

THE NATIONAL QUALITY FORUM

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STEERING COMMITTEE ON NATIONAL VOLUNTARY
CONSENSUS STANDARDS FOR NURSING HOMES

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MEETING

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THURSDAY

APRIL 22, 2010

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The Steering Committee convened in
Salon 2 at the Bethesda Marriott, 5151 Pooks
Hill Road, Bethesda, Maryland at 8:45 a.m.,
David Gifford and Christine Mueller, Co-
Chairs, presiding.

PRESENT:

DAVID R. GIFFORD, MD, MPH, Co-Chair

CHRISTINE MUELLER, PhD, RN, FAAN, Co-Chair

ALICE BELL, PT, GCS

BRUCE A. BOISSONNAULT, MBA

HEIDI GIL, NHA, CCM

TOMAS GRIEBLING, MD, MPH

SISTER MARY ROSE HEERY, BSN, RN

MARY JANE KOREN, MD, MPH

BILL KUBAT, MS

BETTY MacLAUGHLIN FRANDSEN, RN, NHA, MHA,
C-NE

ARVIND MODAWAL, MD, MPH, AGSF, FAAFP

NAOMI NAIERMAN, MPA

KATHLEEN C. NIEDERT, PhD, MBA, RD, NHA

DIANA ORDIN, MD, MPH

PATRICIA A. ROSENBAUM, RN, CIC

PRESENT, CONTINUED:

RONALD SCHUMACHER, MD, FACP, CMD

DARLENE ANNE THOMPSON, RN, CRRN, NE-BC

LISA TRIPP, JD

ROBERT A. ZOROWITZ, MD, MBA, CMD

NQF STAFF:

HELEN BURSTIN

DEL CONYERS

EMMA NOCHOMOVITZ

SUZANNE THEBERGE

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

8:52 a.m.

MS. THEBERGE: Good morning,
everyone.

You should have received expense reimbursement forms by email earlier this week. If you didn't, please email me and let me know. And those should be submitted to Leslie Reeder-Thompson, our meetings person, who you received all the logistics emails from. If you have any questions about that process, send Emma or I an email and we'll help you sort through that.

And for the airport, we have a shuttle leaving the hotel at 2:30 from the front lobby that will take people to Reagan National Airport only. And if you are going to Dulles or BWI, you can get a taxi up front at the bell stand up front. And if you have any other questions about transportation, please let me or Emma know.

Any other questions regarding

1 transportation?

2 (No response.)

3 MS. THEBERGE: All right.

4 CO-CHAIR MUELLER: Well, we are
5 seeing the home stretch. We're going to get
6 there eventually.

7 I want to compliment all of you
8 yesterday on the good job that you did in
9 engaging in the process. I was wondering if
10 there were any reflections that you've had
11 over the night about any ways to improve the
12 process.

13 Mary Jane?

14 DR. KOREN: One of the things that
15 I really would want to get first of all is all
16 the measures well in advance like ten days,
17 two weeks in advance because it really lets
18 you then put the ones that you're reviewing in
19 context and also then be I think a more
20 informed participant in the discussion and
21 certainly in the voting.

22 MS. NAIERMAN: But not just the

1 measures. The voting -- the recommendations
2 by the reviewer maybe not two weeks or ten
3 days, but certainly a couple of days in
4 advance so that we can review what the
5 reviewers have said and chime in in a more
6 informed way.

7 CO-CHAIR MUELLER: Okay. Anything
8 about the process we went through yesterday --
9 how we could improve that? Go ahead.

10 DR. ZOROWITZ: I was a little
11 curious as to how some of these evolved to get
12 to the point where we were voting on them --
13 the first measure, the dementia measure. I
14 think many of us were rather surprised that
15 this was in no shape really to be in front of
16 the committee. And I was curious as to how it
17 got to that point without someone pointing out
18 that the numerator/denominator had nothing to
19 do with the title of the measure.

20 I think it was a little disturbing
21 and I felt bad for Jackie presenting it, kind
22 of walking into a buzz saw.

1 CO-CHAIR MUELLER: Yes, yes.

2 We'll just take that as a comment,
3 or do we have any response? Because I don't
4 --

5 CO-CHAIR GIFFORD: I want to get
6 back at Jackie because she's gotten me a few
7 other times. No.

8 (Laughter.)

9 DR. BURSTIN: In general, we do
10 try to send all the materials out -- all the
11 measures out in advance. For some reason that
12 didn't happen. And we'll make sure that that
13 does happen routinely.

14 Getting the information back from
15 you quickly and having to turn it around is
16 really a challenge, as you saw. So we've been
17 trying to make it as early as possible. You
18 guys get the information and can get the
19 information back to us. But that, to be
20 honest, continues to be a real struggle to get
21 it back in advance so we can share it back
22 with you. But if nothing else, we do try to

1 routinely get the entire set of measures out
2 as quickly as possible.

3 We do screen the forms. And
4 again, I think in screening it the staff
5 mainly looks for completeness.

6 Is there anything missing we need
7 to go back to? We obviously need to add a
8 little quality check to say complete but
9 actually logical. Is there something really
10 just wrong here? We usually rely on
11 committees to do that. But we'll just have to
12 do some more internal processing to make sure
13 that doesn't happen.

14 CO-CHAIR MUELLER: Thank you,
15 Helen.

16 MR. BOISSONNAULT: Can I jump in
17 with one?

18 I hate to be contrary, and I
19 wanted to say something that you should do
20 again, which is those little memory stick
21 things. I mean, I would like to get it in the
22 mail. But that is so much better than like

1 getting miscellaneous emails or going to
2 websites and trying to sort of figure out
3 where Measure 001 is, because I end up
4 printing out 1600 pages. And it costs a lot
5 to shred it.

6 The way that little memory stick
7 was laid out, you don't need to print it out.
8 I mean, it really is so easy to navigate. I
9 think that was a huge plus.

10 The other thing that I would keep
11 and maybe even go further on -- and this is a
12 questionnaire issue -- sometimes we focus a
13 lot on the numerators and denominators and are
14 they the right ones. And we gloss over really
15 important issues on who owns the data, how
16 will the data come. The issue of MDS 3.0 was
17 really central yesterday, and also the fact
18 that they essentially passed a law saying
19 we're going to gather certain data had, I
20 think, relevance to our discussion.

21 And so those sorts of au courant
22 things -- being au courant on the ownership of

1 the data, I think that NQF did a really much
2 better job this time on that whole thing of
3 who owns the data and how are we going to deal
4 with it. And I would even say that almost
5 should be one of the issues --
6 numerator/denominator data ownership and
7 structure -- because that third point was
8 completely in there but not as its own
9 category like how are we going to get the
10 data.

11 CO-CHAIR GIFFORD: On a minor
12 piece, you reminded me. Dede brought it up
13 yesterday.

14 I'd prefer to see the denominator
15 definition first, then the numerator as many
16 people actually try to put the denominator
17 definition in with the numerator definition
18 because you don't understand it until you see
19 that. And just seeing that order helps
20 understand that it's usually what's the
21 eligible and then what are we dividing it
22 into.

1 MS. BELL: Just one more thing,
2 and this speaks a little bit to having the
3 information more in advance.

4 Yesterday, the question was asked
5 at the end were there other measures that we
6 might consider. And I think although the
7 information shared was very good, having a
8 night to even reflect on it, I've thought of
9 other things. And had I had all of the
10 measures in advance and not one component of
11 what I was thinking about is in the context of
12 all the measures we're reviewing, what else
13 might we consider. I think that would be
14 helpful too.

15 CO-CHAIR MUELLER: All right.
16 Thank you for that feedback. And we'll get
17 started.

18 So we're going to start with
19 function measures. And actually we're talking
20 about urinary incontinence and nutrition and
21 activity today.

22 So our presenters I believe are

1 from RTI. I'm sorry. NCQA. Right.

2 DR. BURSTIN: While Sue's getting
3 up to the mic, this is actually a measure
4 that's up for maintenance. It's already been
5 endorsed for the last three years. We're
6 bringing it to you to get an expert consensus
7 of whether it should still remain in the
8 portfolio.

9 CO-CHAIR MUELLER: It's 030, or
10 0030. So on this grid, it's the very last
11 one.

12 And are you from NCQA?

13 MS. MILNER: Yes. I'm Sue Milner.

14 CO-CHAIR MUELLER: Okay. So if
15 you'd just introduce yourself and then you can
16 get started.

17 MS. MILNER: Sure. I'm a senior
18 research scientist in the Performance
19 Measurement Division at NCQA. And I do a lot
20 of work with our geriatric measures. This is
21 one of that particular measurement set.

22 The measure is called Management

1 of Urinary Incontinence in Older Adults. It
2 is one of several measures that we have that
3 is included in the Medicare Health Outcome
4 Survey which is a survey instrument that you
5 discussed about two days ago.

6 There are two items -- questions
7 that are included in this survey. The first
8 deals with the percentage of Medicare members
9 65 years of age and older who reported having
10 a problem with urine leakage in the past six
11 months and who discussed this problem with a
12 practitioner. And the second measure involves
13 the proportion who had a urine leakage problem
14 in the past six months who actually received
15 treatment for that problem.

16 This has been a measure that's
17 been included in the Medicare Health Outcome
18 Survey for several years now. It underwent
19 cognitive testing several years ago when it
20 was first included. Our Geriatric Measurement
21 Advisory Panel has reviewed the measure I
22 believe twice since the measure was created,

1 most recently last year. And we've given you
2 several years' worth of results for this
3 measure.

4 What we see is that there
5 unfortunately hasn't been a lot of movement in
6 terms of Medicare Advantage Plan members or
7 SNF plan members on this measure in the past
8 several years. For the first part, discussion
9 of urinary incontinence, most plans report
10 about 55 percent of people discussing this
11 issue with their provider. The treatment
12 unfortunately is not nearly so good. Really
13 only a third of patients who have a problem
14 with urinary leakage actually receive
15 treatment.

16 So we feel that there's a strong
17 need for this measure, and that plans and
18 providers should be working more closely with
19 patients to engage them in order to get more
20 people into treatment and get more people
21 aware of this problem.

22 So I'll stop there. You have a

1 very long measure work-up. And I'd be happy
2 to answer any questions that any of you have.

3 MS. NAIERMAN: Could I ask a
4 question, please?

5 How will this apply to people with
6 dementia? We're talking about nursing home
7 settings.

8 MS. MILNER: Those folks would be
9 screened out by the Medicare Health Outcome
10 Survey instrument. So you have to be
11 cognitively able to fill out the instrument or
12 respond on the telephone.

13 CO-CHAIR MUELLER: Mary Jane, I
14 believe you're the first reviewer on this. So
15 we look forward to hearing what you have to
16 say.

17 DR. KOREN: Well, I will begin
18 with a disclaimer which is I am not an expert
19 in this area. But fortunately the second
20 reviewer is an expert. So he will fill in for
21 you where I have gaps.

22 Overall I think, as we discussed

1 yesterday, the importance is high. I mean,
2 this is not only a clinical issue. This is a
3 quality of life issue. And I think that the
4 fact that it is a measure has been used. And
5 so we know that it does meet a need.

