measure for discussion or pass on the consent calendar.

CO-CHAIR MULHAUSEN: Jim, did you want

to make a motion?

MEMBER LETT: Yes. I'd like to pull it. Just have a few process questions.

CO-CHAIR MULHAUSEN: All right. So, we're going to review MUC17-258, CoreQ, short-stay discharge measure. And we're open for discussion and questions.

Jim, go ahead.

MEMBER LETT: Oh, thank you. Thanks for being here, Giff.

I wasn't clear as to who bore the resource responsibility for sending out the survey, collecting it, collating it, distributing, who gets the results, who guarantees the quality of the data, and who's the repository and safekeeper of it.

DR. GIFFORD: Well, I can tell you how it is currently being used in the general public domain and everything. I cannot answer how this would be proposed in rulemaking because I don't work at CMS.

(Laughter.)

And I don't know if they can comment on how it's going to be in rulemaking because, if it's in the midst of rulemaking, they can't comment. If it's not, I mean, my understanding of the MUC list is that these would be available for future recommendations.

I can tell you how we would recommend they use it and help that through, but, generally, you're approving -- because I'm on the MAP -- as Erin has pointed out, you're approving or recommending to the MAP whether measures should be considered for future rulemaking. It's hard to make that recommendation when you don't know they would.

Taking off my measure development hat for a moment, I will say, representing AHCA, we have recommended and would like to see this incorporated into public reporting, and that we would support them putting it in rulemaking to make it a SNF QRP measure for either inclusion under Compare or in Five Star. How those details would be done would clearly need to be done.

There's, clearly, a lot of questions that need to be rolled out and answered on that. I will say that -- now putting my measure developer hat on -- when we designed CoreQ, we tried to learn and use the way CAHPS is used in different provider settings. And so, we designed it to be incorporated for existing vendors to deliver it. So, in all the other settings, private vendors, providers contract with private vendors, and they administer the CAHPS Survey following standard protocol.

We, in developing the measures and our submission to NQF, we try to be very explicit in that. We also wanted to start using it before that, just for quality improvement purposes. And so, we brought all the major satisfaction vendors together and agreed on a bunch of standards about how to collect the data and everything else, so that it would be consistent. So, pretty much all the major vendors have now incorporated it into their existing instruments. And at no additional charge, it just added questions to existing

instruments they're administering out there.

If providers out there don't have a contract with an existing vendor and want to use it, some of the different vendors will administer it separately. Or we also contracted with -- or we didn't contract -- we arranged with Nick Castle, who helped develop it and was one of the CAHPS developers at the University of Pittsburgh, he will now administer that survey to collect the data.

So, I can talk about the data administrator. How it would be transmitted to CMS, used in public reporting, I would assume it would be very similar to the way they do the CAHPS in the other settings.

As far as a burden onto the providers, it would only be an added burden, an added cost, if you currently don't collect satisfaction. If you currently do, there's really no added cost to that, unless you collect it and administer it yourself.

What we have found, that those are

highly homegrown instruments. How they're administered, how they calculate stuff is just all over the map. So, what we try to do is bring consistency to the table on that.

We also designed this to be added into existing survey instruments because many providers out there have historical data and did not want to switch vendors or have to switch to anything out there.

And so, we also took some lessons and challenges from the way CAHPS was rolled out in all the other settings to accommodate that as well.

And Lindsay Graham is the phone. I don't know the number. And Nick Castle is, too, to help answer.

Lindsay, how many vendors now do we have? And actually, since it's on the MUC list, a few vendors we didn't even know exist out there have now called us to add it in because they've gotten attention to it.

The vendors, we have regular calls

with them. They're very appreciative of trying to do this in a standardized way and it doesn't sort of disrupt their workflow, either.

Lindsay, how many vendors do we have it on now? Do you know?

MS. GRAHAM: Sure. Giff, can you hear me?

DR. GIFFORD: Yes.

MS. GRAHAM: Okay, great.

We have 15 vendors, and that continues to grow.

DR. GIFFORD: Yes. Does that answer it, Jim?

Thanks.

CO-CHAIR LAMB: Alan, did you want to add, too?

MEMBER LEVITT: Well, yes. Well, first of all, were there any measure-specific questions before we kind of get into the operationalization of the measure? Was there anything specific?

CO-CHAIR LAMB: We have a couple of

others up. So, why don't we go through them?

MEMBER LEVITT: Yes, if you want to do --

CO-CHAIR LAMB: And then, we'll do that first.

MEMBER LEVITT: Maybe we could do those, yes. Then, we can kind of talk about them. Okay.

DR. GIFFORD: Yes, that's fine.

CO-CHAIR LAMB: Okay.

MS. SCHLAIFER: As Erin mentioned earlier this morning, I co-chair the MAP Medicaid Adult Core Set Task Force. And in sitting in on the meeting, partly we listen to all the discussions that go on and all the measures discussed across the three Workgroups to help give us ideas to think about on the Medicaid side as we develop the Medicaid adult core and child core sets.

This is one measure that we identified that we think would be useful on the Medicaid side. And I realize that's not the reason for

the meeting today. But I think, from a MAP Coordinating Committee point of view, which I also sit on, always looking for the potential for harmonization across the various CMS programs. That's one thing CMS has asked the Medicaid Workgroup Chairs, to look at all measures and identify some that would be especially helpful in harmonizing across the Medicare and Medicaid programs, and this is one of the measures that we have identified as doing so.

So, I just want to, even though I'm a non-voting, not a voting member of this group, just put a plug in for it that reason.

CO-CHAIR LAMB: Thanks for sharing that.

Sean, is your card up?

DR. GIFFORD: Could I just comment on that?

We actually have an NQF-endorsed CoreQ for long-stay Medicaid beneficiaries as well as family members. And we're in the process of submitting one for assisted living for residents

and family. And the items and everything are consistent across there. That's why we call it CoreQ.

MEMBER MULDOON: Could you remind me about the timing as it relates to the 100-day window and when that starts, and what, if any, internal biases you've discovered or anticipate related to whether the survey is answered promptly or at the last minute?

DR. GIFFORD: So, I assume, by the 100-day window, you mean we define -- since this is for short stay and the SNF QRP is for short-stay individuals, this would be individuals who are admitted and, then, discharged within 100 days. So, if they're not discharged within 100 days, we consider them long stay.

MEMBER MULDOON: Okay. That's what -- that's right.

DR. GIFFORD: That's what that 100 days is for.

CO-CHAIR LAMB: Sean, did you get what you needed?

MEMBER MULDOON: Yes.

CO-CHAIR LAMB: Okay. Kurt, is your card up?

Oh, it's Robyn. Robyn, can you put your microphone on?

MEMBER GRANT: I apologize for that.

So, I just want to start with a broad comment, which is, while I do not doubt the quality of AHCA's work, I guess I find it a bit -- I question the appropriateness of having an association that represents SNF providers actually be the developer of a SNF measure. So, I just kind of want to go on the record saying that. That troubles me.

But, in terms of my specific comments related to the measure, I think that in just a very general way, the name of the measure I found to be kind of misleading. I'm thinking, as a consumer, when I hear "short-stay discharge," my thought was, oh, this is a discharge measure. And then, I go and, you know, I looked at it, and most of the questions were about patient

experience and satisfaction during the stay. So, I guess I would recommend, if it's possible, to change something, so that it's more reflective about what it is actually discussing.

Second, I think that measuring the patient experience is really, really important. I think throwing the discharge measure question in kind of muddles it a bit. And it strikes me that discharge is so important, has been identified as a priority, that it really deserves its own measure in terms of patient experience because there's so much that goes into a good discharge experience for a resident. So, I was struggling with some of that.

The question about were your discharge needs met, I think as a consumer it's sort of hard to answer that because I don't think most consumers really have an idea of all that's entailed in a good discharge. I mean, all they really can judge is their own experience. I mean, we all know there's so much. Was the individual involved? Were they given choices?

Were they given information? Was their input listened to? And I don't think that a lot of folks realize that those elements contribute to a good discharge experience. So that I was wondering about that question.

And then, just lastly, I'm a little bit concerned about the exclusions as they relate to people with dementia. I'm just worried that their experiences will be underrepresented if we're excluding individuals with dementia with a certain EM score. And then, only allowing legal guardians to complete the form, that leaves out a lot of family members who are actually representing the interest of their loved ones, but who would not be permitted to complete the form.

So, I just wanted to raise those concerns.

DR. GIFFORD: So, with regard to the questions, Nick Castle helped develop these. In a couple of different places, we brought together both family members and residents of long-term

care, short-stay facilities as well as assisted living; did a number of different focus group meetings to identify what were the issues and concerns, rank those. And then, we did a number of rounds of cognitive testing, really worked to get the reading level down to a sixth grade reading level for that, and based on the items on those feedbacks.

So, we had different wording and different suggestions because we thought we knew better. And so, we really based it off of the focus groups with them out there.

With regard to the exclusions, we approached the exclusions with sort of three principles in mind. One, just pragmatic. So, if you're looking at a discharge and someone gets discharged to the hospital and is in the hospital, how do you mail a survey to a hospital? And most of those come back. Unfortunately, some don't. And that's a different group. So, there is just a pragmatic issue of how do you administer to certain people.

We really relied on the literature and satisfaction in all settings that clearly demonstrated that having a proxy fill out the information is not accurate to reflect there. It's a good measure; it just is a different measure.

So, that's why we have a family version of sort of all of these. You're seeing just the resident version here. In that sense, we thought a legal guardian, a court-appointed legal guardian shouldn't fill it out. If there's a DPA, durable power of attorney, or a living will, someone making decisions for them, they can assist filling it out, but they can't fill it out as a proxy.

So, we actually ask a question. One of the questions that we ask is, did you have someone help fill it out or not? And if they helped you, like they're blind or they don't understand, or anything, that's fine, we accept it. But, if they filled it on behalf of the person, we exclude the data because we don't

believe it's reflective of the person's experience and what they are out there. So, that was sort of the rationale we had behind these.

On the rest of the exclusions, we also were trying to be consistent with sort of industry standards. As we've said, we pulled all the people together. We didn't want to propose something that, all of a sudden, all of the vendors across the country had to change everything they were doing.

The other was we looked at what were the exclusions that were used in the CAHPS survey and other settings to try to be consistent where we could in that. I know a number of questions have come up and a lot of them are there.

And it was actually a very interesting experience to look at what all the exclusions were in all the different CAHPS, because they vary from some that say, do whatever you want, to very explicit out there as well.

The other thing we tried to be very explicit in our exclusions, which is not done in

a lot of the surveys, is a lot of surveys will says, we're going to sample women. Well, inherent in that is you exclude men. So, we had actually put down that we excluded men. Whereas, if you look at a lot of the surveys, they just say what they're sampling and they don't say -- they say they have no exclusions. Well, you have exclusions if you're not doing a full sample. And so, again, we tried to be very explicit about that because we really wanted to make it really clear what was going on out there.

And then, the other issue, and the main one on the dementia one -- and we're very open to allowing it in there -- is we set a minimum response rate and a minimum number of respondents that you had to have the data in. Otherwise, the data we didn't think would be reflective. And the variability you would get from a small sample size would far exceed any variability you were seeing related to quality. That's why NQF sets usually -- and CMS follows -- a minimum standard of 20.

So, given the fact that a large number of nursing homes have less than 100 beds, and 20 of those -- you're only talking about 20, and 20 are short stay, and you're trying to do the turnover. If we included a lot of dementia, most of those don't respond or they usually have family members, and that's been the experience. A few would be capable of doing it, but by not excluding them, you drive down the response rate, and you suddenly make a lot of facilities not be able to have usable data, even though they have a minimum number of respondents and they've gotten all the data out there. These we wanted a more representative sample. So, that was the driving behind it.

That said, most of these exclusions don't affect the result, whether you include them or not. We are happy to modify or come back to them or talk to CMS about modifying them in some areas in the dementia.

And frankly, of all the exclusions, this one has actually been somewhat problematic

for some facilities. Even though they all have MDS data, they haven't been able to always calculate it for some. And so, some actually just include it and send it out to everyone, which we're fine with. It just drives their response rate down. And we do have a problem with some response rates in the small facilities.

MEMBER SCHMIDT: So, I'm glad you brought up exclusions because my concern is about exclusions.

DR. GIFFORD: Okay.

MEMBER SCHMIDT: So, in the denominator you say, regardless of payer source and discharged within 100 days. And then, for the exclusions you mentioned one of them is patients discharged on hospice. So, I just wanted to clarify if that is discharged from the SNF on hospice as opposed to discharged to the Medicare hospice benefit while remaining in the SNF.

DR. GIFFORD: Well, if they're not discharged -- technically, if they convert over

to hospice during the SNF, they would not be discharged from the facility.

MEMBER SCHMIDT: From the SNF itself, yes.

DR. GIFFORD: So, they wouldn't get included in the sample. You only get included in the sample once you've been discharged.

MEMBER SCHMIDT: So, potentially, in the rare circumstance where a resident received hospice while in the SNF, but were discharged from hospice prior to going home and, then, went home with no hospice, they would be included in the SNF?

DR. GIFFORD: Correct.

MEMBER SCHMIDT: Great. Thank you.

DR. GIFFORD: And if they go to hospice from the facility, they would be excluded, and that's actually one of the things that's consistent right across the board for most of the CAHPS surveys.

MEMBER SCHMIDT: Yes, I think that the confusion was coming from the language.

DR. GIFFORD: Okay. Yes.

MEMBER SCHMIDT: Yes. Thank you.

CO-CHAIR LAMB: Kurt?

MEMBER MERKELZ: Yes, thank you. Just a general comment.

Even as we've been speaking here, and even in the preliminary analysis, it states that it gets to a core concept of patient experience. And we've been using experience and satisfaction interchangeably, and they're really different. They're really different concepts. Experience really has requirements that need to be met, as opposed to just perceptions that are being made by individual patients or family members. So, I would say really it doesn't really get to experience. It focuses on satisfaction.

I would also echo what Robyn stated regarding how well do you feel your discharge needs were met. I think it puts a lot of responsibility on the individual patients, family members who aren't aware of what discharge needs really need to be, what they should look like.

We should actually be focusing on potentially tailoring our care from the time of admission towards making sure they're meeting those discharge needs, getting medications reconciled, making sure that the patient has access to the medications, making sure that they're safe upon discharge, making sure they're functional, mobility needs are being met at the time of discharge. And I think setting up measures that are more geared toward the patient succeeding after discharge is certainly something I think CMS would benefit from looking at.

Finally, just a comment regarding the sicker patient and the facilities. Certainly, from my past experience in long-term care and post-acute care work, there is certainly a difference in types of facilities. And there are those facilities who tend to take the sicker patient. So, I think, just by default, that type of facility is likely going to be challenged more with their satisfaction return surveys, and it doesn't really get to the quality of the care

that was received in the facility, based on the perception that was received.

While I have a facility across the street that might be beautiful and they only do hips, that's all they're taking as part of their post-acute care. They have a beautiful facility with brand-new TV monitors. So, satisfaction scores are extremely high, but it really doesn't get anything to the quality of the care that they received while they were at the facility. While an older building that doesn't meet any of those nice bells and whistles can provide excellent care, but it may not be recognized in the satisfaction survey based on the nature of the patients.

DR. GIFFORD: We would completely agree that experience and satisfaction are conceptually different measures. Whether they actually end up achieving that, I think it depends on a lot of the wording and everything. And we would completely with the recommending to CMS that they explore developing experience

measures in the areas you talked about with transitions of care, because it's really important. That's not what this measure does, as you aptly point out.

CO-CHAIR LAMB: Paul?

CO-CHAIR MULHAUSEN: So, I was intrigued -- and maybe this gets at the operational part of it -- but the six months' sampling window and how that would, I guess, be operationalized. So, maybe it's an operational question. But the six-month sampling window strikes me as a challenge in programs that are doing ongoing measurement.

DR. GIFFORD: So, I will tell you it's always fun to do any project like this across the country and everything and what you discover. If nothing else, we brought some standardization to sampling and administering of surveys in the industry out there. And that is a technical question we get a fair amount with.

So, we picked the six-month window because we did a lot of modeling with the volume

of admissions and discharges from SNFs across the country. And we wanted to figure out, doing some sensitivity analysis based on different response rates, what would you need to get the minimum respondence of 20. Based on our piloting, we knew some range of that and how many surveys that would come back you would have to exclude because they were not filled out correctly.

And so, we looked at different numbers, and we picked six months, but you end up losing still a fair number of facilities with that. But we felt if you went beyond six months, you just had too large of a time window.

The other thing was we recommended that the survey be mailed out -- Lindsay, correct me if I'm wring -- it's within two weeks of discharge, right, Lindsay?

MS. GRAHAM: Correct.

DR. GIFFORD: Yes, and that was all over the map in the industry. Now you can do it faster, and we recommend you do a faster, but we set a minimum time window.

We also -- I think to some other comment -- we set a window as to when they had to have responses back by. If you didn't have responses back within, I think, three months, you were -- two months, yes -- we just said, no, it doesn't matter. Now some come back and they calculate it, and the vendors give the data. But we said, from a measure standpoint, it wouldn't be in there. So, that was sort of the whole thought process that went behind that six-month window.

We also are really diligent about emphasizing that it has to be in sequence of getting the responses back. Because we do allow you to stop, because there's about 15-20 percent of facilities that are doing huge numbers of post-acute care. And it just did not make sense to force them to survey all the way, because once you get past -- Nick, correct me if I'm wrong -- is it like 120 or 150, you don't need any more in your sample? It just doesn't gather, right?

DR. CASTLE: I think we said 125, yes.

DR. GIFFORD: Yes. And so, we make them do it in sequence. Very few meet that. And pretty much everyone is surveying all the time anyway, but we said you could stop it sooner. But we say you have to have it in sequence.

I'll tell you, the vendors have been really good because they've been sort of trained by CMS for CAHPS surveys in the hospitals. They are always calling us and they're telling providers they can't do certain things. And people were cherry-picking, and it was all over the map.

So, I think one reason we've tried to be so explicit, when you were asking these questions, is we anticipated this and we wanted to be really explicit, because we thought standardization was the most important aspect to get here. And that's why I say, if you think that we should drop an exclusion, we'll drop an exclusion, but we just wanted standardization.

MEMBER LETT: Oh, thank you.

I fully support this measure. It

fills an identified gap that we showed earlier. I like the questions because they are clear and they speak to not the need for expertise or clinical abilities on the part of the person who has experienced that care; just, what did you think? How did you feel?

And I would take respectful exception to -- I think it's great that a SNF provider is developing such a measure because it tells me that they want to learn how they can give a better experience in their facilities. So, for that, I applaud this move.

Just one exclusion question. A lot of times, particularly with post-acute patients, they're going to have multiple BIMS getting down with multiple MDSes getting done. And we all know that, with delirium or with sepsis, people can come in with the very low BIMS and, then, it rises. Do you have anything in the measure about which one do you choose of the BIMS results in order to take it?

DR. GIFFORD: No, we did not specify

that level. I would think that this issue about whether BIMS should be -- if CMS adopts this in a rule, and they probably won't even get this level in rule, but if in the specs they give out -- I mean, none of the rules specify any exclusions for any of the CAHPS surveys anyway.

But I think we would, as CMS develops this in a rule, and there's sub-regulatory rules out of it, I think this feedback they get from this group and others, and the public comments they would have if they put it in rulemaking, should be considered about that. Right now, we don't clarify it because this is actually the hardest thing of the data for any of them, to use to figure out how to do the exclusions.

And it really was just done -- this was one mainly for response rate. And the other was you get, if you include this, you get a lot of responses where the families fill it out. And so, that was the main reason we included the BIMS in there. I mean, there's other people out there that have other issues, and some vendors do

exclude and some don't. So, this is the one we're not a big stickler on because it just drives your response rate down.

CO-CHAIR LAMB: Along those lines, just to cover the public comments -- because you're probably aware there were seen or so public comments?

DR. GIFFORD: Yes.

CO-CHAIR LAMB: And I think we've covered most of them related to the clarity of that statement related to hospice, and that there seemed to be some confusion about how to interpret that.

On the BIMS, a question came up in terms of the cut-point. And what you were just saying, is that the answer to it? It is that the cut-point is more of a sampling issue rather than that the seven should be the cut-point?

DR. GIFFORD: No, what I was saying is whether you want to exclude dementia patients or not. The seven -- I forgot why we picked the seven. Don't you guys use seven for something

else somewhere else? Or maybe -- Nick, do you remember? Or, Lindsay? I can't remember why we picked seven. It's because it was used in other measures in other areas.

Deb, do you use seven in any of the QMs that you guys put together? I know BIMS 7 is a common cut-point for severe dementia. In the risk adjustment models, I can't remember why. We picked it because it's, "Oh, they use that." And if you want to pick six or five, I don't care; pick six or five.

(Laughter.)

Pick 5.5. I don't care.

CO-CHAIR LAMB: The last question I had from the public comments is part of the justification of moving, you know, recommending this measure, is the opportunity for improvement. Just interest is, have you seen any of the facilities that are using this, experimenting with it, that they actually are implementing it in their QI programs?

DR. GIFFORD: So, yes, and so, we've

made it our core of AHCA sort of quality initiative, which we're trying to get people to focus on it, to move it. Where we see it most being used is in post-acute care providers who are trying to partner with their hospitals in DDCI or ACOs, or other models, because the hospitals are recognizing that their satisfaction scores that are tied into the new payment systems for Medicare are linked to the satisfaction that gets completed. And SNF stays are clearly in that in individuals. So, we see a number of people asking for that and trying to focus on that satisfaction side of it.

I'm always sort of amazed by this, because sort of you say you want to do something, how many people start and say, "Okay, we'll go do it." A number of our state affiliates have now incorporated this into their training, about how to improve your satisfaction out there.

The vendors are realizing that this might lead to something going on the MUC list. And since it's been on the MUC list, we've been

getting a lot of calls about that improvement.

So, we are really optimistic that, with raising the vision, the visibility of this, you will see that. And then, as far as an opportunity goes in improvement, yes, actually, when we created this measure, we had a little trouble internally because the average scores went down from what many of them were seeing in their other measures, not by a lot, but a little, just enough that we had just some internal membership management issues.

CO-CHAIR LAMB: Gene? And then, if there aren't any more, then we're going to come back to Alan.

MEMBER NUCCIO: A quick question along the same lines in terms of how they measure and information will be used. The reporting to the nursing homes is done how? And would you believe that this measure is worthy of inclusion on a value-based purchasing as it is in home health?

DR. GIFFORD: Well, we recommend that the measure itself be reported, not the response

on the individual questions, because, then, you're making individual questions measures. And individual questions are not as good reliability and validity of the measure. That said, we think individual questions might help you in quality improvement. But, actually, if you're really trying for quality improvement, you need a lot more questions. And so, that's why we recommended it to be added into -- let vendors use it in their existing questionnaires, so they can explore and get a lot more additional information.

As far as whether I would recommend it, put it in a value-based purchasing, if you look at the sequence of public reporting, public reporting with rating, Five Star, and then, tie into payment, I don't think it's ready for payment because it just hasn't been used wide enough to understand it all yet. I think it's ready to begin to be ruled out for public reporting purposes. Whether there's enough data to support it being used in a Five Star, I don't

know. We're recommending that they use it in Five Star. But, if you ask me the data on it, I don't know, but I think moving that direction, it's helpful because it gets adoption and people using it.

But, for payment, I think in the future it should be used for payment once you get more experience. And I'm optimistic it would be good enough. I mean, if you use the metric of what's being used in other settings for payment, this is just as good. So, then, it should be used, but it just hasn't had that experience yet.

MEMBER NUCCIO: And your comparator group, is it national values, if you were doing public reporting? Or is it just simply this agency has a score of "X" and a rate of "X"? The other one has "Y"?

DR. GIFFORD: Oh, yes, that --

MEMBER NUCCIO: What does that mean?

DR. GIFFORD: That's a really good question. We're actually looking at that now, and I don't have an answer. I mean, we have

several thousand to answer the sort of question, but whether you get the whole nation on there -- I would assume that CMS most likely, if they're going to do it in a Five Star rating system, would use a similar methodology for determining cut-points and values, which has essentially been quintiles. I personally don't like quintiles. I would recommend something else.

And I think this is a measure that would lend itself, as we gain more experience, where you actually could established predetermined cut-points ahead of time for that. What those exactly would be I couldn't tell you today, but I would not do it on a forced distribution.

I shared Deb's view of forced distributions in rating systems. Deb's probably going to comment right now on how, give a recommendation to CMS on how to do this.

CO-CHAIR LAMB: Do you want to comment on that?

DR. GIFFORD: But I think we're

putting the cart before the horse because CMS hasn't decided how they're going to do this yet.

MEMBER SALIBA: I'm not specifically commenting on that, Gerri and Giff, as much as I'm -- and I've raised this concern before about the measure. It's about the distribution of the measure which is related to this idea of a forced distribution. And the distribution that's reported in the metrics for this measure is that the median score is 82.5, which is, you know, it says that that's a gap between 82.5 and 100, but it's not a very big gap really, and that that's the median. The 75th percentile performance is at 88.6, which tells me -- and it says here, "Performance is largely clustered around the median." So, there's not a big distribution on this measure.

And it sounded, Giff, by your last comments, or the comments before the last comments, anyway recent comments, that you're suggesting it needs further testing before -- so, I'm not really sure what we're being asked to do

today in terms of the -- I'm getting a nod from Paul.

Paul, do you want to help me here?

DR. GIFFORD: No, it doesn't need further testing. I'm saying if you're going to use it in a value-based purchasing program, I couldn't tell you what the cut-points I would do at the moment are. I mean, if you ask me recommendations, we have enough data now we could make a recommendation, but I don't know how CMS is going to propose to use it.

We have set as a target for our members that they should be over 90 percent. And I think as we gain more experience, we may actually raise that higher.

And for the very reason you just talked about, I would not use a quintile-type distribution in any sort of scoring system out there. I'm just relaying what -- I'm guessing the way CMS and other stuff might use that process. And you're asking me how they're going to use something that I don't know how they're

going to use. I could tell you how I would recommend using it, but that's not what I think is before the committee.

I mean, you have an NQF-endorsed measure. Its distribution looks similar to CAHPS in other settings and everything else that are being used everywhere else. Now we may not like how they're being used everywhere else, but at least we're trying to follow that process on there.

CO-CHAIR LAMB: Yes?

CO-CHAIR MULHAUSEN: So, I, too, was impressed by how high the median was and the narrowness of the distribution. As I understand, what we really have on the table at this point is a motion to support for rulemaking. And yet, part of the conversation I'm hearing is we don't think it's quite ready for this. We don't think it's quite ready for this.

And the kinds of things that we're talking about are, in my mind, the kinds of things that I could see CMS actually using it.

So, then, I think to myself, well, if we don't really know how the reporting programs would use this particular measure, and it needs additional clarity in terms of its application, is there a reasonable argument against the motion to support for rulemaking and, rather, move it into a motion to support for conditional? So, it would be conditional based on, well, if you want to use this, could you bring it back and tell us how it's going to be used, or something like that?

MEMBER SALIBA: To follow up for one second, I mean, I want to applaud you all for all the work that you've done on this measure. It's great work, and I'm really supportive of the idea of getting consumer voice in terms of the quality of their experience into this instrument. It sounds to me like it would be really useful for a large organization such as CMS to adopt, you know, to embrace this for further testing and trying to understand its performance outside of your volunteer group possibly.

But I think the work you've done so

far has really moved this very far forward and has been really well-done. So, I'm not trying to be negative about the measure as much as I'm not sure that it's ready for this endorsement step.

DR. GIFFORD: So, I'll just take off my developer AHCA hat and put on my MAP hat. And, Paul, I think this is a question we struggle with at the MAP all the time, which is a number of measures come -- particularly when measures aren't even NQF-endorsed. So, often, measures are coming through this committee and up to us in the MAP Coordinating Committee that haven't even been endorsed, and they're asking us to endorse them for future rulemaking. And I think at least what CMS and Kate has relayed to the MAP is that they would at least bring back recommendations on that.

The reason I'm a little on the fence is I don't know how CMS is going to use it. I mean, I know how I would recommend they use, but they've sometimes used measures the way the MAP and the NQF haven't recommended stuff. And I

think if you set the standard that we have to wait until they issue a rule to know how the measure is going to be used -- the only time we ever have some sense about how the measure is going to be used is when it's being proposed under some sort of statutory guidance.

But, even then, once the MAP has put recommendations forth to the Secretary, he or she can use it in any way they want. I mean, that's just the risk that we have to take with that, and we have to decide whether we take CMS on faith value. And I've been very vocal at the MAP level on this very point of not always taking them on face value. I think Kate has recommended that they would bring stuff back for that.

So, I think it's a very reasonable recommendation. I think maybe I misportrayed it. This measure is as good as any other measure that's out there used for public reporting in other settings, and being used for payment and everything else.

How you use it, the devil's in the

details, and we will not know that until CMS makes the recommendation. And there is a public comment period of that.

I do think that this measure, stepping back, looking at this -- now I'm sort of wearing all hats at once -- looking back, meets the level that everywhere else is. I mean, then, this is a new standard that I would say is worthy of raising as a broad issue across the board and bringing up to the MAP that we should talk about as to what's the standard for recommending measures that we don't know what's going to be used in rulemaking. And that has caused a lot of angst at the MAP level, and I can appreciate it causing here.

And maybe I misportrayed it, but we're actively asking CMS right now to add this into Nursing Home Compare. And so, we, the provider community feels it's ready for that level. I mean, not all of our members do, but most of them do.

CO-CHAIR LAMB: Thank you for that

input.

Alan, would you like to --

MEMBER LEVITT: Yes, yes. Thank you.

First of all, sitting next to me, for those who don't know, is Mary Pratt. Mary, as you know, has been a leader in quality at CMS and for many years, as many years as I've been involved in post-acute care.

But, anyhow, Mary has also taken the hat now of being the Program Coordinator for the SNF QRP to help lead this program. So, thank you.

I also wanted to thank Dr. Gifford and AHCA for bringing this measure forward for us. I'll talk about the measure just in a second.

But, first, let's step back for a second, take a deep breath here. The SNF DDP is a statutorily-mandated program. It's one measure, readmission measure. Certainly, we could discuss other potential measures, but the discussion will probably have to be with Congress first, if we were going to be changing that.

Regarding Five Star, the public reporting that is done in the SNF Quality Reporting Program, a plan you've done of the measures in the program, the Five Star program is different. It's not part of this. And so, in the future could possibly things be incorporated? Maybe.