6 What is interesting is that while
7 there's not a huge spread between sort of the
8 worst and the best providers in this area,
9 even the best aren't that good. So there is
10 I think really a lot of room for improvement
11 in this area. Obviously, it is evidence-
12 based. And there's sort of good relationships
13 to outcomes.

14 The thing that I really liked
15 about it was I think often when we talk about
16 treatment we sort of automatically think about
17 pharmacologic, but that there are some very
18 even non-invasive -- I just learned last night
19 -- some very non-invasive procedures that can
20 be done that really can pretty much improve
21 urine leakage. So I think that tied to this
22 needs to be a big educational push to get

1 people aware of that.

2 This measure is harmonized with
3 other similar measures. The other thing
4 that's nice about this one as opposed to some
5 of the others is this is for both genders --
6 male and female, not just female. The measure
7 is very well defined and very precisely
8 specified. So we don't have a problem there.

9 One of the things though that I
10 was concerned about was that we now -- I mean,
11 this is a measure that's being used and in
12 existence -- but in many instances, it doesn't
13 seem like any kind of an analysis has been
14 done about how has it worked out, has there
15 been any testing of the measure's properties
16 since it was endorsed. And there are I think
17 perhaps things to be learned if people had
18 sort of analyzed some of the data of the
19 experience with this particular measure.

20 I also was looking at the
21 applicable care settings, and I had the same
22 question that Naomi did. This is for a

1 nursing home population. And we do know that
2 the presence of dementia is fairly high, which
3 still doesn't mean that people can't answer a
4 questionnaire appropriately worded and
5 administered. So I think that we have to
6 realize that dementia is really a long
7 spectrum of disability. It's not an all-or-
8 nothing phenomenon. And so we really have to
9 be sure that people with dementia, even a
10 fairly significant or moderate amount, are
11 queried so that they can tell about it or talk
12 about it -- bring it up. So that was an issue
13 there.

14 Again, it hasn't been tested for
15 any unintended consequences, any kind of
16 background of how did this work. And so I
17 would hope that that would have been done.

18 But I'm going to stop there
19 because as I said, I think Tomas can probably
20 tell you a lot more about this measure from
21 the sort of the technical end of it.

22 DR. BURSTIN: And actually before

1 Tomas weighs in, I just want to emphasize this
2 is a measure for maintenance. It's not
3 specific to nursing homes. We just thought
4 you guys knew a whole lot about incontinence
5 and we'd take advantage of you being together.

6 DR. KOREN: Okay.

7 DR. BURSTIN: I think the primary
8 use is in fact in the ambulatory care space,
9 although it's applicable across a wide range
10 of settings.

11 DR. KOREN: That's right.

12 DR. BURSTIN: Okay.

13 DR. KOREN: So it's Medicare
14 Advantage Plans and also SNF plans, many of
15 whom are institutional SNFs.

16 DR. KOREN: It's interesting I
17 think that to the extent that you could get
18 this used in assisted living would be really
19 helpful because often continence is one of the
20 discharge break points for assisted living.
21 So the ability to control incontinence in this
22 population is critical for where they're going

1 to live.

2 DR. ORDIN: I'm sorry. I'm
3 reading it now for the first time. Maybe you
4 were going to do this, Tomas.

5 So the denominator is people who
6 say they have either a big problem or a small
7 problem -- any problem?

8 MS. MILNER: I'm sorry. I don't
9 have the survey questions.

10 DR. ORDIN: It says they answer
11 yes. And then the next question, did you have
12 a problem in the past six months. And then it
13 says how much of a problem if any was the
14 leakage for you. And the answer is either a
15 big problem or small problem.

16 Are both those populations
17 included in the denominator?

18 MS. MILNER: Yes. Those are
19 summed to include --

20 DR. ORDIN: Okay. And in the
21 numerator --

22 CO-CHAIR GIFFORD: It's answer

1 question 42 or 43. It's yes or yes to either
2 one. You're in the denominator. It's not yes
3 and yes. It's yes or yes.

4 DR. ORDIN: Well, I think if you
5 answer yes to 42, I assume that you go to 43,
6 right?

7 DR. GRIEBLING: That's how I
8 interpreted it.

9 Basically --

10 CO-CHAIR GIFFORD: So it's yes and
11 yes, not yes or yes.

12 DR. GRIEBLING: Right. I think
13 the denominator is everyone with incontinence.
14 And then 43 tries to do a sub-analysis and
15 stratify them by whether they have a small
16 problem or a large problem.

17 DR. ORDIN: Okay. But the measure
18 has both.

19 MS. MILNER: I can get back to you
20 on that. I unfortunately didn't bring the
21 correct file with me which lists precisely
22 what the questions are and so forth.

1 DR. ORDIN: And my other question
2 is to receive urinary incontinence treatment,
3 is there a specific question on that? Because
4 -- I'm sorry. Is this two measures? Is this
5 one measure? Maybe you can --

6 MS. MILNER: Yes. I believe that
7 that is clarified for the respondent. So in
8 other words, they're given some suggestions as
9 to precisely what treatment means.

10 DR. ORDIN: Okay. So they have to
11 have talked to their provider about it. And
12 then underneath that is like I chose not to --
13 no treatment recommended, I chose not to have
14 treatment, I had one or more of the following
15 treatments -- something like that?

16 MS. MILNER: No. It's not a
17 matter of whether they selected treatment or
18 not. It's whether they received it.

19 DR. ORDIN: Okay.

20 DR. GRIEBLING: So I would echo
21 Mary Jane's comment about this incredibly
22 important problem. I think the science behind

1 this is very strong.

2 The data that you have from the
3 ambulatory setting is very good. And I think
4 that certainly this would be applicable to
5 both assisted living and to skilled care.

6 The other benefits, it is looking
7 at both genders which is very good. The PARI
8 measure, which is an ambulatory care, is
9 focused specifically on women right now. And
10 actually as a urologist, I'm participating in
11 that. So we report on that. So that measure
12 is all women over the age of 65 -- have you
13 asked them about incontinence, which is
14 basically what this does.

15 The numerator has two components.
16 So it's have you discussed it, and then have
17 you had treatment for it.

18 I think there's some feasibility
19 issues. And Mary Jane and I discussed this
20 just a little bit. I think part of it is
21 collecting the data because this won't be
22 captured necessarily in MDS. This is going to

1 have to be collected separately. So there may
2 be some feasibility issues. You'll have to
3 get that either from the records, from the
4 care provider or through survey from the
5 residents -- whether they've actually
6 discussed it with a provider and then whether
7 they've had treatment for it.

8 Treatment is also very broadly
9 defined with this. So it could be behavioral
10 therapy, it could be pharmacotherapy, it could
11 be surgical therapy. And so I guess that
12 would be my question, if there's going to be
13 more of a definition about treatment or if
14 it's going to be very broadly examined.

15 MS. MILNER: Well, our goal in
16 part because of the length of the medical
17 outcome survey and the fact that it's a survey
18 that deals with a number of issues is to be
19 broad. So the focus of the survey is not just
20 incontinence.

21 DR. GRIEBLING: I think the other
22 thing is it certainly harmonizes with other

1 measures in other settings, which is something
2 that we talked about being a goal for NQF. So
3 it harmonizes with the PQRI measurements in
4 ambulatory care yet harmonizes with the A cove
5 measurements incontinence and the guideline's
6 recommendations.

7 MS. NAIERMAN: Can I ask a
8 question?

9 How do you see this applying to
10 people who cannot report as it were if their
11 dementia is such? So if this is self-reported
12 or if the inquiry is with the residents, do
13 you see that population being left out of this
14 kind of survey?

15 DR. GRIEBLING: Potentially. And
16 I think that's one of the potential
17 disadvantages here. And again, I would seek
18 advice from our sponsor about that.

19 Certainly the people that have
20 cognitive impairment or mobility impairment
21 will be people who are at higher risk. And so
22 I worry that we're going to be losing that

1 higher-risk population in this because those
2 are people who may benefit most from
3 discussing it, and even if they can't discuss
4 it, having it brought to the awareness of
5 their care provider -- the clinician -- so
6 that there could be some kind of treatment
7 offered. Because even patients with cognitive
8 impairment or mobility impairment may benefit
9 from some types of therapy -- assisted
10 toileting, those types of things.

11 MS. NAIERMAN: So just a follow-up
12 question, does that mean then in a sense that
13 if a nursing home is being judged as it were
14 or rated by a consumer about the quality of
15 care, will the data then be skewed in a sense
16 because there's perhaps more frequency of this
17 problem in a population that is high risk, the
18 consumer may not be able to get the
19 information on the full extent of the problem?

20 DR. GRIEBLING: I think that is a
21 significant concern for this. And I think
22 that's part of having taken a measurement that

1 was developed initially for ambulatory care
2 and extrapolating and moving it into a
3 different care setting. So I think that
4 caveat has to be taken into account when
5 you're looking at this patient population.

6 DR. ZOROWITZ: Just as a point of
7 clarification, are we voting on this
8 specifically for use as a nursing home
9 measure, or are we voting on it for other
10 purposes -- as an ambulatory measure? Because
11 as a nursing home measure, I think we're kind
12 of understating the usability and feasibility
13 problems. And considering the fact that 50,
14 60, 70 percent of nursing home residents have
15 dementia and that incontinence is a team
16 issue, it's not a matter of discussing it with
17 your provider. It's kind of putting a square
18 peg into a round hole. So I'd just like a
19 little clarification.

20 DR. GRIEBLING: And I think that's
21 actually a very good point. I mean, when I
22 was going out into nursing homes, one of the

1 questions we'd often get asked by the director
2 of nursing is are you going to see everyone of
3 our patients -- everyone of our residents or
4 everyone of our incontinent residents. And my
5 answer was no, I don't think that's
6 appropriate. You already have things in place
7 that allow you to screen for this and to
8 potentially treat it.

9 So I agree that that's a question
10 of whether talking to a physician specifically
11 is the specific issue.

12 MR. BOISSONNAULT: I was -- go
13 ahead, Helen.

14 DR. BURSTIN: Again, this is a
15 little bit of a different measure. It was not
16 submitted specifically for the nursing home
17 project. It was not specific to nursing
18 homes. We put it here because the level of
19 measurement and analysis that NCQA proposed or
20 that the settings for which it's applicable
21 includes nursing homes. So you wanted to take
22 advantage of your know-how.

1 But I do think it would be
2 reasonable feedback. Think about this in the
3 broadest sense of the word -- ambulatory, home
4 health, assisted living, whatever the case may
5 be. If there are specific issues with the
6 nursing home, it'd be a very logical question
7 back to NCQA for them to respond back about
8 how this has worked as part of the work you've
9 done with the nursing home community and how
10 well this has been tested specifically for
11 nursing homes.

12 But I think the intent here was to
13 get your expertise particularly on the
14 evidence, and is this a logical way to
15 approach the issue for the broadest possible
16 population. And if there are specific
17 concerns about nursing homes, that would be
18 really helpful to hear.