But, again, what we have done here is what we have done before. We have brought measures that were not developed by CMS to the MAP to be submitted for the endorsement for a particular Quality Reporting Program. That's been done before in the other programs.

And this is an NQF-endorsed measure. It's been endorsed with all the specifications that we've been discussing here. Certainly of interest to CMS in terms of this discussion, or coming out of this discussion, if the MAP Workgroup came with recommendations of changing specifications to the measure, for example, exclusions, and CMS in the future was going to propose such a measure, I would assume we would,

then, be proposing an application of the NQF-endorsed measure. So, it does start getting a little bit more complicated here.

But I do think we need to understand that this is an endorsed measure that's being used right now by a stakeholder and is being used voluntarily by a stakeholder. It's not mandatorily required, which would be what would be happening in the SNF Quality Reporting Program, which kind of in the end is what we're very interested in, because this is an NQF-endorsed measure already.

And we really do appreciate it. You know, this is a "we" here. Remember, public/private partnership. We appreciate measures that are being used successfully in the post-acute care community to be brought towards us. And when we feel that these measures should come as a measure under consideration, we want to bring them here. I mean, that's part of our mission here.

Giff led off with the devil in the

details, and the devil is in the details, obviously. I can tell you, if you're interested about how things are done in the CAHPS program, for example, if you're interested. But, again, similarly in the CAHPS program, there are vendors, those CMS-approved vendors, and the data is stored internally really within CMS. There certainly is going to be burden for those SNFs that are currently not using a vendor for the measure because it will become mandatory.

Estimates vary. I mean, I asked estimates last year and tried to confirm again, because when we brought the hospice CAHPS measure, I was trying to get an idea as to what the burden was. And the estimate was about $3,000 to $4,000, but it depends on a lot of things, the mode of how the survey is done, the number of surveys that are done, things like that which would affect the cost.

There is other burden, too. I mean, obviously, there's burden still to the hospices to submit the names, not the hospices -- excuse

me -- the SNFs, the names to the vendor.

I love working with the CAS people because, even in the rule this year, the hospice, if you noticed, they actually looked at the burden to the people who are filling out the survey. So, they actually put a burden assigned to that, a maximum amount of burden. So, there is burden that would be, then, mandatory burden unless the SNFs would accept the penalty or be non-compliant with doing this.

Depending on the decision of the MAP and recommendations from that, then we would take the next step to look at the details. And we talk about MIPS and how measures that we think should be working suddenly don't work. So, obviously, there are a lot of operational issues and consequences that come that we need to work out and work together to help to try to figure out whether or not we can fill this gap area, which it is a gap area, with an NQF-endorsed measure that is being used successfully in the community, whether or not that such measure

should be brought into our program for mandatory use.

Then, we would have to figure out those details as to how data that's being collected out there could be operationalized, so that it could work within our program, because that would be absolutely necessary. And that's something we would work with together.

I'm not sure if there are any other questions related to what I just said.

CO-CHAIR LAMB: Any further questions?

I think we've moved from the discussion of the measure attributes now into how it would actually appear in the MIPS program, how it would be administered from it.

MEMBER LEVITT: Yes, QRP. I'm sorry. Yes, the SNF QRP.

CO-CHAIR LAMB: Oh, excuse me, the QRP.

MEMBER LEVITT: The SNF QRP, yes. See, I've led you down the wrong path.

(Laughter.)

CO-CHAIR LAMB: Sorry. You did, Alan.

MEMBER LEVITT: Yes.

CO-CHAIR LAMB: You did.

MEMBER LEVITT: Yes.

CO-CHAIR LAMB: All right. Does anybody have any other questions relevant to MUC17-258 for moving into a vote?

Theresa, did you have a comment?

MEMBER SCHMIDT: Just a quick comment about the operationalization. I think referring back to the hospice CAHPS was really good. And one thing that I like about that program is that they have, I believe, a telephonic requirement as well, and potentially some consideration for different languages. So, to be sure we are capturing patient experiences beyond just the people who can read at the sixth grade level in English.

MEMBER LEVITT: In fact, they assign different burden in the rule to the Spanish version versus the English version, yes.

MS. O'ROURKE: So, seeing no further

cards, our Chairs are asking me to move this into the voting.

I do, first, want to double-check that everyone -- does anyone have an objection to doing a hand vote? I know, historically, MAP has been anonymous voting. So, is everyone okay?

And the second, procedurally, Jim, you pulled the measure from the consent calendar. So, it's your prerogative to put forward a motion for a vote.

For support or conditional support? Okay.

MEMBER LETT: Right. So, just to make sure everybody knows what they're voting on, there's a motion on the table to support MUC17-258, CoreQ, short-stay discharge measure.

Did I get it right?

(Laughter.)

For rulemaking in the skilled nursing facility, Skilled Nursing Quality Reporting Program. So, you're voting to support.

MS. KUWAHARA: Great. So, today you

will have two options on voting. Your first option is yes, meaning you support this measure for rulemaking, and your second option is no, you do not support this measure for rulemaking.

So, I believe at last count we had 22 voting members, 20 in the room here and, then, 2 remotely. Those participating remotely, please submit your answers via the chat function on the bottom righthand corner of your screen.

So, we'll begin. We are voting to support MUC17-258. This is CoreQ, short-stay discharge measure.

Those in favor of voting for option No. 1, yes, please raise your hand.

(Show of hands.)

And those who vote for option No. 2, no, please raise your hand.

(Show of hands.)

Thank you.

And we're still waiting for our remote participants.

MEMBER GOTWALS: May we do that

verbally if we're having computer problems?

MS. KUWAHARA: Sure, go for it.

MEMBER GOTWALS: All right. This is Amy Gotwals, NAAAA. We'll vote in favor. So, option 1, yes.

MEMBER DEBARDELEBEN: This is Mary Ellen Debardeleben, and we'll vote in favor.

MS. KUWAHARA: So, we have 19 in favor of supporting this measure for rulemaking and 1 not in favor. So, it looks like we have 20 voting members. But we did achieve the 60 percent threshold. So, this measure will be supported for rulemaking.

CO-CHAIR LAMB: Thank you, everybody, and thanks for a robust conversation and lots of discussion about the issues.

So now, we will move forward. Thank you, Dr. Gifford, for coming, and thank you for the discussion.

MEMBER LEVITT: Yes, we really do appreciate it. Thank you very much for the discussion that we will be taking into

consideration now for our next steps.

MS. O'ROURKE: So, I think we had one outstanding item on the SNF QRP. We just wanted to touch back with you about gaps. I know we started this conversation in November.

So, just to refresh everyone on some of the themes of our previous conversation, overall, you recommended CMS continue to find ways to address gaps in patient, family, and resident engagement across the PAC/LTC programs, the results of needing more measures addressing the bidirectional transfer of information; in particular, assessing issues like, was the information actually received by the receiving site and did that site have any followup questions?

For the SNF program specifically, there were suggestions, a need for a measure, again, around the appropriate transfer of information, ensuring it's timely and in an accessible fashion; a measure of advanced directives, as well as starting to think about

the issue of getting to the correct medication, going beyond just medication reconciliation, but thinking about the appropriateness and do we have a list of what that patient is on, and is it the correct medication.

So, with that, I do want to open it up and see if these still resonate with the group, or any additional gaps to suggest?

CO-CHAIR LAMB: Heather?

MEMBER SMITH: I know we discussed this today already, but I just wanted to go on the record saying that I think those settings could benefit from a patient-reported outcome quality measure. And I won't bother saying that again, but I would say that for all the post-acute care settings today.

CO-CHAIR LAMB: Heather, if you feel that across, you just keep saying it.

So, patient experience, other gaps in there? I think earlier we had -- and I don't know if these are specific to skilled nursing facilities. So, let me throw them out.

We had a couple of gaps that we talked about earlier in the startup discussions related to -- hang on here -- emotional health, mental health service, and access to care, as well as I think, Jim, you were talking about the med rec needed to be relooked at. So, do those go for SNF as well? Because these were the gaps we identified last year: patient experience, transfers to SNF, and then, transfer of info. Do you want to add those to the gap areas?

These were the gaps that we identified last time we got together. What we are asking now is, are there additional gaps that you would like added to the list for future consideration? That's part of the discussion we've had this morning, is we are having this conversation in the context of a lot of change going on related to Meaningful Measures, MIPS, as well as PROMIS. So, there is renewed opportunity to look at gaps and to put them forward.

These are the ones from last year. Do we want to add anything? And that's going to be

the same question as we go through hospice and the other settings. So, this is sort of the leadoff for here is your chance to rethink, do we have the right gaps? Are these the priorities? Where do we want to be going, especially as we have the opportunity to put input into the playout of IMPACT, MIPS, and everything else we've talked about this morning? Clear? This is a chance to put new gaps on the table or to reaffirm that the gaps that we said last year are really the important ones and those are the priority areas for the future.

Kurt? I'm sorry. Raj, go ahead.

MEMBER MAHAJAN: So, there's transfer of information between clinicians and, then, there's efficacy of transfer from acute care to SNFs. But it does not officially talk about information transfer between facilities. So, I don't want to assume that it exists in between one -- two and three. So, I would like to have that as -- because that's where all the data blocking talk comes. And so, it's information

coming to the nursing home from the hospitals.

And then, based on the conversations we had today, aligning physician and facilities and their measures and their workflows as one of the areas of work.

CO-CHAIR LAMB: Raj, could you clarify that last one?

MEMBER MAHAJAN: Aligning physicians or practitioners and the facilities and their workflows and their measures. I'm not sure how to phrase that, but go ahead please help me, yes. I said aligning physician and facility workflows and quality measures.

CO-CHAIR LAMB: Okay, Kurt?

MEMBER HOPPE: A question about efficacy of transfers. What does that mean? What do you mean by that? I didn't have the benefit of hearing that discussion last fall because I wasn't here. So, I'm not sure what exactly, what dimensions you're looking at.

CO-CHAIR LAMB: Jean-Luc, can you help us?

MR. TILLY: Sure. So, certainly, comparing to that would be the transfer of information, but I think there is also a kind of quality of whether those transfers were burdensome from our patient experience kind of perspective. But I think now would be a great time to elaborate that, you know, get an idea of how we should characterize that.

MEMBER HOPPE: I think there's a lot to unload there, and I would suggest that that may be a discussion for another time, if that's not available right now for your time constraints.

I was thinking more of appropriateness. I was thinking of the transfer did actually occur. Was there an intervening event? I'm not sure what to make of that. Certainly, transfer of information is important.

CO-CHAIR LAMB: So, Kurt, just to clarify, you are confirming keep transfer of information up there as a priority, but you would like to see a deeper dive into the nature of the

transfers? And you've mentioned appropriateness of the transfer. Any other attributes of the transfer that you would like to at least throw out for consideration?

MEMBER HOPPE: I think Jean-Luc spoke about the patient experience of the transfer, if it's burdensome not only to providers, but to patients, and I would add families as well. Whether it was an appropriate transfer, whether there were aspects of the transfer of information that were not appropriately managed.

CO-CHAIR LAMB: Okay. Okay. I have no idea who was next. So, help me out here.

Jim, do you want to go?

MEMBER LETT: Thank you.

I'm kind of with Kurt here in terms of we might need to unbundle some of these rather generic statements. I mean, the transfer of information between clinicians, someone mentioned it's not just between clinicians; it also includes facilities and families.

Also, about unbundling the transfer of

information, I would love to call out -- I don't know how granular you want to get -- a couple of really significant things. One is the presence of dementia, because AMDA just put out a white paper on dementia and care transitions, and it is a massive impact.

The second is specific advance directives.

CO-CHAIR LAMB: Advance directives. Say a little bit more. What about advance directives?

MEMBER LETT: Simply we've gotten in the habit of writing down "DNR," do not resuscitate, which has essentially no meaning in terms of in-of-life care. So, discussions as to what interventions you want. Do you want to transfer back to the hospital? Do you want to ever be on antibiotics? Do you want artificial nutrition and hydration? Those types of really important issues that, No. 1, follow patient preferences, which is patient-centered care, and, No. 2, not incidentally, reduce transitions and

improve the quality of care in folks at the end of life.

CO-CHAIR LAMB: Okay. Thank you.

Kurt?

MEMBER MERKELZ: I just wanted to get clarification regarding what was commented regarding Raj stating expanding to make sure we're capturing the alignment between what the clinician is doing and the care plan. What was captured as the gap that needs to be identified? Because I think I get a sense of what Raj is asking for. I am just wondering if that was what the committee has picked up, and is that what's been recognized as a gap? That there is considerable disconnect between what's being performed by the clinician and the post-acute care, and the plan of care that's being document in the long-term care facility?

MEMBER LEVITT: Can I just make a comment? I mean, again, the gaps we're really trying to identify here are for this SNF QRP. There may also be operational gaps that are just

in general that are occurring, like we discussed before. I would assume that we're looking more for the program-specific. Yes? Okay.

MEMBER MAHAJAN: I think what I'm hearing is several people have commented on No. 2 as that is way too generic and broad, and if we could get a little granular on that. And so, I think everybody agrees with No. 3 and No. 1, and I have added aligning physician and the facility workflows, in QMs, as an additional. But I think everybody else wants to see if we can get a little more granular this year on No. 2, as what does No. 2 mean?

CO-CHAIR LAMB: Okay, Sean.

MEMBER MULDOON: So, my card keeps going up and down. So, I'm going to leave it up.

I'm very much in line with what Alan said. I want this list to be things that this committee needs to work on, not what operators need to work on. And smoothing out the transition of care is certainly one of those things that needs to be improved upon. But the

reason it's on the gap list is for five years we haven't been able to find a way to create a measure that captures some or all of all those things that create risk at the time of transition.

So, we've got to fix this, but I don't know, and I would like to have a discussion, if it's this committee's job to fix it by hanging measures on it that would promote that.

CO-CHAIR LAMB: Anybody want to respond, reflect on that? It's a great question, Sean.

CO-CHAIR MULHAUSEN: So, I want to reflect on it. I don't know how helpful my reflections are.

First of all, it strikes me as backward, as I look at that. So, if I'm holding myself as a post-acute care provider accountable to some measurement and standard, it would be more about what do I do as I'm transferring someone from me to you, although I admit there is an element of reception that probably has best

practices built around it.

And then, the other is, so this literally was a conversation I was having on Monday in a community in Iowa where we're trying to organize this community of healthcare providers to help them reduce readmission rates. And the fundamental root problem, as they see it, is a challenge with transfers. Now I'm not smart enough to answer my own question, which was, aren't there lots of best practices in transfers, in the process? I mean, there certainly are tons of models. There's the Project Red model. There's the Transitions-of-Care Model. There must be a series of best practices that could be developed into a measurement tool that can help SNF providers understand the best practice and apply it in the spirit of improving the effectiveness of their transfer process.

CO-CHAIR LAMB: I'd like to weigh-in from the care coordination standpoint because I think that the issue that Sean has raised is one that we have been grappling on for almost a

decade in that area, and don't see a lot of new measures in that. And so, we really do need to have the dialog about what are Meaningful Measures in care coordination and transitional care.

And I see this particularly since when Pierre did the Meaningful Measures, and coordination and communication is one of the priority areas. It's about time we take a look at what reflects a good transition, and from the patient's standpoint and the providers' standpoint. Because at the care coordination level, what we have is what Don Casey frequently referred to as the one-handed handshake. Did the information go across? Not what was done with it. Did the patient have a good transfer or not? And what does that mean?

So, I think your question resonates for me, Sean, which is we haven't had a good answer to that. But the stars are aligning. It's in Meaningful Measures. It's in the National Quality Strategy as one of the six

pillars of the national quality. It's in all the IOM reports.

So, MAP might be looking at that in terms of what is a Meaningful Measure. Certainly, the Care Coordination Standing Committee now has been merged with Patient Experience and Function. So, I guess I would like to see this committee, if I had my druthers -- and I'll have my other hat on that I co-chair, I'll own I co-chair Patient Experience and Function. It is to make a recommendation that this is a priority area and that we really do need to encourage focused work.

The other thing is we do have preferred practices going back 10 years in care coordination that we have not done anything with. And so, can we bring those forward in the current context and move the needle on this? And is it timely to do that? So, I would like to see this committee say, yes, it is timely. But that's up to all of you. So, I'll take off my other hat that I wear related to the committees.

MEMBER MULDOON: I would have no challenge to any of that. What we found when we have tried to do this in Louisville and Kentucky was that the sloppiest transfer was from the short-term hospital to the post-acute center. And much of that burden lies with the acute care hospital. And so, when it becomes a post-acute measure, our performance on that measure becomes highly dependent on a partner that has a different set of incentives around that.

So, it's easier for the post-acute measure to say, did you send them from you with a leading practice? That's a lower, more workable measure because it is more attributable to the provider in question.

MEMBER SMITH: Well, it kind of depends on how you look at, because, also, when you're looking at the continuity of services, you're looking at, if you're coming from acute to post-acute care, were the tests followed up on, were the results followed up on? So, there are process measures that can get at what would be

attributable to post-acute care, but I think it's very important to think about what does post-acute care have control over, not just what you're getting that's sloppy.

But, if there was a test done right the day before they left, you somehow have to get the results to figure out what you're going to do at the next level. And that's definitely a gap in care coordination.

And also, when you're thinking about transferring patients from different levels, also don't forget about the patient in that; what are their expectations? And how are those expectations addressed and changed? And I don't know the perfect measure for that, but that's a piece that I think is really important.

And then, on the transfer of information between clinicians, there's lots of way nowadays to be able to do electronic transfer, but what's the timeliness of that? And if you're getting it three hours after they're already there, and then, something happens in the

first three hours, you're in trouble. And so, a lot of your electronic records you can transfer electronically, but there's an issue on timeliness. And I think that that is an important piece on the care continuity and the care transitions to think about.

MEMBER HALL: Yes, I would just say the transition-of-care area is something we've been looking at for many years at ONC, particularly between acute and the various PAC settings. There's, obviously, various HHS policies around various requirements for different provider types. Obviously, for the meaningful use providers, what they have to send to other providers of care and, then, what is being, therefore, received by a SNF provider, for example. We hear very routinely that they are either getting too much information, there's gaps in information, and again, the timeliness of that information.

And then, you know, of course, there's also requirements on the long-term care side. We

have participation, obviously, in long-term care. And although it's not required to electronically share that information, the data is what -- you know, there's data requirements around what should be followed, of course, on a discharge or a transfer.

So, there are some existing policies around this. Yet, obviously, there continues to be this challenge.

At ONC we're also just looking, you know, starting to track the EHR adoption levels and interoperability across a number of these PAC settings. And so, one of the first data briefs that we've published this year was around the EHR adoption levels for SNF settings. So, we reported, are able to publish this year that SNFs nationally now are about 64 percent of national EHR adoption rate. So, this is an area where we are seeing increased levels of adoption.

So, looking at that electronic exchange will become of increased importance, and we will be looking at other settings in the PAC

settings to track their EHR adoption and interoperability levels as well. But we'll continue to work with providers around improving the way that information can be exchanged electronically. So, just that consideration.

CO-CHAIR LAMB: Thank you.

Connie?

MEMBER DAHLIN: So, just a couple of things to think about in terms of gaps. One is that I worry a little bit about CMS thinking about end-of-life care only because, when you think about palliative care and advance care planning, advance care planning really gives you the right goals of care; sets for many chronic diseases for these patients who are not going to be on hospice and not be on home health for a long time of not wanting aggressive measures. And so, it's more than an advance directive. It's more than a DNR/DNI. And so, I think this advance care planning for chronic diseases which happens so much in post-acute care and long-term care.

I will just address my second part to the comments of I recently experienced two close deaths of family members who were in their eighties, chronically ill. And although I'm an expert in hospice and palliative care, it was a disaster from start to finish. Every interaction that I had with a home health agency and a hospice agency (a) did not treat me well as a family member trying to coordinate this care; (b) wouldn't give me information, for instance, when a patient -- when one of the patients was discharged from a long-term care setting, I was told they couldn't give me recommendations for post-acute care organizations because it was a HIPAA violation and conflict. Now, for me, it was fine because I gained five more days in the city, a facility, because I spent getting 10 rejections day by day of who wouldn't take them.

So, I think that there is a lot in this patient and family experience that we really forget, that it's not just about the patient. And for these patients that have cognitive

impairment or have older adult spouses or partners, or don't, and then, you have other people stepping in, there's a huge gap in which this whole part of what does long-term care mean; what does post-acute care mean; what is really available? And somehow, we're going to have to measure when it's -- you mentioned going from the acute care facility to that. What is our planning that really happens to really set that in place? Is that done?

But, then, in terms of when that next transfer happens, that's also when it gets lost, when they're going home with a home care agency or a hospice agency or private duty. And so, I think that there's got to be something that we measure because that's very costly care, because the alternative is, then, they start all over again and go back to the hospital, and we wait for them to go through.

CO-CHAIR LAMB: Robyn?

MEMBER GRANT: So, I'm sort of changing topics here and just wondered about a

possible gap being infections. I'm just really stunned by the percentages I've seen, about 380,000 residents who are dying of infections in a year, and 1 to 3 million getting infections. I just wondered if that might be something we might think should be added.

MEMBER LETT: All you asked, are there not a set of principles of good transitions? And I would be remiss, as representative of the National Transitions of Care Coalition, if I didn't say that we've done that. We've looked at all the validated programs out there that reduce 30-day hospital readmissions, and we have found seven essential characteristics that all those plans have. I'll be happy to share with you.

The second thing, Gerri, it's time, I agree with you. It's time, Sean. It's time. The hard part is the doing it. And getting into the gap piece of it is you can't expect a SNF or a hospital to do well on transitions if they're not both responsible for it. I mean, you become a one-armed paperhanger if you're a SNF trying to

do a good job or a hospital trying to do a good job and your partner at the other end of the ambulance is Bagon.

So, I'm back to my old drumbeat about bidirectional measures, that I give them to you. You're responsible for reading the information, for God's sakes. Calling me and saying, "Hey, I got the information, but I've got a few questions that we need to clarify." So, bidirectional measures.

And there is a program, there is a standard for that CMS has put together. And I sit on their TEP for this, infections in transitions of care. And they are now jointly surveying both the hospital and the skilled nursing facility through a transition to see what went on. Did everybody do their job? And if not, what are the gaps? And now, there's no penalties to it at this point in time, but they can, then, present a program back to both the hospital and the SNF and say, "Here's where things fell down, guys. Go to it."

So, end of sermon. Thank you.

CO-CHAIR LAMB: Let's take a moment here because we are now through the SNF quality reporting.

Alan, you have yours. Did you want to say anything before we move to another area?

MEMBER LEVITT: Okay, yes. I could say a lot of things, but I will try to be brief.

In terms of the gaps identified in the program, I guess what is important information for us and for other people who are reading this document and may be submitting measures under consideration to us outside, you know, non-CMS measure developers, is to really get a clear idea as to a consensus of gaps that a particular program has. This isn't just for CMS; this is for all measure developers who are out there who may submit measures like we just saw before.

And there are a lot of great ideas here. There are a lot of things we could do.

Connie, I'm so sorry, you know, your terrible experience. It's, unfortunately, not

uncommon experience. And I think that's why we're all here today, because we know that and we know that we can do better and make things better here.

The devil is in the details for every measure. I keep looking at Tara, Dr. McMullen, back there. Hopefully, she's back there again.

Because, you know, being able to take these ideas, best practices, and trying to put them into a quality measure that is as least burdensome as possible, that can show performance differences, that can be meaningful, is a challenge. And that doesn't mean we shouldn't try to look at those challenges, because in post-acute care we all know that's what we do.

But understand that there are such challenges to things that you would think would be intuitively obvious. Because if they weren't -- if they were obvious, they would have been done already.

But, please, keep giving us this information. Please give us consensus gaps,

well-defined gaps, not just for us, but for other measure developers, as we keep going through all these programs.

MS. PRATT: And I would like to add, if there are best practices out there, there must be metrics associated with those to determine that they are the best. And we continue to invite measure developers to the table. Clearly, AHCA has been working steadily for a number of years, and so have other developers, but we do need more.

I don't want to say that misery loves company, but, you know, we've been in this business for a long time and we would really appreciate more, especially as these more complex concepts come to light, because these are really the heart of much of the care that occurs for people.

And also, just to say I'm the youngest of seven. All my siblings are Medicare beneficiaries now and retired. So, please help me out here.

(Laughter.)

Oh, yes, as my Medical Officer.

(Laughter.)

So, thank you all.

CO-CHAIR LAMB: Let's take a moment and just kind of see where we're at and make some decisions here. So, Paul and I and Erin and Jean-Luc and Miranda are going to throw out some choices. So, bear with us for a moment.

So, here we are at three o'clock. And on our schedule we are at 1:30.

(Laughter.)

And that's not to say -- this has been what we wanted to accomplish together.

So, here's the suggestion. Does Pierre have a hard stop or are we good?

MS. KUWAHARA: No.

CO-CHAIR LAMB: Okay. So, where's the suggestion. All right? It is to take the other areas, hospice, long-term, IRF, and so forth, home care, and we'll go through them. But, rather than do generic gaps, okay, we've talked

now about the patient experience being very important. We've talked about the attributes of the transfers being important, that we do need to do work in those areas related to appropriateness, timeliness, the type of information.

So, rather than kind of repeat general things that are true across all of post-acute/long-term care, would you all be comfortable in looking at what are the gaps we identified last year? And, then, speaking specifically to that setting, we will just take the experience of care and the transfers as a need, a priority across all settings. But, if we could heighten any unique issues to those settings in the next time together, would that be okay with everybody to do that? Okay. And then, we can add to it. It sounds like that's okay.

Now we do need to do input on measure removal, and Pierre is with us. So, after we do the kind of let's go through the settings, see if there are unique things -- because you are

experts in these unique settings and you may have measures that you really want to bubble up, and you've thought that we need to add measures. Let's do that.

Then, we'll have Pierre talk about the measure removal criteria. Now the two topics at 3:30 and 4:00, NQF attribution work and guidance on attribution challenges in PAC/long-term care and equity, were for our information. They were not actual essential topics. They were more to keep us informed. So, we could either do them more briefly or we can take them off the agenda. What's your pleasure on that?

We must do the measure removal. We must do public comments. And, of course, I mean, what would this day be if Paul and I didn't summarize?

(Laughter.)

CO-CHAIR MULHAUSEN: Completely lost.

(Laughter.)

MEMBER DAHLIN: Gerri, are there materials for some of the ones that we would

possibly take of the agenda that we could still review and get the information?

CO-CHAIR LAMB: Go ahead.

MS. O'ROURKE: Yes, so the materials are in your slide deck. So, if you want to review, I think the main thing would be the attribution session was really Taroon, Jean-Luc, and I looking for some help with our homework on another project. We have another paper NQF is developing about patient attribution, and CMS has asked us to think a little bit about complex patients and, in particular, the home health setting. So, we wanted to tap this group's collective input. If we don't get to that today, the deck has everything we were going to share, and we would welcome your input via email or, if you would want to talk to us offline, we would be most appreciative. So, that was really our intent there, was to get input for that project.

MEMBER MAHAJAN: Or, alternatively, we can have a phone call in a week or two weeks and just get that done.

CO-CHAIR LAMB: We've got a couple of options. We can read stuff and we can have a phone call. Also, we have another, say, hour and 45 minutes scheduled for this meeting. I don't know -- typically, folks will be leaving to catch planes.

We could, if there is interest in doing either and/or attribution and equity, dedicate like 45 minutes to gaps, have Pierre walk us through the measurement removal, and then, spend the last 15 minutes just knowing what the issues are in attribution or equity. Any or all. Do you want to do that? Spend about 45 minutes, have Pierre talk, see where we're at, see if we want an update on attribution and equity? Or we will do a phone call, so that we don't lose our opportunity to have some into the process. Is that good?

Thanks for bearing with us. Was that a yea? Oh, good. Okay. Thank you. As past Chair, we value you.

With that, we're going to move into --

oh, I'm sorry, Alan, go.

MEMBER LEVITT: No, I'm sorry to interrupt.

But just you did a really nice paper on attribution in the NQF, and I would certainly recommend everybody, if you haven't seen it, to take a look. It is a challenge. It's really a challenge.

I know you were looking at it. Actually, post-acute care I think was the bad guy in some of the attribution.

(Laughter.)

But it is an issue that we have to deal with, obviously, as well in post-acute care in terms of trying to make sure that we are developing measures that the outcome -- you know, that we are appropriate in terms of outcome determinations.

But, if we don't discuss it, please just look at the paper.

CO-CHAIR LAMB: I don't know about the rest of you, but you just whet my appetite and

now I need to read the paper. And I would like to have a discussion together. So, we will come back to that attribution issue.

Okay. So, with that, then -- thank you for kind of putting that on the table, Alan.

Where are we? We are moving into hospice, and let's focus-in on the unique aspects.

Erin, are you -- no, it's hospice. Jean-Luc, it is you. Would you kick us off here?

MR. TILLY: Of course. So, the hospice program, as you're probably familiar with, is just a penalty-for-failure-to-report program. So, the data sources there are the hospice item set and the hospice CAHPS.

So, here are just the measures that are currently in the program. You will see there are a lot of things that kind of are lumped into this idea of a comprehensive assessment at admission. So, just treatment screening, pain assessment screening, capturing treatment preferences, the CHAPS hospice survey, and then,

a process measure around hospice visits when death is imminent. So, two different kinds of measures that are related to the timing.

And here are how the measures fit into the hospice high-priority areas for measurement. So, those are high-priority areas that this Workgroup had identified in the past. And here, you know how those measures are fitting into that currently. You can see a couple of gaps there. So, access to the healthcare team on a 24-hour basis and avoiding unnecessary admissions are both areas the Workgroup had identified in the past that haven't been addressed as yet.

Here are the few gaps that CMS had identified. So, symptom management outcome measures, timeliness and responsiveness of care, care coordination, and being responsive to patient and family care preferences. These have all been addressed, those measures recently added to the set.

And so, here you have the previous gaps that this Workgroup identified this past

session. So, medication management at the end of life, provision of bereavement services, and then, the kind of more general patient care preferences that we've discussed in other settings.

So, with that, I think I'll turn it back over to Gerri and Paul.

CO-CHAIR LAMB: Paul, do you want to pick up?

CO-CHAIR MULHAUSEN: So, we can see here the gaps that we've talked about in the past. And I guess at this point we're curious about your reflections on those gaps, especially whether or not, as you consider the program, whether there are additional gaps you identify and want to share, as well as the exercise we just went through, which is, is this granular enough, can it be filled out more and in a way that could be operationalized?