19 MR. BOISSONNAULT: If I can just
20 jump in.

21 So this is the illustration that
22 makes the point I was saying before about the

1 data because I think feasibility when they ask
2 the measure developer, this is a required
3 field or set of fields from what CMS -- if
4 it's ambulatory patient in Medicare Advantage,
5 this is an already existing form that needs to
6 be filled out. It's not new work for the
7 providers if it's a Medicare Advantage
8 patient, correct?

9 MS. MILNER: Well, let's take a
10 step back.

11 So CMS for Medicare Advantage and
12 special needs plans requires that those plans
13 complete the Medicare Health Outcomes Survey.

14 MR. BOISSONNAULT: On every
15 patient who falls in that category?

16 MS. MILNER: No, not on every
17 patient.

18 The way the survey works is we
19 pick a rather large cohort. And we follow
20 them for two years. And they're asked the
21 same series of questions during each year.
22 So it's a sample from each Medicare Advantage

1 plan and each SNF plan.

2 Now it just so happens -- again,
3 most of the population that is reporting this
4 measure on the Medicare Health Outcomes Survey
5 is a non-institutionalized population. There
6 happen to be some special needs plans that are
7 institutional SNFs. So those individuals, if
8 they're mentally capable of filling out the
9 survey on a piece of paper or they have a
10 telephone and we can follow up with them that
11 way will be in the sample frame and will
12 complete the survey.

13 But I mean, CMS is really
14 assessing largely ambulatory people in the
15 Medicare Advantage and SNF population with
16 this particular measure. That's the cohort
17 that it's aimed at.

18 MR. BOISSONNAULT: I like it more
19 after asking you the question and I'll just
20 say why. This is not a measure of provider
21 performance. This is a measure of plan
22 performance which is why you are representing

1 who you do.

2 And so, the applicability to
3 nursing homes because of the database
4 definition that we're drawing from is actually
5 not an issue because we're not asking for a
6 measure that would work potentially with the
7 sampling methodology that you're describing in
8 the nursing home setting. There may be parts
9 of this definition. But the data -- the
10 questions when you dig into them say that this
11 is a measure of planned performance, and
12 therefore -- with all due respect -- I
13 actually think this is not. And I still think
14 we can vote on it.

15 But my caveat would be with
16 respect to Robert's comments. Feasibility may
17 be N on this one in the nursing home
18 environment because we don't gather the data,
19 right?

20 DR. ZOROWITZ: There are MDS 3.0
21 questions about incontinence. And I don't
22 remember what they are off hand.

1 But it's collected in a very
2 different way a) because of the high degree of
3 incontinence and the high degree of dementia.
4 Much of the information about urinary
5 incontinence is gathered observationally by
6 staff rather than by asking the patient. And
7 it is in the MDS 3.0.

8 So there is a mechanism for
9 gathering the data in the nursing home. But
10 this is not a feasible way of doing it in the
11 nursing home. And I think this is an
12 excellent measure for the ambulatory
13 environment.

14 But I mean, I would ask Ron with
15 Evercare, for instance, a high percentage of
16 Evercare patients -- Evercare is essentially
17 a SNF.

18 MR. BOISSONNAULT: I just want to
19 unplug myself from the conversation and say
20 I'm very comfortable with this as an NCQA
21 measure. Unless something comes up, I'm not
22 comfortable if we're voting on it as a

1 provider measure -- period -- for nursing
2 homes.

3 DR. BURSTIN: Let me try it one
4 more time. I'm sorry. I don't think I was
5 clear.

6 We're using you really as more of
7 an expert panel here about a measure for which
8 we think you're going to know a whole lot of
9 stuff.

10 It really is an issue. This is a
11 health plan level measure that NCQA does.
12 They do specifically indicate in their form to
13 us in that measure submission that applicable
14 care settings would include nursing homes.

15 But again, it's a level of health
16 plan performance. You're not voting on it in
17 terms of its entry into the nursing home set.
18 So it's more of a broader conversation about
19 the measure. We'll then move it on to our
20 consensus, then approval committee who will do
21 the final maintenance decision.

22 We're using you as an expert

1 panel. So take it from that perspective.

2 I do think it's important
3 information back to NCQA since they've checked
4 that applicable care settings would include
5 patients in nursing homes that it probably
6 needs more study in terms of how you could use
7 -- that's what it says on the form. It does
8 say --

9 MS. MILNER: Right. But Helen,
10 that's because they're institutional SNFs.
11 And there are some people in the sample frame,
12 and in the sample each year who are in nursing
13 homes.

14 DR. SCHUMACHER: Right. So if --

15 MS. MILNER: We're not saying
16 there are a lot.

17 DR. SCHUMACHER: If I could just
18 comment then.

19 So it doesn't seem like it would
20 be a very useful measure for institutional
21 special needs plans who exclusively enroll
22 people who live in nursing homes. It doesn't

1 seem like it would be a very good way to get
2 information about those residents. It might
3 be a good measure for people who live in the
4 community, but not for institutionalized
5 residents because of the way the data is
6 obtained.

7 And I think part of that is
8 cognitive status of the residents. The other
9 part is just a practical matter of how do you
10 survey nursing residents. Most of them you
11 can't get a hold of. You can't call them.
12 And many of them aren't going to be able to
13 fill out a survey.

14 MS. GIL: I would like just to add
15 that while I agree that probably a majority of
16 residents cannot be interviewed, we're really
17 pushing the individualization of care. And I
18 think we need to remember that as we think
19 about this very, very important proactive
20 issue with dealing with the quality of life
21 issue.

22 I think the assisted living on

1 what Mary Jane said is just an amazing place
2 to start this, test it, and really see. I
3 think the push for education that she also
4 mentioned we found in assisted living that are
5 proactively working on these issues. The
6 biggest barrier is the resident who doesn't
7 want to self-communicate or expose the
8 problem. So I think the education coming with
9 it is real important.

10 MS. MILNER: Well, I very much
11 appreciate the feedback. One of the things
12 that our Geriatric Measurement Advisory Panel
13 will be looking into this summer is the
14 development of measures around dementia. And
15 I can clearly see that incontinence is
16 definitely something that we want to explore
17 further in that particular population. So I
18 very much appreciate this discussion.

19 CO-CHAIR MUELLER: Just one point
20 of clarity for me. Currently do any nursing
21 home residents get a survey in the mail to
22 complete this if they're in a Medicare

1 Advantage Plan?

2 MS. MILNER: If they have an
3 address and the Medicare Advantage Plan has
4 it, then they're certainly eligible to
5 participate in the sample frame. And if they
6 respond either by mail or by telephone and
7 meet the criteria for the survey, then yes,
8 they can participate.

9 CO-CHAIR MUELLER: So the point
10 that I'm trying to get at is this could
11 potentially or has been potentially used with
12 nursing home residents already.

13 MS. MILNER: Yes, it has.

14 CO-CHAIR MUELLER: Have you ever
15 been able to pull out the data and see how it
16 looks compared to others or what kind of
17 response rate was received?

18 MS. MILNER: We haven't analyzed
19 the data at that level. Typically what we do
20 is we analyze the data at the aggregate plan
21 level.

22 CO-CHAIR MUELLER: Yes. But I was

1 just thinking --

2 MS. MILNER: But we do have
3 individual patient-level data. So yes, the
4 kind of analysis that you're talking about is
5 possible. And with funding, that's something
6 that we certainly would consider doing.

7 CO-CHAIR MUELLER: Okay.

8 CO-CHAIR GIFFORD: Any final
9 comments on this because we don't need to vote
10 on it? It's a feedback to a CSAC and --

11 DR. BURSTIN: We'll take it to
12 expert -- and we'll proceed. And I think the
13 feedback about use of it in nursing homes is
14 really helpful. So, thank you.

15 MR. BOISSONNAULT: I think it's a
16 great measure for comparing plans. I think it
17 is unfeasible at the nursing home level.

18 DR. SCHUMACHER: But again, it may
19 be a great measure for comparing plans except
20 for institutional-based plans that enroll only
21 people who live in nursing homes.

22 DR. MODAWAL: I just had a comment

1 about the treatment part of the new measure in
2 terms of how you worded it. And sometimes a
3 person may consider a tablet or some
4 prescription in a medication. And as you
5 know, a part of the treatment for incontinence
6 is also advice in terms of exercises and
7 Kegels and all.

8 And I wonder if treatment is the
9 right word. It could be advice or/and
10 treatment may be a better way to phrase the
11 second part because many persons may not like
12 to take tablets or have side effects, and they
13 may be doing some exercises and using other
14 forms of scheduled voiding and things like
15 that.

16 MS. MILNER: This is a good point.
17 And when the measure was originally developed,
18 we did a fair amount of cognitive testing with
19 patients in order to really try and understand
20 when we say the word treatment, what do they
21 perceive that to mean.

22 And the measure is phrased this

1 way because as a result of the cognitive
2 testing, that was the best way it was felt to
3 capture all of those treatment options. And
4 certainly Kegel exercises and advice and that
5 kind of thing have been a treatment modality
6 for a very long time.

7 So it's not --

8 DR. MODAWAL: So there was no
9 confusion on the part of the persons taking
10 the survey that a physician or a provider
11 mentioned you can empty your bladder every two
12 hours or just do some exercises, the same as
13 a taking a tablet or a medication for that?

14 MS. MILNER: Yes. When we did the
15 cognitive testing, we explored the degree to
16 which people understand exercises and kind of
17 physical and behavioral changes that they make
18 themselves to the treatment. And patients
19 perceived it that way.

20 DR. MODAWAL: Okay.

21 CO-CHAIR MUELLER: So not vote,
22 right? Okay.

1 Well, thank you so much. We hope
2 this was helpful.

3 MS. TRIPP: Actually, can I chime
4 in just quickly?

5 Since you came here seeking
6 feedback and not a vote, I was just wondering
7 if you had any questions for the panel because
8 I don't know if you asked any questions. But
9 before you left, I thought I'd just make sure
10 that there wasn't anything else you wanted
11 from the panel.

12 MS. MILNER: I think that you've
13 all provided very helpful feedback. I'm going
14 to do some more thinking and certainly talk
15 with some of my colleagues about precisely how
16 this is used and so forth in institutional
17 SNFs. But you've certainly given me some
18 ideas as to how we might be able to use the
19 survey information that plans already spend a
20 lot of money to collect in order to generate
21 some more information which would be helpful
22 for quality improvement purposes around this

1 topic.

2 So thank you all very much.

3 CO-CHAIR MUELLER: Okay. We're
4 going to be moving to 002. And our sponsor
5 for this is the RAND Corporation. We're
6 wondering if they are on the phone.

7 MR. WENGER: You have Neil Wenger,
8 and I think Carol Roth is also on the line.

9 CO-CHAIR MUELLER: Well, Neil, if
10 you'd like to get started presenting the
11 measure.

12 MR. WENGER: So this is an MDS-
13 based measure that is predicated upon the
14 large amount of literature indicating that for
15 patients with incontinence who have the
16 ability to toilet, that behavioral
17 intervention should be entertained first.
18 These data are available in MDS indicating
19 whether patients have incontinence, whether
20 their incontinence is deteriorating and
21 whether they have a functional capability to
22 toilet.

1 Those are the denominator
2 indicators. And in order to pass the measure,
3 one must have received toileting assistance
4 during the time period which also is collected
5 both in 2 and MDS 3.0.

6 We have been able to implement
7 this in a large sample of nursing home
8 patients who are dual eligible in about half
9 the counties here in California. It
10 demonstrates actually only a small proportion
11 of the patients do enter into the denominator.
12 But it also demonstrates that the scores are
13 low and that there is need for improvement.

14 This measure, just like the one
15 that we presented yesterday, is part of a
16 battery evaluating care for vulnerable older
17 patients. And this measure from a validity
18 perspective has been related to the quality of
19 life incontinence scale in community-based
20 patients though not in nursing home patients
21 in a trial that we conducted.

22 But the statistically significant

1 relationship occurs only when one takes the
2 composite of quality that includes both
3 diagnosis and treatment and not just this
4 measure alone.

5 I'm glad to respond to questions.

6 CO-CHAIR MUELLER: Tomas, if you
7 want to present.

8 DR. GRIEBLING: So from an
9 important standpoint, an incredibly important
10 problem, high prevalence. There's a lot of
11 data from a scientific standpoint supporting
12 behavioral intervention, both in nursing home
13 settings and in other settings.

14 When you look at the majority of
15 those studies however, they have a very
16 targeted focus in terms of how that behavioral
17 intervention is delivered to those residents.
18 So from a scientific standpoint, although
19 there's very good data to support this, my
20 concern is that it's lumping this together
21 based only on the MDS definition which is
22 scheduled toileting, prompted voiding and

1 bladder re-training. So the data itself also
2 includes things like pelvic floor exercise.

3 It's unclear the standard to which
4 the behavioral intervention will be delivered
5 from facility to facility. And I think that's
6 a concern. So I think facilities could say
7 that they do bladder re-training but the level
8 and the quality of how they're actually
9 administering that I think could vary quite
10 widely. And I'm going to actually ask Alice
11 to come in on that in a minute.

12 In terms of usability and
13 feasibility, I mark partial for both of these.
14 I think again it depends on staffing in large
15 part. And then the question of whether that's
16 the appropriate therapy, whether scheduled
17 toileting is going to work for some patients.
18 And we really probably need to be a little
19 more individualized in patient care for this
20 measure. That's my concern.

21 MS. BELL: And I would add I think
22 a couple of things.

1 We do know that prompted voiding
2 alone when it's done correctly, when it's done
3 on a 24/7 basis, when there is consistency in
4 the intervention is a very effective
5 intervention. I agree with Tomas. The
6 problem here is the definition of the
7 intervention and how specific we are and what
8 the standard is for implementation and
9 performance of that measure.

10 As well, the issue that we're
11 looking at only patients who can self-toilet,
12 which is a concern to me because I think
13 conceptually and in reality, prompted voiding
14 is an effective measure regardless of whether
15 the patient can self-toilet or not or an
16 effective intervention. And so I'm not sure
17 why we're carving out the population to only
18 look at patients who can self-toilet.

19 Those would be my primary
20 concerns.

21 CO-CHAIR MUELLER: We'll open it
22 up to the committee.

1 CO-CHAIR GIFFORD: Bill is the
2 secondary reviewer.

3 CO-CHAIR MUELLER: Oh, I'm sorry.

4 MR. KUBAT: No, that's fine. The
5 secondary review would be what I would just
6 echo what Tomas and Alice have said with maybe
7 one additional comment.

8 I think as we've said with
9 virtually everything that's been presented,
10 the importance of this issue is stance. I
11 mean, that's not the question. But in terms
12 of the readiness of this measure, particularly
13 where it talks about under the validity that
14 the outcomes haven't been tested, that's a
15 significant issue or question for me.

16 CO-CHAIR MUELLER: Neil, would you
17 like to comment on some of the issues that
18 were raised?

19 MR. WENGER: I think that the
20 first issue raised is a valid one. We are
21 limited by what MDS collects and whether such
22 data in any way reflect the trials that have

1 demonstrated effectiveness is not clear.

2 However, I have to comment that
3 this measure in the community-based sample is
4 part of the collection of measures that goes
5 through both diagnosis and treatment that is
6 directly related to improvement in
7 incontinence quality of life based on serial
8 measures from patients and the outpatient
9 setting.

10 So that suggests to us that we are
11 getting at important components though they be
12 derived from in that case the medical record,
13 and in this case MDS. So it suggests the same
14 kinds of things that you see in clinical
15 trials. In fact, the effect of high-quality
16 care or higher-quality care is not much
17 different than the effect of a drug, at least
18 at low dose in these intervention trials. So
19 it gives us some belief that these data that
20 are collected to identify numerator cases are
21 important.

22 The issues concerning not

1 excluding people who don't have toileting
2 function based on the MDS is an interesting
3 one, and was debated by our expert panel
4 during the exclusion process. And it's very
5 much similar to the conversation that we had
6 yesterday that they felt that there are many
7 cases where patients with advanced dementia
8 could very much benefit from such treatment,
9 and you would want it to be provided to them.
10 But to say that a treatment was inadequate
11 because someone with advanced dementia didn't
12 receive a behavioral intervention may not fit
13 well with the capabilities of many of the
14 patients. And therefore, they shouldn't be
15 included in the denominator.

16 MR. BOISSONNAULT: I have just a
17 quick question which is if I understand the
18 measure as designed, you would expect that
19 nursing homes that have favorable results on
20 your measure would also have lower use of
21 pharmacy for this purpose. And if that is
22 true, if that is a measure of success, then

1 have you done any validity testing to see if
2 the process that is being recommended by this
3 measure actually delivers the results that
4 might indicate that it's working?

5 In other words, when you looked at
6 the sample populations, are the nursing homes
7 that do this showing lower use of pharmacy to
8 treat incontinence?

9 MR. WENGER: That's a great idea.
10 Now one would just like for all of these other
11 outcome measures that you're debating, one
12 would need to be able to adjust appropriately.
13 But that would be a really, really nice way to
14 validate this measure.

15 But one must also recognize that
16 the measure applies only to a small proportion
17 of patients. So it may be difficult to see it
18 at the nursing home level because again, it's
19 only a small proportion of the incontinent
20 patients who will qualify for this measure.

21 DR. GRIEBLING: This is Tomas
22 Griebeling again.

1 A couple of questions related to
2 when you talked about the community care data
3 that you have, I'm assuming those are people
4 that are residing in the community, not in a
5 facility. Is that correct?

6 MR. WENGER: Correct.

7 DR. GRIEBLING: And what type of
8 interventions were included in that? Because
9 the way the measure is designed, your limited
10 because of what MDS collects which is
11 scheduled toileting and prompted voiding, and
12 "bladder re-training." So my concern is does
13 that really match the type of intervention
14 that was probably provided to those community
15 dwellers which was probably much more
16 interaction in terms of pelvic floor exercise,
17 pelvic floor training, diet modification --
18 those types of things? And so I'm concerned
19 that there may be sort of a leap here in
20 looking at that data from communities and then
21 applying it to a nursing home.

22 MR. WENGER: I would agree with

1 you. And maybe I'll let Carol comment on
2 this.

3 But in that analysis, we are
4 beholding to what the primary care providers
5 document in their medical record. And I might
6 posit that MDS collects much more standardized
7 valuable information than what a clinician
8 happens to document about what they did for
9 urinary incontinence, though it is likely that
10 they're doing more pelvic floor exercises, or
11 at least documenting that sometimes.

12 Carol, can you comment?

13 (No response.)

14 MR. WENGER: Maybe we lost her.

15 But I --

16 MS. ROTH: I'm sorry. I had my
17 mute on.

18 Probably the most common measure
19 that we found was the pelvic exercise. But
20 overall, we felt that we generally found a
21 very low incidence of that anyway overall in
22 terms of behavioral intervention.

1 CO-CHAIR MUELLER: This is Chris
2 Mueller.

3 When you look at the MDS 3.0
4 items, the best we're going to get for a
5 numerator is that they've had a trial of a
6 toileting program. We're not going to know
7 what type of behavioral intervention.

8 And the other item that's missing
9 from the numerator is how to determine that
10 they are self-toileted -- who are able to
11 self-toilet. So that was not in the
12 numerator.

13 MR. WENGER: That's part of the
14 denominator.

15 DR. GRIEBLING: It's in the
16 denominator. It's G.1.A.i), ability to self-
17 toilet.

18 And this goes back to the
19 exclusion criteria which are going to be
20 advanced dementia and poor prognosis which is
21 essentially people toward the end of life.
22 Unfortunately this isn't going to capture

1 people who are cognitively intact but may have
2 mobility impairment that prevents them from
3 self-toileting. So we're going to lose that
4 population with the way the exclusions are
5 defined.

6 MS. TRIPP: Also, I think they
7 need to go back and re-write them with the MDS
8 3.0 because these are 2.0 measures. And one
9 of the items in their denominator, that
10 question is no longer in existence on the MDS
11 3.0. So we'll need to remove that.

12 MR. WENGER: I think we responded
13 to that in the question period. Carol, can
14 you --

15 MS. ROTH: Well, actually the
16 whole point of the transition to 3.0 did come
17 up although the clarification questions that
18 we were asked to answer were limited. And we
19 were asked to only respond to the questions
20 that were specified. So even though some of
21 the questions asked about that transition, we
22 didn't report all of it although we have done

1 that crosswalk.

2 CO-CHAIR MUELLER: Bob, you were
3 going to say something.

4 DR. ZOROWITZ: Yes. Just as
5 another question of clarification, are we
6 voting on this as a time limited measure as
7 well?

8 CO-CHAIR MUELLER: According to
9 this no. That box is not checked.

10 CO-CHAIR GIFFORD: As a committee
11 as we did yesterday, someone who asked for
12 time limited it up, and we can take anyone and
13 move it down. We're not going to vote on what
14 they --

15 DR. ZOROWITZ: I mean, as I look
16 at this it says to me it fits many of the
17 criteria. It's a very important measure. I
18 think it measures something that we need to
19 know about. It's an important quality
20 indicator because the data collection is both
21 feasible and usable assuming that it can be
22 crosswalked to the MDS 3.0.

1 I guess the question is because
2 this is going to be looking at a fairly
3 limited population. As a publicly recorded
4 measure, is this going to reflect overall the
5 quality of incontinence care in the nursing
6 home? Or is this going to be too narrow to
7 really reflect for public recording purposes
8 -- management of incontinence is an extremely
9 important issue in nursing homes. It is
10 under-recognized, under-treated.

11 So I can't overstate the
12 importance of an incontinence measure. The
13 question is whether for public reporting
14 purposes, is this just too narrow. So I'm
15 just wondering what's the purpose of it,
16 particularly if it's not going to be a time
17 limited measure. I mean, I would recommend
18 that it be time limited to see how it's going
19 to fall out after a period of time.