Do you like these gaps? Do you still see them as gaps? Can we eliminate one of them?

MEMBER MAHAJAN: Wasn't No. 3 already

addressed in the set we saw?

CO-CHAIR MULHAUSEN: Can we go back a slide? Yes.

MR. TILLY: Right. So, I think the care preferences there were a little bit different than what's captured in the CAHPS hospice survey. So, rather than patient experience or patient satisfaction, we're talking more about care preferences and, also, kind of different for the beliefs and values addressed piece.

CO-CHAIR MULHAUSEN: Theresa, I've been staring at the screen instead of looking to my right. So, please, we welcome your input.

MEMBER SCHMIDT: Of course I have something to say about this.

(Laughter.)

Do you mind putting it back on the gaps slide? Thank you.

First of all, provision of robust bereavement services is something we definitely advocate for, both in terms of thinking about

what makes and how do we define robust bereavement services, but, also, are the services themselves having the needed impact on the families and caregivers, which was behind my question about the PROMIS measure in part earlier? So, that's definitely an area that I think that there's a gap.

Also, included in the Medicare hospice benefit is the need to use volunteers, but there really aren't any quality measures related to volunteer utilization.

These are both measures that kind of have process components to them, but the statement that more outcomes, and specifically clinical outcomes measures, are needed is definitely at the top of our mind as well. All of the measures in the Hospice Quality Reporting Program today, based on the hospice item set, are process measures.

And the CAHPS measures are based on surrogate reports. So, as Dr. Gifford mentioned earlier, research has shown that surrogates often

don't provide an accurate view of the patient experience. So, it's important that the voice of the patients themselves be elevated as part of this program.

Finally -- well, not finally; I have two more -- psychosocial and spiritual care is an area where I think we've identified gaps before. Hospice provides emotional support, spiritual support, psychosocial, psychological support as well. And to ensure that those needs of the patients and of their families are being met is an important concept for us.

Definitely agree with the burdensome transitions of care for patients and families and the need to recognize and improve that.

And now, I'm almost at the end. I think it's important that measures support a diversity of diagnoses. So, not just outcomes that are important for elderly terminal cancer patients, but also outcomes for more of the Alzheimer's and dementia populations, two groups that have grown in hospice care.

So, thank you.

CO-CHAIR MULHAUSEN: Connie?

MEMBER DAHLIN: Yes. So, I think the other gaps that I'm kind of worried about that we're going to need to monitor is whatever happens with health care, this whole part with pediatric hospice and pediatric palliative care. We're going to need to look at it to make sure that some of those measures we're able to still monitor and think about what happens with a child experience, with their long-term care and some of their post-acute care issues.

And then, I think the other part, that I will back Theresa in terms of thinking about this whole interdisciplinary team part, that we don't really measure that. That's really what makes hospice special. And I would even push it farther beyond the required disciplines of medicine, nursing, social work, and chaplaincy, but rehab is really important. Nutrition is really important, particularly if we're going to keep these people safe at home.

And then, last, of this other gap that we haven't really measured, but I think makes a big difference as we, again, think about wherever our health care is land. This 24-hour, quote, "accessibility," you know, that usually is a phone call. But, for these families when they're in crisis, they can just feel so alone and so without anything. And so, I don't know what that really means right now. So, I can't help CMS in that. But I think that's going to be an area that we mean, what does 24-hour access mean and does that need to be more robust?

Thanks.

CO-CHAIR MULHAUSEN: Carol?

MEMBER SPENCE: I thank you.

I want to start with one of the identified gaps, which is the medication management. I'm not too sure what the concept was behind that. But I would say that that is already rolled into a lot of the symptom management, which should be a combination of medication and other things.

And it also could be part of something I'm about to mention as a gap, which has not been addressed in hospice at all, which is safety. There's been very little mention of that in hospice. It is different in hospice in that so much of the vast majority of hospice care does take place in the home. Patient autonomy is a huge piece of that. So, the whole concept of safety in the hospice setting is quite different, and I think it deserves its own look.

Just transferring or borrowing measures from other providers is not really going to do justice to the concept in hospice, and I think it should be identified as a gap and, then, looked at for its unique properties there.

So, I would say that medication piece, if you were going to take something off, I would take that off and just recognize how integral that is to so many of the other areas of hospice care.

Adding, or enhancing I guess, or changing a bit what Theresa said, I can't

emphasize enough the role of the family caregiver in hospice. Hospice is unique, also, in that we recognize the family and the patient as the unit of care.

The CAHPS hospice is not just a set of surrogate measures, however. It does, in part at least, recognize that the family member is a unit of care, because there are questions on that that do relate just to the family caregiver.

The one big focus on there, however, is on instruction, is on education of the caregiver, preparing them to provide the care. However, what that leaves out is the difference between simply instructing someone and actually enabling them to provide the care, making them feel that they are confident that they can do it, but also that hospice is there.

And it goes back to that 24-hour access that Connie was just talking about. That caregiver should feel like hospice has got their back, that they are there, that they are not alone in this. And that is not captured on the

CAHPS, and I think that is a significant gap that could be worked on and added to the CAHPS, because the CAHPS is the vehicle for getting the caregiver's perception of the care that they received as well as the patient.

CO-CHAIR MULHAUSEN: Alan?

MEMBER LEVITT: Well, thank you all again. Great, great ideas for us.

I want to first introduce Carol Schwartz who is the measure lead for hospice and for home health. So, I wanted to welcome Carol to the table to listen to this.

As you probably know from the rule this year in the future measures section, we are asking for comments on some of the claims-based measures that are under development. We agree that we need to continue measure development and are interested in filling these gaps as well.

Talking up the hard instrument again, but just the idea that, with good assessment instruments, with items that mean a lot for patients, also comes development of quality

measures off those items. So, we are looking forward to being able to continue to develop more and more Meaningful Measures for this program.

CO-CHAIR MULHAUSEN: Kurt?

MEMBER MERKELZ: Thank you.

I certainly want to echo certainly everything that's been stated. Certainly, trying to achieve safety, making sure that we're addressing the spiritual/psychosocial needs of individuals represents significant gaps that aren't accounted for in hospice extremely well.

I think further clarification on my end of what we're actually getting to regarding medication management at the end of life, actually trying to achieve specific outcomes, I think is certainly lacking. We're able to assess at the front end. And really, the hospice item set, you know, our current measurements and the Hospice Quality Reporting Program, the hospice item set, everything is captured at the initial visit, everything. So, it's not reported out until the patient dies. But further qualitative

data of what took place after that initial assessment isn't captured at all in the hospice item set data.

So, certainly having patient-reported outcome data and a focus to outcome data, but, also, specifically quality-of-life outcome data, having identified patient prioritized, quality-of-life domains represented and captured is certainly an area that needs to be identified.

We often address quality of life as the reduction of negative attributes, but when we really get to the value-add that hospice is bringing to the end-of-life care experience, we need to make sure we're doing things and promoting things that make the end of life more meaningful for the individual patient, making sure we're capturing components of who they are, being, belonging, becoming. And I think putting positive attributes and making sure we have a way of capturing the positive attributes that we do for individuals at this time of life is important, and not just reduction of the

negatives.

CO-CHAIR MULHAUSEN: Kurt?

MEMBER HOPPE: As Carol said before, I didn't have the ability to understand what was discussed before, but she talked about the medical management. I came off thinking that that gap was something else. And mine was the physician accountability for medication management.

It's nice that the facility has something. And I'm also thinking about our MIPS discussion. It's been a long time since I've been a hospice physician, but I do remember that getting certain physicians, and other providers now, that can prescribe narcotics and other medications to actively wanting to be engaged, either clinically or culturally, with hospice was sometimes a problem.

So, right there when it said medical management, that was my thought, the physician, nurse practitioner, or PA responsibility in actively helping the hospice with a patient that

was undergoing increased pain or was undergoing or having some of the symptoms that we associated with certain times of dying. I'm not sure if that was addressed previously.

CO-CHAIR MULHAUSEN: No, that's very helpful.

Carol, you've been going up and down.

MEMBER SPENCE: Yes. Sorry. So, I'll just go up.

I just wanted to say one thing about patient PROs and hospice and acknowledge the challenges in getting patient-reported measures. Over a third of hospice patients die within seven days. Back when the HQRP was first instituted there was a patient-reported outcome measure regarding pain. It sounds like the absolute perfect measure, and CMS withdrew it after just putting it in place for half-a-year, only a quarter's worth of data collection, in addition to the piloting that they did of it. And it was for multiple reasons.

But, now that HQRP has been in place,

HIS data collection has been in place, I really would like to see that measure, or a permutation of it, revisited because hospices are much more used to that. That was the first out of the box. It's a tough place to start for a whole set of providers that have never done any quality reporting, many of whom still don't know what a numerator/denominator is. You know, they thought monitoring something was doing quality measurement.

And I also appreciated back when Karen was reporting about rural, about easing into it. Hospice didn't get eased into it and they should have been. So, I think perhaps that's been a lesson learned, and I heartily endorse that easing into it.

But, again, this is a real challenge in hospice. I think it can be done. And again, I think that measure should be revisited with perhaps also at the same time testing of that caregiver response, so you know what that gap is. So, as that patient does get sicker, you could

over time pull in that caregiver's report and understand and actually statistically be able to, then, know what that caregiver's response is in relation to the patient. So, you could also perhaps use the caregiver as a surrogate on some of these symptom management outcome measures, which we dearly need.

CO-CHAIR MULHAUSEN: Any other comments regarding the gaps for the Hospice Quality Reporting Program?

(No response.)

Okay. Let's move to the next one.

CO-CHAIR LAMB: Long-term care hospital. Miranda, are you doing that one?

MS. KUWAHARA: I am.

So, like the other QRPs, this is a penalty for failure to report program. It was established under the ACA. And since federal fiscal year 2014, LTCHs that failed to submit data are subject to a two-percentage-point reduction of the applicable annual payment update.

Three measures were finalized in the fiscal year 2018 IPPS Final Rule. They include compliance with spontaneous breathing trial by day two of the LTCH stay, ventilator liberation rate, and changes in skin integrity post-acute care pressure ulcer/injury. And this will replace NQF No. 0678, percent of residents or patients with pressure ulcers that are new or worsened, short stay.

CMS identified the following domains as high priority for future measure consideration: effective prevention and treatment, which was addressed through ventilator-related measures; making care safer, which is addressed through modifications to existing pressure ulcer measures, and then, communication and care coordination, addressed through transitions and rehospitalizations as well as medication reconciliation.

Last year MAP identified gaps in the LTCH QRP measure set. These include the need for measures addressing the transfer of information

between attending clinicians, rather than being limited to transfers of information between settings. MAP also recommended adding measures addressing nutritional status. And then, MAP recommended adding an LTCH-specific CAHPS survey to assess patient experience of care.

And then, during our most recent web meeting in November, the Workgroup noted special considerations for LTCH transfers, specifically measures assessing the acute-to-acute transfer between hospitals and LTCHs.

CO-CHAIR LAMB: Okay. Gaps? Additional things? Confirming previous gaps? Adding gaps?

Sean?

MEMBER MULDOON: So, these are all getting at the right things. I think the TAPS is going to take care of itself because that's in the pipeline.

Everything that we talked about around transfer of information and that transition-of-care coming into a SNF I think applies to coming

into a long-term care hospital, as well as on the transfer out side, because, you know, probably a third to almost 40-percent of LTCH discharges end up going to another institutional entity in the post-acute care segment.

So, I think that list looks pretty good to me. I've got in the back of my mind this mental health/behavioral component that overlays your ability to get well. And that one is still out there. It was mentioned on the previous slide. So, I would have no objection to adding something related to that, either assessment or outcome, with the understanding that many of these are going -- many of the psychiatric diagnoses will be not chronic, because we already know about the chronic ones. But I've got no objection to those being added as a reminder of a gap.

CO-CHAIR LAMB: Caroline?

MEMBER FIFE: Even though this falls, again, under the fact that I can't pass up the opportunity to tilt a windmill and it's

pointless, but last year I mentioned that you would probably regret going through with the pressure injury terminology change. So, I just have to go on record as saying, I think you will regret that. It's still not clear that you will be able to code that under ICD-11. That's not a done deal. I realize they're working on it, but if it doesn't have an ICD-11 code, it's going to be interesting.

Also, it's possible under ICD-11 that all pressure ulcers will now have become wounds, because injuries are wounds. If so, they have to be secondarily coded by the thing that caused the wound. On top of that, this terminology now includes device-related pressure injury, which very specifically means that the device caused the thing. The manufacturers can get ready for this. It's going to be expensive for them.

This will also make it more difficult to defend pressure ulcer litigation against facilities. If you are an LTCH, call your law firm because you will pay for this monetarily,

and so will the providers who work there. It's going to be ugly, and I will enjoy telling you, I told you so.

CO-CHAIR LAMB: Kim?

MEMBER ELLIOTT: I just want to support what Sean said about the mental health or behavioral health. I think that's really critical to get these people ready to get out of that facility. So, we do need to manage the depression and things like that, which come along with those types of care and services.

CO-CHAIR LAMB: Other suggestions, confirmations of the gaps?

(No response.)

Okay. The next one is -- what are up to here?

CO-CHAIR MULHAUSEN: IRF.

CO-CHAIR LAMB: IRF.

CO-CHAIR MULHAUSEN: Miranda.

MS. KUWAHARA: It's me again.

All right. So, again, we're looking at another penalty for failure to report program.

Under this program, this applies to all IRF facilities that receive the IRF PPS. So, that includes IRF hospitals, IRF units that are affiliated with acute care facilities, and IRF units affiliated with the critical access hospitals.

Data sources for the IRF QRP measures include Medicare fee-for-service claims, the CDC's National Health Safety Network data submissions, and IRF patient assessment instrument records.

One measure was finalized in the fiscal year 2018 IRF PPS Final Rule. This measure is titled, "Changes in Skin Integrity Post-Acute Care: Pressure Ulcers/Injury," which will replace NQF No. 0678.

CMS identified the following domains as high priority for future measure consideration: making care safer, which is addressed through modifications to a current pressure ulcer measure, and then, communication and care coordination, which is addressed through

discharge to the community, potentially preventable readmissions, and med rec.

And here, we have the MAP's recommendations for gaps identified last year. We have experience-of-care measures related to patient and family engagement. Additionally, during the November 13th web meeting, Workgroup members cited refinements to infection measures, given low incidence, as an additional gap.

CO-CHAIR MULHAUSEN: Okay. So, again, the exercise is a reflection on gaps. Anything that you think needs to be amplified from previous lists of gaps and anything you think ought to be added at this point.

Sorry, I'm slowing down at 3:30.

(Laughter.)

Yes. No, no, I need some caffeine probably.

(Laughter.)

So, anyway, the same exercise. Any gaps that you perceive.

Caroline, I'm assuming your

reflections from our last conversation apply here as well?

MEMBER FIFE: They do.

CO-CHAIR MULHAUSEN: Yes, very good. Sean, you have the floor.

MEMBER MULDOON: Yes, I'm a little curious if the experience with information transfer around the arrival into an IRF or in an acute rehab unit -- you know, given the more and more medical comorbidities that I'm told about somehow matters less or is better handled under an IRF setting, because it's conspicuous in its absence.