20 MR. BOISSONNAULT: I would also on
21 the quality improvement side echo some of
22 Robert's remarks, which is I think sometimes

1 in health care we focus too much on effort
2 instead of results. And if the result we're
3 trying to get here is lower interventions with
4 pharmacy when other less costly and
5 troublesome interventions are possible, I
6 guess I would rather see us get the data on
7 the results because we know how much we're
8 spending on pharmacy. We know who these
9 patients are. And I would rather have a
10 results measure than a proxy process measure
11 frankly where there's no science saying that
12 when you do this you get the desired result.

13 DR. GRIEBLING: And I would echo
14 that. I think it is narrow in focus. We'll
15 look at a very limited population of
16 residents. And it's focused specifically on
17 process. So I think facilities could end up
18 having very high quality marks for this
19 because they've implemented a program but
20 there's no look at whether the program is
21 actually applicable to a given resident and
22 ultimately whether it's effective.

1 CO-CHAIR GIFFORD: I think an
2 interesting kind of side comment that we don't
3 need to spend too much time on is if we think
4 the MDO item is too vague and inclusive, why
5 is it an MDS item? I mean, even if the MDS is
6 supposed to be used for care planning purposes
7 and for documentation and for triggering
8 everything else, it sounds like the way it's
9 worded and structured it's a worthless item.
10 And we've had that criticism for a lot here.

11 So there's a lot of money, time
12 and effort spent in collecting the MDS, and
13 I'm a big believer of the MDS.

14 One of the interesting things we
15 talked about this is how much we want perfect
16 clinical specificity at each individual
17 patient encounter versus sometimes we want to
18 exclude people because it's a justifiable
19 exclusion but there may be only 100 cases in
20 the entire country. And so figuring out how
21 you exclude is not going to change anyone's
22 measure overall.

1 And so I don't know where exactly
2 you go with that. It sounds like what Neil is
3 saying is that at least in the outpatient
4 setting, the same sort of vagueness of a
5 question, they're seeing a validity in some
6 relationship because there's always some
7 trend. It's not perfect. It's clearly not
8 what we'd want an individual case area. But
9 when you're sort of getting a higher-level
10 sense about a facility overall if it gets too
11 vague, you end up not seeing any validity
12 because then it really is a wash. But they
13 seem to be capturing enough.

14 But it's also I think feedback to
15 CMS that as they hear the comments about MDS
16 items that are too vague to be used in a
17 measurement set. I'd ask if they're so vague
18 here, how could you use them on patient care
19 because that's really what the MDS is supposed
20 to be done is for patient care. If they're
21 that vague, it's a worthless question on the
22 MDS. Get rid of it.

1 MR. BOISSONNAULT: Could I just
2 respond to that?

3 Sometimes when you raise a useful
4 bit of internal information that mid-level
5 clinical staffs can use at a hospital or a
6 nursing home to the level of a nationally
7 reported grade for which pay for performance
8 might even be involved, these simplistic
9 process measures have perverse consequences
10 exactly like the doctor described where you
11 create a check box. And we saw it with some
12 of the CMS measures on process where a beta
13 blocker and an aspirin are absolutely
14 essential internal measures for hospitals.
15 But as soon as they became publicly reported,
16 they sort of lost of their correlation to
17 mortality which is what we were trying to
18 improve.

19 And so, I don't know -- I'm not a
20 clinical expert in this area -- but because it
21 may not be one of the 50 measures that makes
22 it to be looked at for nursing homes, that may

1 not be reason not to ask it for internal use.

2 DR. ORDIN: I have a question of
3 the proposers of how did you anticipate this
4 being used? Because I think you're right.
5 You're dealing only with over age 65. I think
6 it was similar to the measure we discussed
7 yesterday which was it had to be dual eligible
8 Medicare/Medicaid, and you have to have the
9 administrative data available. How are you
10 using them in California? How do you foresee
11 them being used in other settings? I mean, do
12 you see this being helpful for public
13 reporting for people to use in rating nursing
14 homes?

15 MR. WENGER: Well, the feedback
16 that we have received from nursing home
17 administrators is that they felt that this
18 measure comparing themselves to other nursing
19 homes could stimulate them to do better
20 nonpharmacologic incontinence treatment for
21 capable patients who could be toileted.

22 We didn't have a conversation with

1 them concerning public reporting necessarily.
2 But if they felt that it would push them from
3 a quality perspective, then it's likely the
4 public reporting will do the same thing.

5 CO-CHAIR GIFFORD: Any final
6 comments or questions for RAND?

7 (No response.)

8 CO-CHAIR GIFFORD: I would suggest
9 then giving the comments a vote on time-
10 limited approval with update on the crosswalk
11 with the 3.0 and at least an exploration
12 whether RAND could look at a conversion
13 validity test of how this measure looks with
14 treatment I think, Ron, as you brought up --
15 if that's possible or not.

16 MS. TRIPP: Actually, David, if I
17 could ask a question before.

18 CO-CHAIR GIFFORD: Yes.

19 MS. TRIPP: I think there are some
20 really important points being brought up about
21 the possible effect of public reporting for
22 this particular measure. And so I guess my

1 question is can you assess the likelihood that
2 this measure would create a false impression
3 that incontinence is being appropriately
4 identified and treated? That really worries
5 me for taking a tiny picture of a big problem,
6 and it creates a rosy impression. I think
7 that could have very adverse consequences for
8 nursing home residents. I think it's bad
9 policy.

10 DR. GRIEBLING: I would concur
11 with that assessment.

12 CO-CHAIR GIFFORD: So I would add
13 then for RAND to give us some feedback on the
14 impact of this measure on either gaming by the
15 industry or misleading information that
16 effective management is actually being done
17 when it may not be effective management. Is
18 that a way to put it?

19 MS. TRIPP: Yes. I don't think I
20 was so much thinking of it as gaming or being
21 misleading. I was just worried about the
22 construction of the measure itself might paint

1 the wrong picture so that it takes a very
2 serious big problem and makes it look like
3 it's going just fine.

4 CO-CHAIR GIFFORD: Well, I think
5 Neil did allude to it early on that in this
6 outpatient this has to be done as part of a
7 panel in conjunction at least with diagnosis
8 and other issues. So I think some more
9 information on that would be helpful from RAND
10 as well.

11 MS. BELL: And if I could just add
12 -- and not to beat a dead horse -- I think
13 what I'm struggling with here is a couple of
14 things is that we've had in place this concept
15 of bladder re-training, prompted voiding,
16 behavioral interventions for incontinence for
17 a long time, and we're not seeing improvement.
18 So the issue is at this point for me first of
19 all how do we define those methods because
20 people say they're doing it. But what it is
21 is not well defined. And second, what is the
22 outcome?

1 So what is critical to me is are
2 we seeing a) less of an incidence of
3 incontinence developing because we know the
4 numbers in terms of the risks of patients who
5 come in continent and within a year are
6 incontinent while we're supposedly doing the
7 right thing. And secondly, what is the result
8 of these interventions once we define the
9 intervention actually on managing the
10 incontinence and associating it with the type
11 of incontinence which there's distinct
12 differences based on the type of urinary
13 incontinence as to what treatment is going to
14 be effective?

15 So I know that's a lot more than
16 is on the table. But that's what I'm
17 struggling with because I don't think this
18 gets us anywhere near there.

19 DR. ORDIN: I want to follow-up on
20 what Lisa said again because I thought that
21 one of the criteria for usability -- I mean,
22 one of the whole purposes of going to NQF is

1 that it is a publicly reported measure. And
2 I can see where this measure would be very
3 useful to a facility.

4 But in terms of usability and
5 usefulness to the public, which is I
6 understand an important criterion here, I
7 don't feel that it has been demonstrated that
8 it's been met. And I'm not sure that public
9 reporting on this has even been trialed. Am
10 I right?

11 MR. WENGER: Right. It has not
12 been publicly reported.

13 DR. BURSTIN: NQF-endorsed
14 measures are intended, meaning the idea is
15 they're appropriate for public reporting.
16 There's not a requirement at initial
17 endorsement that the measure's actually been
18 out there or used for that purpose. It just
19 lets you believe it passes the criteria for
20 endorsement, and as such could then be used
21 for that.

22 We would examine at the

1 maintenance period of three years whether the
2 measure's actually been out there for public
3 reporting yet. But it would be an early test
4 of a measure that hasn't yet gotten out in
5 that way to see if it's in fact been publicly
6 reported yet.

7 DR. ORDIN: Not that it's been
8 publicly reported, but the information you get
9 from public reporting is useful. I considered
10 that during --

11 DR. BURSTIN: One aspect of those
12 on usability that you would have to consider
13 strongly. Yes.

14 CO-CHAIR GIFFORD: So yes, I'll
15 maybe add what Dede said and Alice and Lisa
16 said. And they've said it better than I. But
17 I think that's probably precisely what I was
18 trying to get at in terms of the outcomes
19 issue.

20 And the other issue for me has
21 always been as I looked at all of these
22 measures, and considering our discussions

1 yesterday in terms of what other domains and
2 types of measures need to be considered and so
3 forth, it was hard for me to look at this with
4 this particular measure with all of those kind
5 of questions that have been named to think
6 that it provides that much more compelling
7 value, that this needs to be added in lieu of
8 other things that need to be explored and
9 added in terms of measures.

10 So I think in terms of
11 harmonization, how does it harmonize for the
12 consumer that's looking at Nursing Home
13 Compare? Because they're not looking at
14 Nursing Home Compare vis a vis Hospital
15 Compare vis a vis other ones. They're looking
16 at the measures that are on Nursing Home
17 Compare and how does that help me discern, and
18 does this one provide that much more
19 compelling value in the midst of all of that.
20 I don't think it does.

21 DR. GRIEBLING: And I think the
22 problem is because it's looking at process.

1 Did we deliver this rather than looking at
2 outcome? Did it have an effect?

3 CO-CHAIR GIFFORD: I think this is
4 going to be a fun vote to watch happen.

5 I will put out -- and don't be
6 swayed by saying -- I think it should be a
7 consensus. I'm going to put it out and it may
8 well go down.

9 Time limited with a crosswalk to
10 3.0 looking at potential conversion validity
11 with the medication if possible, this issue of
12 both gaming, misleading, but also the
13 usability from a reporting standpoint.

14 I guess I'll start with
15 abstaining. Anyone need to abstain from the
16 vote?

17 (Dr. Ordin abstained.)

18 CO-CHAIR GIFFORD: You're going to
19 abstain from the vote? Okay.

20 Anyone not in favor of that vote?

21 (Thirteen not in favor.)

22 CO-CHAIR GIFFORD: All in favor of

1 that?

2 (Four in favor.)

3 CO-CHAIR GIFFORD: So 13 to 4 with
4 one abstaining. So it does not pass.

5 Anyone want to make any other
6 recommendation?

7 (No response.)

8 CO-CHAIR GIFFORD: They're
9 comfortable with that? Okay.

10 Next measure.

11 Neil and Carol, thank you very
12 much for getting up so early in California
13 time.

14 MR. WENGER: Thank you.

15 CO-CHAIR GIFFORD: Hopefully the
16 conversation was good feedback to you all.

17 MR. WENGER: Good. Thank you.

18 CO-CHAIR GIFFORD: Okay. On to
19 measure 19 -- RTI.

20 MS. CONSTANTINE: Good morning,
21 everyone.

22 I would just like to start by just

1 asking a question given these three measures
2 are incontinence, catheterization use and UTI.
3 If I should talk about the group of them as a
4 whole or if you'd like me to focus -- just
5 give you a short overview with the first one
6 or one at time? The group? Okay.

7 Okay. The purpose of the first
8 measure dealing with incontinence is the
9 proposed measure reports the percentage of
10 low-risk, long-stay residents who lose control
11 of their bowel or bladder in nursing
12 facilities.

13 I'm sorry. Nineteen? Okay.

14 And specifically by low risk, we
15 mean that those residents who are not severely
16 cognitively impaired or totally dependent in
17 mobility, are not comatose or have an in-
18 dwelling cath or an ostomy. In regards to
19 what we mean by losing control of their bowel
20 and bladder, on the items on the MDS 3.0, it's
21 specifically those residents who are
22 frequently or almost always incontinent of

1 bowel or bladder.

2 In regards to importance, the
3 impact of incontinence profoundly effects
4 nursing home residents in regards to
5 embarrassment, generally in health and quality
6 of life factors such as social functioning is
7 affected by incontinence, and physically
8 managing incontinence can help prevent
9 infections, pressure ulcers, other
10 complications, and mentally as well the
11 treatment can promote well being of the
12 resident by restoring their dignity and social
13 interaction.

14 We also know that scheduling
15 toileting and bladder programs can
16 successfully be implemented among nursing home
17 residents to address incontinence and the risk
18 factors. And this includes residents who are
19 cognitively impaired.

20 In using the MDS 2.0 data looking
21 at the data from April to June of 2009, CMS
22 reports that the national prevalence of this

1 quality measure was 49.4 percent, and it
2 ranged from a low average of 37 to a high of
3 about 69 percent. So we know that this is a
4 major concern.

5 In regards to the background,
6 there are no changes in the measure
7 specification per se, but there have been
8 changes in the MDS 3.0 focused on making the
9 measure more accurate. Specifically in the
10 MDS 2.0, there is a little bit of a different
11 set of response options. And those are
12 continent, usually continent, occasionally
13 incontinent, frequently incontinent, and
14 incontinent, and it's in the last 14 days.

15 For the MDS 3.0, the usually
16 continent was eliminated. And the look-back
17 period is now seven days. And one of the
18 issues with the previous measure was that
19 asking staff to think about two weeks back was
20 somewhat daunting, whereas a seven-day look-
21 back is something that's much more usable and
22 I think feasible for the nursing home staff.

1 Also, in regards to looking at the
2 issues of those cognitively impaired residents
3 that are in the high-risk group, again we have
4 the brief interview of mental status which is
5 a performance-based measure and will better
6 help us to identify those residents, although
7 staff assessment -- there's some items that
8 are also utilized to identify those residents.

9 In regards to the proposed cath
10 measure, it reports on the percent of long-
11 stay residents who have had a cath inserted in
12 their bladder over the last seven days in a
13 nursing facility. And again, this has been an
14 issue that has been definitely recognized
15 because overuse of catheters to manage
16 incontinence other than for short periods is
17 a potential sign of sub-optimal care and an
18 indication that further assessment in
19 alternative treatment could be offered. And
20 then were not properly monitored or
21 maintained, caths can cause chronic pain or
22 infections leading to greater functional

1 decline and obviously decreased quality of
2 life for the resident.

3 And the in-dwelling cath quality
4 measures can serve as a potential reminder to
5 facilities about the importance of assessing
6 and limiting cath use whenever possible. And
7 at any given time, more than 100,000 residents
8 in American nursing facilities have catheters
9 in place. And using the MDS 2.0 data from
10 April to June of 2009, the national prevalence
11 average was 7.7 percent with the low of 5.2 to
12 a high of 11 percent. So essentially, the
13 data items for the MDS 3.0 are the same as
14 2.0. But again that look-back period has
15 decreased from 14 days to seven days.

16 And additionally, during our
17 technical expert panel and also clinical input
18 from some research by the University of
19 Colorado, there was concern regarding
20 neurogenic bladder and obstructive neuropathy.
21 And those have been added as specific
22 exclusions as part of the measure.

1 Let's see. And for the UTI, the
2 purpose of the proposed measure is to report
3 the percent of long-stay residents with a
4 diagnosis of UTI in nursing facilities. And
5 again, nursing facility residents often
6 develop infections. And among these, UTIs are
7 very common.

8 The symptoms of urinary tract
9 infection include fever, painful or difficult
10 urination, frequency and urgency, blood in the
11 urine, flank pain, and even deterioration in
12 mental status such as increased confusion.
13 Some patients who develop urinary tract
14 infections go on to develop blood infections.

15 And so again using the MDS 2.0
16 data, but to give you an idea of the
17 prevalence, the average for April to June of
18 2009 was 9.7 percent with the low from 5
19 percent to a high of 14 percent. Another in
20 terms of importance of the measure, it's
21 significant in that it's the only quality
22 measure that really targets infection. And

1 this is obviously an important indicator of
2 how facilities manage and prevent infections.

3 So essentially the underlying
4 items of the MDS 2.0 and 3.0 are the same.

5 But there was some question in regards to
6 having some false positives and negatives.

7 There was one study that had been performed in
8 2004. And the MDS 3.0 although the items
9 haven't changed, it's much more focused in
10 terms of having a more precise definition of
11 UTI. And also it still does look at the
12 treatment of UTI in the last 30 days.

13 And finally, a small change,
14 unpublished data analysis of the MDS 2.0 by a
15 Dr. Mor of Brown University found some
16 seasonal variation in this particular measure.
17 And to address this, the proposed measure uses
18 a six-month average for the facility rather
19 than the data from just one quarter.

20 And that's it.

21 MS. GIL: Can you just give us an
22 overview of the change in definition on the

1 3.0?

2 MS. CONSTANTINE: Sure. For the
3 urinary tract infection, it requires a
4 physician, a nurse practitioner or a physician
5 assistant or a clinical nurse specialist to
6 have the diagnosis of UTI in the last 30 days
7 -- oh, I'm sorry -- a physician, nurse
8 practitioner, physician assistant or a
9 clinical nurse specialist must be the one that
10 diagnoses the UTI in the last 30 days. Or you
11 could have the symptoms attributable to a UTI
12 which may include fever, urinary symptoms,
13 pain or tenderness in the flank, confusion or
14 a change in mental status, change in the
15 character of urine or current medication or
16 treatment for a UTI in the last 30 days.

17 DR. GRIEBLING: So I think
18 Roberta's done a very nice job of summarizing
19 the improvements that have been made in the
20 continence measures in MDS 3.0 compared to
21 2.0.

22 In terms of importance, clearly

1 established, huge problem. Incontinence and
2 cognitive problems are often cited as the two
3 most common diagnoses leading to nursing home
4 placement. I gave that complete -- in terms
5 of scientific data, I also thought the
6 information was not quite complete.

7 The one caveat that I would have
8 is in the way the numerator statement is
9 worded, I'd want to make sure that when we
10 analyze data in the future we're able to sub-
11 stratify whether residents were incontinent of
12 bladder, whether they were fecally incontinent
13 or whether they had dual incontinence because
14 we know clearly from data that people who are
15 dually incontinent of both bladder and bowel
16 are much more vulnerable and have
17 significantly worse outcomes. So we don't
18 want to cluster them all into one group. We
19 want to be able to sub-stratify that.

20 The other thing that's really nice
21 about this measure is it's looking
22 longitudinally at this. So if I'm

1 interpreting this correctly, it's going to
2 capture people who come in continent and then
3 identifying people who may become incontinent.
4 And Alice pointed this out that that's a huge
5 concern. And you cite data about that in the
6 references that the risk of developing new on-
7 set either urinary or fecal incontinence is
8 fairly high in nursing homes and how to try to
9 prevent that. So I think this measure is
10 getting at that. So I think the usability and
11 feasibility are both very high.

12 CO-CHAIR MUELLER: As the second
13 reviewer, I absolutely concur with what Tomas
14 said. And also this part about stratifying
15 urinary incontinence from bowel incontinence
16 I think is a real important issue particularly
17 because the care interventions are so
18 different. So you don't really know what
19 you're moving -- urinary incontinence, bowel
20 incontinence. And I would be curious about
21 the discussion that might have occurred in
22 regards to proposing this measure and

1 continuing to keep those two together.

2 Otherwise, I did rate everything
3 as complete.

4 MS. CONSTANTINE: In regards to
5 given that the measure is or -- bowel or
6 urinary incontinence, there's a lot of
7 attention given to urinary incontinence but
8 not so much at times bowel incontinence which
9 is equally important. And so I think that the
10 thought was initially that with this quality
11 measure to be sure that you include both.

12 But I certainly appreciate the
13 fact that stratifying would be important
14 especially also having a category of bowel and
15 bladder because they're at most risk. And we
16 would certainly take that back.

17 CO-CHAIR MUELLER: Just to clarify
18 then, there would be two measures that would
19 be publicly reported?

20 MS. CONSTANTINE: I think it's
21 like we could stratify to take a look at
22 bladder, bowel and bladder and bowel.

1 CO-CHAIR MUELLER: Yes, dual.

2 DR. GRIEBLING: I think it can be
3 one measure. But I think the way the data are
4 ultimately presented needs to allow people to
5 interpret the percentages whether it is
6 urinary only, fecal only or both.

7 MS. CONSTANTINE: Okay. Thank
8 you.

9 DR. GRIEBLING: And that's going
10 to be really important because that will lead
11 them to interventions and potential changes in
12 interventions which could lead to changes in
13 outcome.

14 MS. CONSTANTINE: Okay. Thank
15 you.

16 CO-CHAIR MUELLER: Thank you for
17 clarifying.

18 DR. ZOROWITZ: The measure has
19 been in use. And I found this a very useful
20 measure. I think as a public reporting
21 measure, it's a very good measure of nursing
22 home quality. Internally for quality

1 improvement purposes, we've also found it
2 useful.

3 When somebody flags on this
4 measure, it's very easy to dig down into the
5 MDS and found out whether it's bowel or
6 bladder and take action on it. So as far as
7 publicly reporting, I'm not sure that the
8 distinction is going to be that important.

9 And many of the behavioral
10 interventions that apply apply to the other,
11 although pharmacologic interventions are very,
12 very different. But behaviorally, there's a
13 lot of cross over. So my experience has been
14 that the measure as written -- previously
15 written with MDS 2.0 -- works pretty well.
16 It's a good outcome measure. And I understand
17 the rationale behind keeping them combined.

18 So far as public reporting, I'm
19 not sure that separating them out would be all
20 that useful.

21 MR. BOISSONNAULT: I just want to
22 -- because you're familiar with the MDS. So

1 in other words, if you have eight in the
2 numerator, you can go back to your own
3 internal data. And is this typical of the
4 nursing home setting where they could go back
5 to their internal data and say here are the
6 eight that were incontinent and you actually
7 are looking at the charts and can say this is
8 this kind of incontinence?