CO-CHAIR MULHAUSEN: Gene, I think you came up first.

MEMBER NUCCIO: I don't know exactly how to frame my comment. I was just sort of reflecting -- I mean, we are talking about quality measures. And I was thinking about, what do I see in the newspapers about these sorts of settings, whether they're nursing homes or long-term care facilities? And you see things about

abuse and you see things about just general poor quality care or lack of care to the patients. And I'm thinking specifically of the news in Florida, okay, where the patients lost power and they were in the 100-plus-degree temperature.

I don't know whether this is part of this. I don't know whether there are agencies at the state level that do checking of conditions of participation and whether the facilities are compliant. I was wondering if there's any value of trying to engage the folks that do survey and certification in this whole effort to integrate what they're finding with these patients. And it sort of could be applied to many of these institutional types of settings.

Again, I don't know how to frame my comment.

CO-CHAIR MULHAUSEN: Kurt?

MEMBER HOPPE: I just wanted to respond to Sean. I think one of the reasons why in IRFs some of the discussions and some of the transfer of information is a little less clunky

is because we have a big, mandated pre-admission screening procedure. As much as we may not like it sometimes, and it can be very time-consuming, but it does require us to do a second check and a double-check of everything we have. And it does require us, especially ones that are certified, to be able to go talk to patients and make sure that we are giving patients and family a lot of information. So, that kind of tool is in place, and it enforces a lot of discussion.

It sort of reminds me when MDS came in for SNFs, that that did promote quality and some discussions that were previously not available. So, I think that's the reason why IRFs, it feels like there's more engagement.

CO-CHAIR MULHAUSEN: Jim?

MEMBER LETT: Since I think IRFs could loosely be defined as skilled nursing facilities on steroids, I think the same thing around transitions, about information passage, medication, correct medication list, et cetera, might be worthwhile to enter here as well.

There's a lot of transitions from that, far more than LTCH.

CO-CHAIR MULHAUSEN: Yes, and what we've done is taken notes on Sean's reflections and your comments. So, I think it will probably be there next year.

Raj?

MEMBER MAHAJAN: So, just thinking about the Meaningful Measures, that whole circle and the big slide, I think it applies to IRF, but probably all settings is something on opioid use. I think with everything going on nationally with the epidemic, and everything, I think that, again, is another issue where you will have a physician and the facility be responsible for coming up with something, where if somebody prescribes an opioid, can you have some criteria that have to be met to use that, something around that? And it can go for all four levels.

CO-CHAIR MULHAUSEN: All right. Any other reflections, comments, additions?

Dr. Levitt?

MEMBER LEVITT: Well, thank you all for the comments.

Again, certainly elder abuse is something that we are all concerned about, particularly in the long-term care and nursing home setting.

And, Dr. McMullen, once again, is interested in looking at measures associated with that.

Those measures or that sort of measure wouldn't really fit into this program, which is the IRF Rehab Quality Reporting Program.

But, no, we are, obviously, interested in continued measure development, identification of gaps, making more and more Meaningful Measures. So, please continue to think about programs. We don't mind seeing bullets up there for us all to be thinking about.

CO-CHAIR MULHAUSEN: Okay. If no other comments, then I think we'll move on to the Home Health Quality Reporting Program. And Erin is going to lead us in that discussion.

MS. O'ROURKE: Thank you.

So, again, another failure for penalty to report program.

Data from this program are reported on the Home Health Compare website.

Potential information sources include: the OASIS instrument, the CAHPS survey, and Medicare fee-for-service claims.

I know we're short on time. So, I will not read you all the measures in the program, but in your reference material, in case you need it.

And, yes, everything can thank the CMS team for their great work to remove measures here.

So here, you can see a lot of progress has been made addressing some of the high-priority domains that had previously been identified.

And then, the gaps that the Workgroup had identified last year were measures to adopt care plans for congestive heart failure. We also

started talking in November about a potential gap around opioid use and balancing that with pain management. So, I did want to bring that back to you, if you want to continue that conversation as we continue to refine this list.

CO-CHAIR LAMB: Additional gaps that you want to mention, bring forward?

(No response.)

I have to say I have the same reaction to this one that Sean had to one of the last ones, which is, wow, that's all we came up with last year?

Anything else?

Gene, go for it.

MEMBER NUCCIO: Sorry, I would disappoint Alan if I didn't speak.

(Laughter.)

We have many gaps.

I guess, again, my methodologist side is coming out to me. But one of the things that we hear consistently from home health agency representatives has to do with maintenance

measures. That is, keeping patients out of more expensive and intensive settings once they get them.

And so, from a methodological perspective, I think one of the things that home health agencies would like to see is some type of measure. Perhaps it's a utilization kind of measure. You could measure it with claims or you could measure it with OASIS, but that looked at the length of time that we keep patients from returning to more intensive care settings.

This, by the way, hospitals would love this because their 30-day rehospitalization rate in many cases is highly dependent on the quality of the home health agency. And so, collaborative efforts between acute care settings and home health, and nursing home kinds of settings, would be of value. So, I mean, it's a different kind of thing than we've been talking about because it's a type of measure.

We certainly would like to hear, have more in the way of the patient -- another type of

measure would be the patient voice in all this. So, as you heard earlier from Tara and Stace, the PROMIS work is promising.

(Laughter.)

At the same time, we've actually been thinking about this whole issue of the provider assessment of change in the patient's status versus the patient's perception of the change in the patient's own status, versus the caregiver's perception of that change.

And so, we have sort of a diagram -- and I will disappoint Alan that I won't draw it today -- that it's sort of overlapping Venn diagrams where the three perspectives of provider, patient, and caregiver overlap, and at that point of overlap is what is really happening with the patient. And so, I mean, that's sort of the conceptual model that we have begun to play with out at the University of Colorado in terms of how to make this happen.

CO-CHAIR LAMB: Gene, can I just ask for just a little more here? On that issue of

how long somebody stays in home care or stays out of the hospital or more expensive -- right now, we are looking at readmission rates, hospital readmission. Is the gist of this measure, then, to flip it and to say the length of time somebody stays in the community?

MEMBER NUCCIO: That is one way of measuring it. And again, we've done some preliminary work. In home health, as all of us, in terms of claims, it's a 60-day kind of window. However, every 60 days a patient is on care, we do a recertification of that patient's status on both functional and some clinical issues, clinical characteristics.

And so, one of the things we're looking at is the number of periods of time where the patient remains out of the hospital and either is maintaining that level of performance or perhaps increasing that level of performance even. So, we're investigating that.

Now we are quite well aware of unintended consequences of measures. That is, if

you're incentivizing people to maintain a person from going back to the hospital, then you're incentivizing the person, the agency to keep the patients on care for a long period of time, which is going to cost CMS more money.

So, trying to balance that sort of perverse incentive with the idea that truly keeping patients out of more expensive and intensive care is a meaningful and good goal for many home health agencies needs to be respected.

CO-CHAIR LAMB: Thank you.

Liz?

MEMBER HALL: Yes, so just to respond to this, I just wondered -- and I guess it's a question just for the group. You know, a lot of what we are hearing, I think, more and more at ONC is around the importance of not only sharing clinical information, but having a better understanding of a person's social determinants of health and being able to share that information and support a person's needs around that. So, I know that later on in the agenda you

were going to talk about health equity and SDOH. But I just wondered in terms, particularly around home health and as people go back in the community, about people's thoughts about measures that might support SDOH needs.

CO-CHAIR LAMB: Anybody have any thoughts for Liz?

(No response.)

MEMBER FIFE: In one of our QCDR measures, we had included in our patient-reported nutritional screening the two-question survey on food insecurity, which I had to actually cry on the phone to get CMS not to reject yesterday. So, we say we care, but it's hard.

CO-CHAIR LAMB: We're not going to make you cry with this comment on this one.

MEMBER FIFE: Gene may have solved one of my really tormented problems, which is I see the world through the lens of people with chronic wounds, and they go through all of these sites of care that we're talking about.

And I mentioned the analysis we did of

cost, which is $96 billion, most of which is subacute care. And I haven't mentioned wounds in any of our gaps because it doesn't, after we have stated framework as this sort of high-level thing, somehow that seems too disease-specific. So, amazingly, I can be intimidated into not saying anything.

(Laughter.)

But, nevertheless, one of the issues around people with chronic wounds is trying not to have them end up being hospitalized for acute episodes. However, we just realized that the vast majority of their spend is subacute care. I don't know whether that's a good thing or a bad thing. But, nevertheless, it never occurred to me that we might try to craft measures that really are specifically looking at the success we have in keeping them out of acute care episodes. Maybe that's the win for us that I hadn't really grabbed onto.

It's kind of an exciting way to actually get a better look at those people as

they transition through all of these different care sites, because these are people who we really realize chronic wounds, it's not that we're going to heal them. We're never going to heal them. Their heal rate is like 30 percent. They're always going to have this thing. It's like diabetes. So, it's an interesting idea. I really like that idea.

CO-CHAIR LAMB: Alan?

MEMBER LEVITT: Just a couple of comments, again, that Carol, Gene, and I think about gaps all the time in home health. Maintenance measures is a really important topic for us. Over half I think, 60 percent of home health referrals, first of all, come from the community. They're not from a hospital. So, they're not readmissions. They're essentially hospitalizations if they go into the hospital from home health. And so, that's an outcome to look at.

But the existing stabilization measures that were around for a long time in home

health, since OASIS first came out, are all topped-out. They're topped-out measures that really could no longer be used to measure quality for our providers.

And so, the hope is, with better assessment items comes better new measures. And so, that, hopefully, as the assessment items that are coming forward in the IMPACT Act becomes parts of our program, we can start looking at saying, well, how can we build stabilization-type measures that would be applicable in home health, would be applicable in the long-term care setting as well?

So, these are identified gaps, and I assume they're Workgroup gaps as well. And we'll continue to be working on this.

CO-CHAIR LAMB: Okay. We're going to move now into -- we have Pierre Yong coming back to talk about measure removal criteria for our input.

How about if we aim for about -- oh, do we need to do public comment right now?

MS. O'ROURKE: Yes. So, I was going to propose if we could open for public comment.

If during the public comment, if everyone wants to stand and take a stretch break while we queue up the phone lines? I know we've had you all sitting for a while and perhaps everyone could use a little time out of your seat. But we are short on time.

So, Operator, could you the lines for comment?

OPERATOR: Yes, ma'am.

At this time if you would like to make a comment, please press * and, then, the No. 1.

(Pause.)

And there are no public comments at this time.

MS. O'ROURKE: Shall we get through Pierre and, then, maybe a five-minute stretch?

CO-CHAIR MULHAUSEN: I think a five-minute stretch.

MS. O'ROURKE: Okay. Why don't we? the Chairs have asked for a five-minute stretch

and, then, we'll reconvene.

All right. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:50 p.m. and went back on the record at 3:57 p.m.)

CO-CHAIR LAMB: Here's the plan for our last hour together. Okay. We're going to spend about 30 minutes talking with Pierre about measure removal criteria and offering input.

We'll get a brief update on attribution and the paper we heard about. And we'll figure out what next steps might be. And then we are going to bring the meeting to a close. We will be done by 5:00. So Pierre. Thank you.

DR. YONG: So great. So this is I thought a nice way to sort of close the circle at least on sort of the measures discussions.

Continuing on from earlier in the day, I mentioned when we were talking about Meaningful Measures that we are also internally starting to look at the actual measure sets for each of our

17 programs that we work on.

So wanted to take the opportunity while we had you here to really pick your brains and get some feedback and reactions about the criteria we should be thinking about when we do this evaluation. And we're doing this, just so you know, across the workgroups. And we'll be discussing it at the coordinating committee as well.

So we pulled together some sort of framing questions as well as some draft criteria for you to react to. But we'll keep this fairly short in order to maximize the time for our discussion. So if you move to the next slide, please.

So these are some considerations that we pulled together. So, again, they're drafts, so feel free to react to them. If there is anything missing or there's things that you think are important to note, we welcome that feedback.

First, that the measures that we want to keep are meaningful to patients and providers,

that they're patient-centered, that they're current with clinical guidelines. And as you know, you know, and you're intimately familiar, there are sometimes and often are specific statutory requirements a la IMPACT for the PAC programs that we need to meet and that's why we have certain measures in the programs.

Measure types, outcome measures are things that we've talked about as having a preference for. We certainly recognize that often times there are not outcome measures. There certainly is space for process measures, particularly process measures that are approximal to outcomes of interest, and so, but generally prefer outcome measures.

Variation and performance, looking for measures where there's continued variation in performance so that we are continuing to drive quality improvement.

Performance trends, so looking at how the, if a measure has been in a program for several years, looking at how the performance on

that measure has been, whether it's improving or whether's it's static or actually getting worse.

And so thinking then more broadly, if it's not heading in the direction that we are hoping they should head in, like whether, one, it's a useful measure or whether there needs to more like quality improvement efforts directed towards that particular quality issue. But those are considerations that I think we can take into account. If you move into the next slide.

Burden is something we've talked about today. But certainly the amount of burden associated with the measure is another key consideration.

Unintended consequences is something that has come up in some of our discussions, but is another key consideration.

Operational issues, we had a lot of discussion around operational issues with the CoreQ measure today. So that's certainly another key consideration.

And the final element that we put on

was alignment, in particular, within and across CMS programs, but also with private pairs to minimize unnecessary duplication, harmonization of measures to the extent that we can do that. So we can move to the next slide.

This is just the framing question. But are there criteria? You know, we showed you some draft ideas that we had that we should consider as we review the measure sets for our quality reporting and accountability program.

So I'll stop there and turn this back to Gerri and Paul.

CO-CHAIR LAMB: Thank you, Pierre. Can we go back two slides so that you can look at the criteria and offer suggestions? So these are the criteria that are being considered right now.

Pierre, how do these relate to the ones that when we do measure maintenance, they, you know, that we go through in terms of continuing them as endorsed or recommending endorsement?

DR. YONG: On the endorsement side,

maybe Erin can sort of comment on that. But I think they align pretty closely. But --

MS. O'ROURKE: Sure. Apologies. Could you repeat the question?

CO-CHAIR LAMB: I was just wondering, the criteria that Pierre just put forward for measure removal, how do they relate to what we go through when we look at measure maintenance?

MS. O'ROURKE: Sure. So I think, as Pierre was saying, these are questions that we ask the standing committees to think about.

Obviously, the endorsement process is more about the scientific merits of a measure rather than whether it's in or out of a specific program. But at least, you know, I haven't done the one-to-one mapping, but I see burden very much tied to the feasibility criteria that we ask our standing committees to take a look at.

Similarly, we are always asking for input on potential unintended consequences, something we do think about in the endorsement review process. We also have, you know, a

separate process if anyone determines there is an unintended consequence. So we like, we even review it faster.

Again, operational issues I think tie back to both our feasibility and use and usability criteria where we want input on is this measure possible. Does it give you information you can work from and actually improve?

Alignment, not necessarily an NQF criteria, but we do ask our developers to under the use and usability criteria provide any information about where else the measure is being used. And we do expect that NQF endorsed measures are in use.

Oops, let me go back to the previous slide to just --

DR. YONG: And as it relates to that particular point as well, there is the related and competing measures process.

MS. O'ROURKE: Oh, that's a good point, yes.

DR. YONG: You know, that's not

necessarily in the context of a program as it's being used here. But conceptually it's very similar.

MS. O'ROURKE: And then I think here under, these three at least all to me really align with our importance to measure criteria. We want to ensure that endorsed measures are meaningful.

NQF has obviously noted a role for process measures. But we've continually emphasized a need for more high value measures. We only endorse measures that have a variation in performance. If a measure is determined to be topped out, it would go into our, what we call reserve status.

And then performance trend, we do ask developers to demonstrate that there is a quality gap and any information they can tell us about performance over time.

Is there anything I missed there?

DR. YONG: Yes, the only other thing I would emphasize as part of measure type is

that, you know, this is where we would look at the evidence.

If we're looking at process measures, really looking at the quality, quantity, and consistency of the evidence of the process as it relates to the outcome of interest. So while outcome measures are preferred, we would be looking a little bit more broadly in terms of that piece.

But overall, the criteria aligned very closely. It appears to be more focused on the measure set in the context of a particular program.

CO-CHAIR LAMB: Reactions, suggestions?

(Off mic comments.)

MEMBER DEBARDELEBEN: Hey, this is Mary Ellen Debardeleben. And I wanted to bring up some considerations that we've had within our IRF quality reporting program. Can you hear me?

CO-CHAIR LAMB: Keep going, Mary Ellen.

MEMBER DEBARDELEBEN: Okay. Thanks. I just wanted to make sure.

So I'm not sure whether these would fall within performance trending or meaningfulness or perhaps both or maybe even a separate bullet. But in relation to our infections, we have spent the past several years since 2012 reporting on CAUTI and since 2015 on MRSA and C. diff.

We actually just got, our IRF compare site was updated yesterday. So I went in and looked for MRSA. We have 1,199 IRFs on the IRF compare site. And of the 1,199 IRFs, only one IRF actually had a data score for MRSA. The other 1,198 IRFs had a NA because the incident rate was so low.

There is a cost and time resource utilization to report that data. Even though there aren't infections, there are required data elements that have to be put into the NHSN. And so it's frustrating for providers that spend the time and resources away from patients to report

this data to not get anything back from the system.

So there's only one IRF that's actually going to get a score. And the score is actually same as the national average.

We've also seen a trend in CAUTI infections. So of the -- and this is updated as of yesterday. Of the 1,199 IRFs, 811 of them, which is almost 70 percent now, have an NA.

And so that, within the IRF industry, CMS's burden estimate is about $1.5 million to report CAUTIs on an annual basis. And we've done that for the past five years, so, you know, $7-plus million.

So 70 percent of IRFs in the system are getting an NA. So that's not helpful for the providers. It's not helpful for the public.

And for that rating for CAUTIs, it does continue to go up with the number of hospitals that have that NA continuing to increase. It's at 68 percent today. But last quarter it was at 53 percent.

So at what point does there actually have to be data, you know, for there to be calculated data for those measures to continue in the program, because we're not getting data back? But it does take a lot of time and money to put that data into the system.

I also wanted to note that the on assessment items, there are multiple items that can be duplicated on assessment tools. And we can be documenting the same item, whether it's functional items or comorbidities, in some way to streamline different measures to ensure that there isn't redundancy for providers in reporting measures.

And then the last point was, I know underneath -- well, there are some calls that have happened in the past few months. And there's actually one scheduled for tomorrow about the proposed removal of flu vaccination for healthcare personnel from the home health program. And that's at the CMS, the QRP level for that program. But there haven't been similar

discussions in other provider programs.

And so when we determine that a measure is not effective or reliable in one aspect of post-acute care, at what point do we need to reevaluate it in other levels of care? Thank you.

CO-CHAIR LAMB: Thanks, Mary Ellen. Alan, did you want to respond to any of that before we move on to other comments?

MEMBER LEVITT: Thank you, Mary Ellen. It's Alan. Well, first of all, the call tomorrow is regarding the use of the flu vaccination measure in the home health quality of patient care star rating. It's not in the home health quality reporting program. That's not what the call will be about.

I invite everybody to listen in tomorrow. I will be part of that call if you want to listen.

Obviously, we are looking at all of our measures in all of our programs in Meaningful Measures.

I do want to point out certainly when it comes to CAUTI that when you, when we look at the NHSN reports back ten years ago when it first came out, and again, it was voluntary reporting. And I think probably only 100 or so IRFs were there. The rate that was seen in the IRFs was actually highest. It was the highest rate that they had. It was done differently than the SIRs are currently done. And so there certainly was a need for looking at a CAUTI measure as part of the program as it, as part of that study.

If you look at the OIG report that looks at adverse events going on in inpatient rehab facilities that came out, it's an interesting report, and look at harm events going on, they looked at all different events. They were -- infections was not the highest on the list. The highest was actually medication delirium, probably a need for some sort of drug regimen review measure if that outcome is what we see.

But the rate of infections that was

seen in that report was a little over five percent there. And even in our potentially preventable within stay IRF measure that we have, it's now part of the quality reporting program. When we're looking at measure development in terms of what types of patients get transferred to acute care, about one and a half percent of the IRF patients get transferred out due to infections.

And so definitely there appears to be infections going on, impact settings, and certainly in IRFs. And we're looking at the measures that we have finalized regarding those infections and, you know, have the same observations that you have.

I don't know, Pierre, if you wanted to add anything. No. Okay. But thank you. Thank you for your comments.

CO-CHAIR LAMB: Thank you. Gene.

MEMBER NUCCIO: Just many of the items on the list, Pierre, the eight items get to general psychometric characteristics of the

measure. And as most of you know, NQF has started the scientific methods group to look at complex measures and certainly around the issue of reliability and validity. And I presume that that's sort of part of this, captured in your criteria.

The other thing that's not specifically out there that I'd like to suggest is looking at the risk adjustment capability or the quality of the risk adjustment in prediction models that are done especially with the outcome measures, that when you're looking at competing measures and one has a C-statistic of .6 and the other has a .75, there really is no question as to which one you should be looking at.

And the third point I just wanted to quickly make was that I would caution -- and I didn't really see it up here. But I caution CMS to ensure that measures that capture unique characteristics about individual post-acute care settings are not tossed away because they appear only in that setting.

So I think just because a set of measures might be unique to that setting, it might be something that defines the true character of that setting. And so I would caution against removing measures that would do that.

CO-CHAIR LAMB: Other comments, other suggestions? Sean.

MEMBER MULDOON: So would there ever be a situation where you've measured it, it's an okay measure, but you just don't know how to interpret it because it's not a unidirectional, you know, high is good, bad is low or the opposite?

We run into that with our internal readmission rate where there is a probably a U-shaped curve where quality is sitting at the bottom of the curve and not at the absolutely lowest readmission rate or necessarily horrible care at the absolute highest one because of all these things that you either don't measure or don't understand. Or is the assumption here that

these are all unidirectional?

MEMBER LEVITT: Thank you, Sean, for the question. Every measure that is in development or measures that we propose have a purpose. And so, you know, we're -- if they no longer demonstrate meaningfulness in terms of the results going out, those would be measures that we'd want to consider for removal, replacement, changing specifications, et cetera, et cetera.

When it comes to the one example you gave of the readmission measure, certainly the expectation of CMS is not there are no readmissions that occur. But the expectation is that with appropriate measure development and risk adjustment that, you know, we can look at the attribution that an LTCH would have in terms of the, any contribution to either an increased or a decreased readmission rate.

MEMBER MULDOON: So the removal consideration is, would be either lost its usefulness or --

MEMBER LEVITT: Well, multiple things,

again. There could be a better measure that we've developed. I mean, my hope is, as I've told everyone here before, is 20 years from now we have better measures than we have right now. And as we build those better measures with the better ideas that we all have and our next generation has, we will be removing the old measures.

CO-CHAIR LAMB: Thank you. Just one final thought from me is in the measure type. And I realize that these are truncated, and they're more for discussion. Is I would feel better if the caveats about process measures were down there as well, because there are some situations that the process measures are important. And not to have those there makes me a bit uncomfortable.

I understand they're preferred. But in certain situations, and I can think of several in care coordination, those process measures are really critical to understanding impact.

Comments before we move to

attribution? Okay. Thank you, Pierre.

DR. YONG: Thank you. That was helpful.

CO-CHAIR LAMB: In our final time here, we're going to talk about attribution. And Erin is going to fill us in on the paper and what some of the issues are. And then we'll figure out where we want to go from here.

MS. O'ROURKE: That sounds good. Actually, Taroon and I are going to do this together since there's a few slides, and we know you've been sitting a long time. So, Taroon, do you want to start and then I'll finish up?

MR. AMIN: Absolutely. So just to give everyone context, this project has been done in two phases. We've completed the first phase, which resulted in the report that Alan just described earlier. And then we are beginning our second phase of work.

So just to give, make sure we're all on the same page, the purpose of this attribution work is that with various different pieces of

legislation, IMPACT and MACRA, we're obviously moving and focused on the conversation around value-based purchasing.

And there's, as we move toward outcome measures, cost and resource use measures, the question of who is responsible is a question that comes up often.

Attribution generally can be defined, I want to make sure we're all on the same page on the definition, as the methodology used to assign patients and their quality or resource use outcomes to providers or clinicians.

And attribution models help us to identify the patient relationship that could be used to establish accountability for those costs and quality.

As we think about, again, as we think about moving away from fee-for-service to alternative payment models the question of shared accountability comes up often and over and over again.

So we embarked on an environmental

scan, if we could move to the next slide. We embarked on an environmental scan working with our colleagues at the University of Michigan, Andrew Ryan, who specifically led the environmental scan, to actually just categorize what's out there in terms of the attribution models and what the elements of an attribution model would entail.

I think we noticed through the various endorsement and selection processes that really what we're even describing as an attribution model wasn't clear.

And so one of the activities of this work was really just to define from the environmental scan what an attribution model would entail. 163 models were evaluated that were in use or proposed for use. 17 were currently in use. 89 used the retrospective attribution approach, 89 percent of them. And 77 percent of them attributed to a single provider, mainly to a physician.

The commissioned paper findings noted

a few pretty important elements. First, that best practices to defining an attribution model were not determined. And existing models are largely built off of previously used approaches.

And the trade-offs, quite frankly, were not very clear in terms of when the measure developer or program implementer, the trade-offs weren't necessarily clear to the users.

There was no standard definition of an attribution model in the field. And the lack of standardization across the models made it very difficult to evaluate.

And again, noting the importance of the attribution model to a program score, again, making at least the transparency made it incredibly important. So if we move to the next slide.

Some of the challenges that we identified through this work is that, you know, greater standardization among attribution models was really needed to be able to compare between models and then really to allow best practices to

emerge.

There is little consistency across the models. But there was very good evidence that changing the attribution rules had a significant impact on results and, therefore, on provider scores in these various programs.

The lack of transparency, how the results were attributed and allowed no way really to appeal the results of the attribution model when there potentially might be wrongly assigned responsibility.

To address these challenges as a piece of foundational work, we decided to at least begin by developing a set of guiding principles in the development and use of attribution models, making recommendations relating to those guiding principles, and then, as a first step again for the field, to create an Attribution Model Selection Guide as a first step to potential evaluation of these models going forward.

These models allow for, these products we believed, or at least the committee believed

and based on the feedback that we received, would help with greater standardization, transparency, and stakeholder buy-in in terms of the use of these models, particularly for payment purposes. And so, you know, I can just move on from there.

There was, again, as we think about the guiding principles, some of the preamble statements that were made by the committee in the work was really to acknowledge the complex, multidimensional challenges to implementing attribution models, really being guided by the purpose and the data available, grounding any approach in the National Quality Strategy as the attribution plays a critical role in advancing those goals, and recognizing attribution can both be referring to the attribution of patients for accountability purposes and then also attribution of results of a performance measure.

They also highlighted that the absence of any gold standard for designing or selecting attribution model, that you must really understand the goals of each use case. And

again, the application of this and the purposes of the MAP work in which we're convened to discuss is incredibly relevant.

And then the key criteria for selecting an attribution model are the actionability, accuracy, and fairness, again, which two concepts but not really clear how they would be applied, and transparency as a first step.

So, with that, maybe I'll turn it over to Erin to walk us through some of the guiding principles and the elements of the measure, the Attribution Model Selection Guide.

MS. O'ROURKE: Absolutely. So I don't want to belabor this so that we can get to the conversation. But on this side you see the guiding principles the committee laid out for attribution.

They felt a model needs to fairly and accurately assign accountability. They've reemphasized that attribution is an essential part of measure development, implementation, as

well as policy and program designed.

The considered choices among the available data are fundamental to the design of an attribution model. The committee noted that models should be regularly reviewed and updated. They emphasized that models should be transparent, as well as consistently applied, and that the attribution model should align with the stated goals and purpose of the program.

So to start to reconcile this tension between the desire for clarity about an attribution model's fit for purpose and the current state of the science that left no real evidence about what are best practices and what we should be doing, the committee also noted there's a desire for a set of rules to clarify about which models should be used in a given circumstance. But they did not have enough evidence to support the development of such rules.

So to try to move beyond this and to advance the field, they developed what they

called an Attribution Model Selection Guide. It was a tool designed to aid measure developers, measure evaluation committees, and program implementers on what are the necessary elements of an attribution model. This was intended to represent the minimum elements that should be shared with an accountable entity.

So I apologize. This slide is hard to read. But we can also send around the paper that has this in case anyone's interested.

It's a series of questions asking, say, a measure developer or someone designing a pay-for-reporting or value-based purchasing program, to ask about what's the context and the goal and then, you know, what outcome are they trying to achieve.

What's the evidence base for this? Is this the current state, or are you trying to drive a change? What is the accountability mechanism? Is it reporting, payment, quality improvement? Then finally, which entities participate in this program?

Next it asks you think about how the measures relate to the context they're being used, thinking about things like the inclusion and exclusion criteria. And do you have an adequate sample size to draw fair conclusions?

Next, the guide asks you to think about who are the entities receiving attribution. Which units are eligible for the attribution model? Can the accountable unit meaningfully influence the outcome? Do the entities have a sufficient sample size to meaningfully aggregate measure results? And are there multiple units to which the attribution model could be applied?

And then, finally, how is the attribution performed? What are the data that are used? Does everyone have access to the data? What service do you use to drive assignment? Does the use of those services assign responsibility to the correct accountable unit?

What are the details of the algorithm that you're using to assign responsibility? Has the reliability of the model been tested using

multiple methodologies? Then what's the timing of the attribution computation?

MR. AMIN: Erin, before we move on, if we can go back to that slide for a second. So, and we may just want to sort of fast forward to the Phase 2 of this work.

MS. O'ROURKE: Yes.

MR. AMIN: But before we move on from this slide, I just wanted to highlight a few things.

First, since there was no standard definition of what an attribution model meant, what you can see from this guide is it basically outlined the elements of an attribution model. So that was number one.

Second is to have all these elements be transparent in the decisions that were made and then to describe the trade-offs that were made since there is no gold standard.

So the selection guide is intended to allow for that structure and transparency to, for the purposes of actually developing either

measures or for the purposes of programs.

MS. O'ROURKE: Excellent. Thank you. So then I'll go through this very quickly and skip a few slides.

The final product out of this paper was a series of recommendations that built on the principles and the selection guide. Essentially, the committee recommended that measure developers and program implementers use the Attribution Model Selection Guide to evaluate the factors that go into the choice of an attribution model.