9 DR. ZOROWITZ: Yes.

10 MR. BOISSONNAULT: Does that meet
11 your concern?

12 DR. ZOROWITZ: No. And I agree
13 with you that in terms of public reporting, it
14 may not be as big an issue. But certainly if
15 people are going to be using this for any kind
16 of research or developing subsequent
17 interventions, if you lump all of it together,
18 there's no way you're going to be able to
19 separate that out.

20 And I agree that you can find that
21 in the MDS. But it would be nice to have it
22 within the measure as well. And I think it's

1 a relatively simple thing to do.

2 In terms of the type of
3 incontinence, the measures in MDS don't
4 address that in any way shape or form. Is it
5 urge, stress, overflow? Never addressed in
6 any of these measures.

7 MR. BOISSONNAULT: If I can
8 address it, that's a difficult question
9 because as you know there's a lot of mixed
10 incontinence in nursing homes. I think it's
11 way beyond the scope of MDS to gather that
12 kind of information.

13 But just for anybody that is not
14 familiar with how MDS is actually used in
15 nursing homes, there's really two ways of
16 getting at the information. One is on an
17 individual basis. When an MDS is filled out,
18 it immediately will generate wraps and care
19 plans for individual items. But also, I don't
20 know if most nursing homes, but at least many
21 nursing homes are collecting data
22 electronically, and therefore have easy access

1 to electronically analyzing the data. So for
2 instance we can go to an item and if it says
3 that 30 percent of our low-risk patients have
4 lost control of their bowel and bladder, it's
5 very easy to identify those patients that flag
6 and then to drill down and look at the actual
7 MDS items that led to that flag and see which
8 of them are bowel and which of them are
9 bladder.

10 So internally as a QI measure, it
11 doesn't matter that they're combined because
12 we can separate them out. And I would imagine
13 most nursing homes, if not all nursing homes,
14 can do that. For public reporting purposes,
15 I see less utility to dividing them out. For
16 research purposes, nationally I think the MDS
17 data can be separated out.

18 So I'm kind of looking at this as
19 voting on it as a quality measure for public
20 reporting purposes. My own feeling would be
21 that it's adequate the way it is.

22 CO-CHAIR MUELLER: Bill?

1 MR. KUBAT: Just a couple of
2 comments.

3 One of the things that was
4 striking to me as I was looking at the
5 documents is that surely it is a continuation
6 measure and 2.0 to 3.0. But those refinements
7 seemingly will have a significant impact
8 because the averages move from 10.-something
9 to 7.-something. And the extent to which
10 that's all a function of the look-back period
11 or more refinement in terms of things like the
12 culture pending issue that I've heard folks
13 reference -- the culture issues and treatment
14 issues -- that piece is not clear to me. But
15 the numbers moved. And they dropped 3 points
16 approximately. And that's a significant piece
17 to note in light of the importance of the
18 measure.

19 The other thing that is striking
20 to me -- and I don't want to belabor this
21 point so I'll just say it -- but when we've
22 had the earlier discussions about the issue of

1 wording in the negative or wording in the
2 positive, well, this is one that lends itself
3 that way, or at least to overt consideration.
4 And that whole process is a conundrum to me
5 because I hear CMS say that's maybe our intent
6 that we want to do more of that in light of
7 harmonization. I hear us say and NQF say that
8 we consider it as they're written. And if we
9 invert it, it's not an NQF-endorsed measure.
10 But this is then being introduced by CMS.

11 So I'm not sure what the message
12 is in that light. So I just let it go at
13 that. It's an important measure.

14 DR. ORDIN: I think this is going
15 to be true for all the CMS measures. It was
16 yesterday.

17 Again, the exclusion of people
18 with missing data and ensuring that really was
19 a long-stay population. So maybe we could
20 just say it once.

21 And I do want to say another thing
22 about the positive versus the negative. I see

1 these a lot and I find it very confusing.

2 But somehow if someone is seeing a
3 93 percent versus a 97 percent, it isn't as
4 striking as if you see a three percent versus
5 a seven percent. So I think for some of these
6 lone numbers, maybe there is a public
7 reporting advantage of having lower being
8 better when you're reviewing these small
9 numbers just so there in the face more.

10 MR. KUBAT: Well, and again, I
11 don't want to belabor that point. But what I
12 say maybe in response to that is look at
13 Hospital Compare.

14 DR. ORDIN: Right. That's my
15 point too.

16 CO-CHAIR GIFFORD: Okay. So we're
17 going to vote on summarizing and to approve
18 the measure as is with two minor modifications
19 which is close the 100-day loophole, address
20 the missing data-issue, and provide -- I'll
21 summarize that dialogue between -- ask the
22 vendors to provide back data looking at the

1 measure with bowel alone, incontinence alone,
2 the two combined or bowel overall and get a
3 sense what would it look like and then give us
4 a recommendation as to why the experts or
5 given the data and the frequency how best it
6 maybe should be presented and differently look
7 at it. Because I think until we actually see
8 the data, it may be the bowel and urine
9 incontinence is so highly correlated, it
10 doesn't even matter that you have bowel alone
11 in there. But at least until we see that
12 data, it's hard to have that. So that would
13 be the vote before us.

14 DR. ORDIN: And I would add one
15 other thing that if we're going to ask them to
16 do that, I think we have to ask them -- as
17 with the influenza -- to show how they're
18 going to publicly report it in a way that is
19 understandable to the public.

20 CO-CHAIR GIFFORD: Okay. So the
21 caveat is not only look at it, but the
22 recommendation is how it would be best to

1 communicate that to address the usability
2 portion as well. It's a good comment.

3 You want to add more?

4 MR. BOISSONNAULT: No. Some are
5 conditional which I don't think we actually
6 do. These are just recommendations.

7 The question is --

8 CO-CHAIR GIFFORD: The two
9 conditions would be to close the 100-day
10 loophole and the missing data. The bowel
11 thing would be a recommendation.

12 MR. BOISSONNAULT: Okay.

13 CO-CHAIR GIFFORD: Okay?

14 MS. CONSTANTINE: Okay. Thank you
15 very much.

16 CO-CHAIR GIFFORD: Anybody else
17 want to comment on that I put forward and
18 clarify it? No?

19 Approve two conditions, close
20 loophole, missing data, give us data on bowel
21 and how to present. How's that?

22 (Unanimous agreement.)

1 CO-CHAIR GIFFORD: Oh, you already
2 voted. Good. All right. Great. Okay.

3 I want to make sure everyone's
4 clear on the recommendations. Okay.

5 Next one. I guess, we had also 3
6 but we have some reviewers. The reviewers
7 want to comment on the catheter piece.

8 Is there anything to add that's
9 not been mentioned? I will say that the
10 loophole, the missing data one is already
11 there. But catheter, anything unique about
12 the catheter we want to talk about?

13 CO-CHAIR MUELLER: Naomi? I think
14 you're the primary reviewer on this one.

15 DR. SCHUMACHER: No, I am.

16 CO-CHAIR MUELLER: I'm sorry.

17 DR. SCHUMACHER: I am.

18 CO-CHAIR MUELLER: You are?

19 DR. SCHUMACHER: Yes.

20 CO-CHAIR MUELLER: N-A-I looked
21 like Naomi to me. That's why I went there.

22 DR. SCHUMACHER: Okay. So just a

1 couple of things.

2 So this measure is residents who
3 have or had a catheter inserted and left in
4 their bladder.

5 Just one thing before I launch
6 into this. I just wanted a clarification.
7 This was a five-day look-back period because
8 I thought you said a seven-day. And I saw
9 five-day look-back.

10 MS. CONSTANTINE: Okay. Let me
11 doublecheck it. I think it's a seven day.

12 DR. SCHUMACHER: I think it was
13 written as a five-day look-back. And so just
14 a clarification on that.

15 Catheter in the bladder at any
16 time during the five-day look-back period or
17 daily during the five-day look-back?

18 MS. CONSTANTINE: Any time.

19 DR. SCHUMACHER: Okay. That's
20 what I thought.

21 So this one captures the
22 percentage of long-stay residents, and again

1 the 100 day we talked about already, who've
2 had an indwelling catheters in the last five
3 days noted on MDS 3.0. It's a process
4 measure. Was previously endorsed.

5 The importance I don't need to
6 talk about.

7 The five-day look-back period,
8 there was comment in here that it was felt to
9 minimize the assessment burden, reduce the
10 opportunity for error, and that it performed
11 well during national testing.

12 The exclusion that was mentioned
13 was residents with neurogenic bladder or
14 obstructive uropathy. These conditions were
15 felt to justify catheter use to reduce the
16 risk of other complications.

17 And we already talked about the
18 missing data piece. I noted that as well.

19 Reliability scored very high on
20 this one on the University of Colorado and the
21 RAND studies. There was comment that the
22 measure stability was unstable over time with

1 18.9 percent of the facilities having a
2 significant change from one quarter to the
3 next.

4 Validity. There was the comment
5 that you made about seasonal variation which
6 was similar to variations that are seen in
7 hospital and skilled nursing facility
8 utilization.

9 Usability and feasibility I
10 thought were good.

11 I just had a couple of questions
12 and concerns that I want to raise for the
13 group.

14 One was about the effect on this
15 measure when you do exclude neurogenic bladder
16 and obstructive uropathy. On the data that we
17 saw, the mean percentage on this measure from
18 MDS 2.0 was only 5.6 percent. And there was
19 very limited variability across facilities.
20 The inter-quartile range was noted to be less
21 than five percentage points. So wondering
22 about that.

1 Also, the fact that those
2 diagnoses I think relatively frequently -- and
3 I'll let Tomas comment on this as well as the
4 secondary reviewer -- but I just wonder if
5 those diagnoses are on record. And I've seen
6 those diagnoses get put on the record when
7 somebody just has like one episode where
8 they're not able to void in the hospital and
9 they get that diagnosis. So how is that
10 diagnosis going to be taken into consideration
11 here? And does that create an excuse to leave
12 a catheter in for a longer period of time
13 because they carry that diagnosis from the
14 hospital?

15 I doubt this would happen, but is
16 there an opportunity to gain the system by
17 having a physician put that diagnosis down so
18 the catheter can be left in place? I don't
19 think that would happen. I think it would be
20 easier to just remove the catheter. But I'm
21 just raising it as a possibility.

22 And then I think Tomas had also

1 some thoughts about the F-TAG for incontinence
2 and some other comments.

3 DR. GRIEBLING: I would concur
4 with Ron's comments. I think in general this
5 has been very well structured, clearly strong
6 importance in scientific background.

7 In regard to the diagnoses of
8 neurogenic bladder and obstructive uropathy,
9 I think that is a concern to put them in an
10 exclusion in the denominator, with the concern
11 being that those people could then simply have
12 indwelling catheter placed as an easy out.