They recommended that models be tested, that models be subject to a multi-stakeholder review, that attribution models should attribute care to an entity that can actually influence the care and the outcomes, and that attribution models used in mandatory reporting or payment program should meet some minimum criteria.

And again, that's all detailed in the paper we'll send around. But we want to get to the conversation and where we're going from here.

So we are working with CMS under contract to develop a follow-on paper to provide some continued guidance and to tackle some of the issues that came out of this first paper that we weren't really able to take on, to tackle really.

So thinking about things like unintended consequences, issues around data integrity and data collection, attributing complex patients, special populations, in particular, we wanted to bring this to you all because we were asked to think about home care and how that attribution, that may be a particular attribution challenge.

Thinking about attribution as we move to more team-based care and a lot of these models, as you may have briefly seen on one of those slides Taroon went to, assign accountability to a single primary care physician. But everyone knows there was a team involved in that care. And how do we reconcile where we are with where we're going to, you know, more global payments and team-based care?

Thinking about some questions around testing attribution models and how we could start to do this. And then finally, asking if there's ways we could improve the Attribution Model Selection Guide so that we're, you know, continuing to enhance its usefulness as a tool for the field.

So, again, I'll just briefly -- we are developing a second white paper. We're hoping to get some input into this from you all today.

And with that, I want to just see if you have any guidance for the team here on how we should consider attribution issues in post-acute and long-term care and in particular, any special challenges in home health, and to finally follow up on Alan's point that perhaps the first paper framed PAC/LTC as a bit of a bad guy.

One of the issues we kept hearing from the hospital contingency was that a lot of the current readmission measures --

MEMBER LEVITT: Right, the MSPB measure.

MS. O'ROURKE: Yes. And --

MEMBER LEVITT: Right, right. The hospital-based outcome measures that go for 30 days after that the question with the attribution of the PAC.

MS. O'ROURKE: For the spending measure, they felt a lot of the remaining variability is from your PAC costs rather than the hospital billing with readmission. That once the patient is out of the hospital and into the post-acute provider's care, where is the responsibility?

So I think with that we could open for --

CO-CHAIR LAMB: Caroline.

MEMBER FIFE: So 15 percent of Medicare beneficiaries have a chronic wound. And one of the problems that we have when we are trying to partner on the care that's provided by home nursing agencies is that they will not divide up the -- what's the name of the form that you sign for the home nursing, the skilled

nursing care at home? I'm sorry. I'm blocking on the name of the form. It has numbers.

They will only allow one doc to sign for that. And these patients have an average of 12, 10 different medications that they take.

So, if I write the wound care orders, they want me to sign the form that transfers the responsibility for all of their medications to me as the person who's just writing their wound care orders. So I'm not going to do that.

So I have to send the wound care orders to their primary care doc, otherwise I have to be responsible for everything that they take. And many wound care docs have been sued over signing that form.

So it's just a huge problem. And I'm not aware of a statutory reason why they can't do that. They just won't. So that doesn't help your problem. I'm just pointing out the layers of complexity involved in that.

The other problem with one of the models had to do with looking at the plurality of

services provided. So, when somebody has a horrible wound, and they're seeing somebody for wound care. And I realize this is a unique thing. I'm just hoping this example is useful.

What happens is that the doc who may be seeing them for that kind of service is seeing them more often than their primary care doc. But because there's no specialty involved, I ended up being held accountable for all the readmissions of all of those patients who had congestive heart failure and all the other primary conditions that CMS was tracking for readmission.

I got dinged on that on my QRUR. And I had no way of saying, wait a minute, that wasn't my responsibility. I was seeing them for this other thing. But I did provide the plurality of their E&M services that year. And so it was fairly devastating. And fortunately it didn't adjust my payment too much. But it was a pretty interesting example of how you can be hurt by that.

CO-CHAIR LAMB: I'm delighted to have

this topic on the table. It's been on the table and off the table primarily I think because of the concerns about unintended consequences. And it's really complex. And the connect to payment makes it even more complex.

So the question that I have is the commitment to see this through, because if I just take the example of team-based care and we've been talking all day about the fact that diverse team members are involved. And as we deal with that, not all team members are qualified providers and eligible to participate in programs. We heard that with MIPS. You know, we see that with using the care coordination payment codes is it gets into some very sticky ground.

So it's essential to measurement. But, you know, I guess the bigger question, and I don't know that you can answer it, is when it gets into that sticky place that has very significant cost implications, what are we going to do with it, because I've been on committees that have really tap danced towards this and then

dropped it because of those issues. Jim, and then Alan.

MEMBER LETT: This one's going to be real easy I can tell you. What I will do is give you a model of what we did. I served -- funny you should mention, Alan, the OIG report on post-acute harm and readmissions back to the hosp. But I served on the physician workgroup that evaluated the charts. And we got into attribution, obviously, when somebody goes from acute to post-acute, whose fault is it, particular around Dlostridium difficile infection. That was a 12-rounder.

And the only way that we found that things could get decided was you had to basically set criteria, whether people liked them or not, and get those criteria from basically an infallible source, that you may disagree with it, but you respected it. And it was applied evenly to every case of CDI.

And we ended up going to CDC and having a phone conference with them about, okay,

tell us about the disease, tell us about how long before symptoms show up and diarrhea begins in post-acute care, after which it is post-acute care's attribution, before which it is the acute side.

So, looking at that model, I don't see a simple way, other than setting up some, probably some TEPs with people from -- if you're thinking about readmissions from SNF, with skilled nursing facility people, hospital side people, and hospital and SNF personnel, because, boy, it takes a village in both those places to -- I can write the best order set in the world, but if the orders aren't taken off or the nurse doesn't turn the patient or, or, or, or.

So I think you're going to have to, along the model I'm talking about, get some infallible sources that everybody will agree, okay, I may disagree with the decision, but I respect the source of it, and apply them for what it's worth.

(Off mic comments.)

MEMBER LEVITT: This is Alan. Another thing that keeps me up at night is attribution. I wish I had the report, because the beginning of the report I remember talked about the fact that, you know, we seem to live in the world of siloed care and that, you know, the idea of attribution is that, as in quality, whenever we do root cause analysis, anything like that, that's a system approach that's really, you know, that there are pieces of it that likely are including those who are taking care of the patient.

Anyone who says that they're, you know, I have no attribution to something in terms of a bad outcome, likely it doesn't have attribution to a good outcome, too. And so, you know, if they're not really, you know, involved in either good or bad, why are they involved in the first place?

The problem is really the model not the attribution. It's trying to develop the model that is, can best show this and demonstrate this fairly. And there is no easy answer to try

to figure this out.

But I think we all have to accept the fact as a community that, you know, attribution does exist and that we need to figure out better ways of being able to define that and to measure that so that we can, you know, fairly measure performance based on, you know, these sorts of outcomes.

(Off mic comments.)

CO-CHAIR MULHAUSEN: Can I respond to that, because I think, Caroline, you're on to something here? But I have a very different --

(Off mic comments.)

CO-CHAIR MULHAUSEN: I am a primary care provider, geriatrician. And what I see out of that experience, which I admit was very painful for you, is an incentive program asking you can you do this differently. Can you and I become a team? And, of course, we can't because you're in Houston. But can you and I become a team where I, we start to co-manage people together? Then I'm very happy to take sort of

the --

(Off mic comments.)

MEMBER LEVITT: Right. I just would also remind you in this discussion that, you know, the attribution we're talking about is not, you know, provider specific attribution that you were talking about, that it's really program, you know, in terms of a provider who is a setting-specific.

CO-CHAIR LAMB: Heather, and then Raj.

MEMBER SMITH: I'll try to keep my comments brief. I do think this is a complex topic. I don't have solutions. I do think that in trying to solve this, though, we should strongly think about piloting so that we can better examine potential unintended consequences. I mean, I've certainly heard radical things, like if you touch the patient, you get the attribution for the measure. And then everyone has skin in the game. So, you know, that brings attention to it.

I don't know that that type of thought

process is the right way to go about it. But I do know that there are definitely providers like physical therapists who are, don't have any cost measures, you know, anything that uses an E&M code for an attribution methodology were left complete out of.

And I don't think that that's right, because our providers, then, lack feedback and don't see the full picture of what's going on and some of the pressures that their colleagues are under.

And so, you know, I do think this is complex. I recognize when you tie it to payment it takes, you know, it goes to a different level. But ultimately, these measures are here so that we can improve the quality of care to the patients that we serve. And, you know, getting that information to providers is what helps to make that change. And so it's important for that reason as well.

And so, again, I think of things like, you know, is there someplace that's doing this

well or has ideas and could that be pilot tested so that we can get some better answers to these questions.

MEMBER MAHAJAN: Thank you. So I do want to talk about physician attribution into the MIPS program or before that. And so we all know that the value modifier and what happened to the physician. And I am always embarrassed to show my QRUR, because I am top at quality but the cost is high because I'm 80 percent post-acute long-term care practice.

So, and we were all kind of relieved a little bit when site 31, which is short-term, was out from attribution. But 32, which is long-term care, still stays in.

And we have big groups that have lost of millions of dollars because of the value modifier adjustment. And we thought, you know, with MIPS, since cost was out, it will be good and we'll eventually figure something out.

And then, you know, boom, comes 2018 final rule and cost comes back. And methodology

is still not the new one, but it's the old methodology, which is the value modifier on methodology.

So, for us, we still are responsible for the cost of taking care of these vulnerable patients.

So there is a hope somewhere. I don't, I am not, and the devil is in the detail about how do you get compensated additional for complex care management, which is there in the 2018 rule. But, you know, how do you calculate that for nursing home docs?

And then, so, yes, we are at -- that's a double-whammy. Not only you're taking care of this vulnerable population, but you're getting punished for doing that because of the way the cost is attributed to you.

And then on the suggestion side is I think 31 level of care is right to be an APM, and so whoever wants to look at it and help people develop something. And I think based on either utilization numbers or peer quality numbers or a

combination of that, it could be a very -- but folks that practice in that site do not have an association that is, you know, just loaded with resources to do all that kind of work.

So, but you're talking about folks that take care of this vulnerable population in the setting that is fairly expensive to CMS.

CO-CHAIR LAMB: We have two more folks with their signs up. So let's give the last comments to Deb and Theresa. And then we're going to wrap it up.

MEMBER SALIBA: So this expands a little bit on the last comment and simply to say that we tend to take an approach with these measures of looking at single conditions like heart failure or COPD. And we really need to be thinking about the complexity of a lot of these patients, not just in SNF but in hospital and in outpatient and across care settings.

And I know I'm making it even more complicated to do the measurement. But it's going to be really important for really

understanding the outcomes in this population.

MEMBER SCHMIDT: I agree with that. And I also wanted to kind of build on Raj's comments about alternative payment models. As we move toward more of the population health initiatives, more and more it will be shared accountability. And it's kind of yours, mine, and but now we're in the territory of ours, right, so with shared savings and approaches.

Even taking off my hospice hat, putting on my post-acute hat, I remember when hospital readmissions started being measured, I was working with a lot of nursing homes. And we were trying to do everything we could to reduce readmission rates of their patients so they could be what we were calling providers of choice in their communities.

So, even though the hospitals were being held accountable and the patients attributed to them, at that time we were already looking ahead to taking responsibility for moving those rates.

CO-CHAIR LAMB: So, Erin, you're going to send out that paper to all of us. And what are our options for continuing to think together?

MS. O'ROURKE: Yes, this is excellent. And thank you for these thoughts. This has been great as we start to develop the second paper.

So we'll get you all the second paper and maybe send these questions via email. If you've got some extra time and want to give the paper a read and send us some input, we would greatly appreciate it.

I think we'll look into what's feasible as far as maybe scheduling an optional call if anyone wants to join. But I do need to check that we have resources available. But, at the minimum, we'll the paper and would love your thoughts via email if you are willing to generously donate more of your time to NQF.

Yes, so I think that is our, is it for what we needed to get through for the day.

(Off mic comments.)

MS. O'ROURKE: Let's do one more

public comment and then let Paul and Gerri summarize. And we'll go through the next step. Operator, is there anyone on the phone who wants to make a public comment?

OPERATOR: Ladies and gentlemen, if you'd like to make a public comment, press star 1 on your telephone keypad, again, star 1 for a public comment.

MS. O'ROURKE: Anyone in the room?

(Off mic comments.)

MS. O'ROURKE: I appreciate you keeping me honest on the comment period, Alan. So I think with that, let's turn it to our co-chairs for their thoughts on the day.

OPERATOR: Apparently, no public comments.

CO-CHAIR MULHAUSEN: This has been a wonderful day, excellent discussion. We managed to accomplish our one action item. And we managed to think strategically about how we can help CMS move forward and improve measurement of quality in the setting that we're expert in and

that we love so dearly.

I want to thank Gerri for helping me through the whole thing. Apologize for my absence seizure somewhere around 3:30 this afternoon. I've recovered with a little Diet Coke. Anyway, and it's been a pleasure to work with you today. So thank you.

CO-CHAIR LAMB: Let me add thanks to all of you for hanging in and the folks that couldn't. It's been a really excellent day. The range of topics that we've covered are truly amazing.

I also want to thank the NQF staff for arranging all of the dialogue opportunities that we've had. You were wonderful. Thank you to CMS. Thank you, Alan. Thank you, Pierre. Thank you, Liz. Thank you, all the folks who came in to talk to us.

I'd just like to return, as Paul has. We had two goals. We accomplished both. One was to give our advice on MUC, which we did. Two was to think strategically together and look to the

future.

So thank you for a very, very productive day. And I'm going to look forward to continuing this discussion and really looking at the gaps in how we can move the field forward. So thank you.

(Applause.)

MS. O'ROURKE: Pierre, did you have a comment?

DR. YONG: Yes, yes, sure. I just wanted to add my thanks and pile on.

But in particular, I want to thank all of you for volunteering and taking time out of your very busy schedules to spend time with us not just today but across the webinars and other feedback that you put in, the time you put in. So thank you very much. We really do appreciate it. And we really do consider it seriously as we go through our internal process.

Also I do want to thank Gerri and Paul for their efforts in facilitating the entire effort for this workgroup this year. Wanted to

thank NQF staff, Erin, Taroon, Jean-Luc, and Miranda.

And then you've met a number of CMS staff today. But there's a literal army. And I do want to thank them, because without them this, all the work that you saw and sort of, would not have been possible.

But so I just want to thank them, including Stace Mandl, Mary Pratt, Alan Levitt, Tara McMullen, Chris Gross -- I told you it was an army -- Lorraine Wickiser, Kelly Miles, Cindy Massuda, Carol Schwartz, Joan Proctor, Maria Durham, Michelle Geppi, Helen Dollar-Maples, Brendan Loughran, Nidhi Singh-Shah, and Sophia Chan.

But without all of them, they all touch different pieces of the MAP process. So they were all critical to making this a success. So thank you all.

(Off mic comments.)

(Laughter.)

MS. O'ROURKE: It all goes to Pierre.

So just to add our thanks. I don't want to belabor it and keep you all from missing your flights. But thank you all again. We depend on you every year to generously give of your time and come here and provide us with this excellent input. So thank you very much.

And thank you especially to Paul and Gerri for expertly leading us through that meeting. We very much appreciate your continued efforts and all the work you did with us to get to today. So thank you very much.

(Whereupon, the above-entitled matter went off the record at 4:53 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 Wkshp
Measure Applications Partnership

Before: NQF

Date: 12-13-17

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