13 The other option for treatment for
14 those patients is intermittent
15 catheterization. And there's clear data to
16 show that intermittent catheterization has
17 significantly lower morbidity associated with
18 it in terms of infection and problems. The
19 problem is it's a significantly more labor-
20 intensive treatment on staff. And so my
21 concern is that we may sort of gain the system
22 in that people will then just put a catheter

1 in these people and not even try to do
2 intermittent catheterization which would be
3 preferable if it's possible. So I think that
4 would be the one thing.

5 I think this does harmonize fairly
6 well especially with the F-TAG. I think it's
7 316 is about urinary incontinence and catheter
8 use in nursing homes. So I think that's a
9 good thing with this measure.

10 DR. KOREN: The other problem that
11 you could get into is that often people come
12 from hospitals and they've had a catheter in
13 for a long time, and particularly with old men
14 when you first took it out. They do have
15 obstruction and they can't pee. And so a
16 trial of intermittent catheterization in fact
17 can relieve what's an obstructive uropathy.
18 And so we really have to look at that.

19 DR. GRIEBLING: Well, and
20 similarly looking at them is the patient
21 potentially a candidate for medical therapy?
22 So if they have obstructive uropathy, could

1 they potentially benefit from alpha blocker
2 medications or 5-alpha reductase inhibitors or
3 things? I think that's beyond the scope of
4 this. But ultimately trying to pair it to
5 pharmacology and polypharmacy, are they on
6 medications that are putting them into urinary
7 retention -- those types of things?

8 But I think that's again beyond
9 the scope of what's being proposed here.

10 CO-CHAIR GIFFORD: So what I'd put
11 before the group then is approve as a measure
12 with two conditions: close the loophole and
13 missing data, the numerator and a
14 recommendation to provide data on the number
15 of times exclusions happen -- percentage of
16 that -- both by neurogenic and obstruction --
17 look at it both together, and potentially
18 recommendation to the CMS as well, some look
19 at the accuracy -- this is from a sort of a
20 reliability/validity testing -- but some
21 accuracy of the diagnosis of obstructive and
22 neurogenic bladder.

1 The CMS, you may want to give this
2 guidance since it's probably an F-TAG through
3 this -- Jean's still here -- through this
4 survey shop, these were all out there. And we
5 can actually doublecheck on this from a data
6 check standpoint. It would be helpful.

7 So before us approve with two
8 conditions, one recommendation.

9 DR. BURSTIN: Just a quick
10 comment. I guess there was a question about
11 the fact that two of these measures were
12 paired in the last round, and do you want to
13 address that issue again this round?

14 CO-CHAIR GIFFORD: What do you
15 mean paired?

16 DR. BURSTIN: Two measures that
17 would always be reported together is how they
18 were in the last round. I just think it's
19 worth at least having that discussion.

20 CO-CHAIR GIFFORD: Well, let's do
21 them all and then we'll come back to that.

22 DR. BURSTIN: That would be fine.

1 Yes.

2 CO-CHAIR GIFFORD: Okay. Ignore
3 the woman to my left.

4 (Laughter.)

5 CO-CHAIR GIFFORD: Okay. Any
6 abstaining?

7 (No response.)

8 CO-CHAIR GIFFORD: Anyone opposed?

9 (No response.)

10 CO-CHAIR GIFFORD: All in favor?

11 Okay. It passes.

12 (Unanimous agreement.)

13 All right. The next measure and
14 we'll come back to Helen's point in a second.

15 Eighteen -- UTI?

16 MS. GIL: Okay. Obviously an
17 update to the 3.0.

18 This indicator is going back to
19 what to -- was saying about the drilldown. I
20 think it really impacts in terms of looking at
21 all kinds of issues relevant to care, and
22 importantly so individualizing bladder

1 programs as well as obviously infections. So
2 I think this obviously has significant
3 importance.

4 The seasonal variation I think is
5 an important aspect as well that I think it's
6 really important with this change. And we
7 should also note that this is limited to long
8 stay based on the ETI from hospital rate. So
9 I think that makes a lot of sense as well.

10 In terms of testing it to make
11 sure that over time it's valid is obviously a
12 piece in our timely limited testing. Its
13 usability and feasibility is high. This is
14 pretty straight forward and complete from my
15 perspective.

16 Bill?

17 MR. KUBAT: Nothing to add to that
18 other than the notation again that the UTI
19 numbers dropped. And the extent to which what
20 element of the refinements in the 3.0 are
21 contributory to that, but three percentage
22 points -- I mean, dropping from 10.-something

1 to 7.-something is significant. And in terms
2 of how that's reported, communicated,
3 explained in terms of the drop I think is an
4 important piece. And this probably relates to
5 any or all of the issues that we've reviewed
6 -- all of them that relate to 3.0.

7 At the time that I was looking at
8 this last week, the train-the-trainer session
9 was going on, and there was discussion there
10 that some things are being changed as we spoke
11 or as the meeting was taking place. And so
12 the overarching question was are there any
13 changes that had been done prior to all of
14 this work being done or are anticipated that
15 impact how any or all of this is considered.
16 I assume the answer to that is no. But I
17 don't know that with certainty.

18 But the other thing also to
19 acknowledge that because there are significant
20 changes in the refinement of the RAI manual
21 and the fact that that's not going to be out
22 until end of May, early June at best, it just

1 compresses the time frame for implementation
2 and just exacerbates all that training and
3 education pieces.

4 DR. GRIEBLING: I would agree with
5 both of the reviewers. I think this is a very
6 important measure and something that's very
7 usable and very feasible.

8 On a little bit more of a subtle
9 note, which I'm not sure we're going to be
10 able to capture at a measure level, is the
11 definition of urinary tract infection. And my
12 fear in this and what I see clinically are a
13 lot of people that are sent to me for
14 evaluation of "recurrent urinary tract
15 infections" who in actuality have asymptomatic
16 bacteriuria. And there's clear evidence that
17 shows that the overall prevalence of
18 asymptomatic bacteriuria both in community-
19 dwelling elderly woman particularly and long-
20 term care residents is about 20 percent, and
21 that longitudinally over time those numbers
22 stay similar but it often changes individuals.

1 So if you look at a population of
2 people now, about 20 percent will have
3 bacteria in their urine that's completely
4 asymptomatic, and generally the recommendation
5 is those people don't need antibiotic
6 treatment. If you look six months from now at
7 the same population, you'll have about 20
8 percent, but it may be different women.

9 And so that's my fear in this of
10 people getting misdiagnosed as having a
11 urinary tract infection. So I think the real
12 clarity is just making sure that we're
13 defining it correctly as symptomatic urinary
14 tract infections.

15 MS. ROSENBAUM: And just to ask
16 about that, I was wondering about that when
17 that was going on because is that defined as
18 symptomatic?

19 MS. CONSTANTINE: Yes.

20 MS. ROSENBAUM: So that's how
21 somebody would judge that and mark that down
22 as an infection.

1 DR. GRIEBLING: Right. The way
2 that I read this measure, it is defined as
3 symptomatic. And we need to remember that in
4 the elderly population, symptomatic is
5 different than in young people. So fever,
6 chills, dysuria, pain with urination, common
7 in young people, not as common in older
8 people. So the criteria about confusion,
9 anorexia -- those types of things -- are
10 important in this measure because those are
11 symptomatic in older adults.

12 MS. GIL: Tomas, thank you so much
13 for mentioning it. I have it in my notes
14 simply again going back to that drilldown
15 where you're really looking at the data. A
16 lot of times, you are looking at that
17 reoccurring issue at the end of the day. So
18 being able to really cipher that out I think
19 is important and why I asked for the
20 definition. So thank you for that, Tomas.

21 DR. ZOROWITZ: As an interesting
22 side note to this, I concur with everything

1 you've said. Urinary tract infections are
2 probably over diagnosed in nursing homes. And
3 one I think attractive perhaps side effect of
4 this measure would be to give an incentive to
5 nursing homes to more accurately define who
6 has a urinary tract infection and who doesn't.

7 It would be nice to reduce your
8 measure simply by accurately diagnosing
9 urinary tract infections and not -- what
10 happens practically is a patient becomes a
11 little bit more confused. A urine sample is
12 obtained. It shows bacteria, and they're
13 diagnosed with a urinary tract infection when
14 in fact it was asymptomatic bacteriuria. And
15 the confusion may be because of medications,
16 because of fluctuations and delirium because
17 of fluctuations of dementia. And I think this
18 will help keep facilities honest in addition
19 to looking at the other quality implications
20 of it.

21 MS. ROSENBAUM: Actually there is
22 a published definition for that from my

1 organization. Because if you're surveilling
2 infections in a long-term care facility, you
3 have a written definition. And it excludes
4 the bacteriuria -- the asymptomatic.

5 So as long as that's used, and it
6 sounds like from what you stated about the
7 criteria for an infection, it's pretty much
8 along that line.

9 DR. GRIEBLING: And part of that
10 issue is that often -- and I concur with all
11 of those comments -- is that often that
12 diagnosis is then made solely on the basis of
13 a dipstick urinalysis, and there are
14 significant issues with the overall
15 sensitivity of specificity of a dipstick
16 urinalysis. The sensitivity is -- but the
17 specificity is not great.

18 Clinicians then need to move to
19 the next step which is to do a urine culture
20 to make sure that the treatment is then truly
21 treating an organism that's going to be
22 responsive to whatever that therapy is.

1 Again, that's beyond the scope of
2 the way this measure is designed. But
3 ultimately that's what we need to try to get
4 to.

5 MS. GIL: I just want to mimic
6 what Robert said real quickly again in terms
7 of making the data usable for organizations
8 because this is why we're all here. We want
9 this data to be looked at and used to drive
10 care and outcomes. So something that can help
11 streamline this would be very important.

12 CO-CHAIR GIFFORD: CMS?

13 DR. LING: Just one additional
14 comment and a response.

15 We appreciate the concurrence with
16 the toil that we put in to try to focus this
17 on symptomatic and to take the emphasis away
18 from asymptomatic bacteriuria. And this was
19 one of the areas that we focused so intently
20 on that caused a little bit of a delay for the
21 manual. So it was well intended.

22 DR. GRIEBLING: And I think it's

1 really important that you did that. I think
2 that's very, very important.

3 DR. BURSTIN: One issue on the
4 horizon in terms of harmonization is we're
5 about to embark on our large HAI project this
6 year, actually in the next couple of months.
7 And CDC is submitting an updated case
8 definition and measure to NQF around UTIs,
9 especially catheter-associated UTIs. So I
10 think we just need to make sure we harmonize
11 that going forward.

12 That won't be endorsed for at
13 least nine months. But I think it's an
14 important future thing to make sure the same
15 rates of UTIs that go into hospitals we should
16 really be defining the same way.

17 CO-CHAIR GIFFORD: It's really
18 important as we do that because I work with
19 CDC everyday, but also bridging the geriatric
20 world.

21 CDC defines UTIs in the young
22 people. And what you're hearing here is it's

1 very different in the elderly. And this issue
2 came up on -- and the geriatric -- whatever
3 this -- the geriatric measures panel that I
4 was on, we talked a lot about the same thing
5 with that.

6 So what I hear before us is
7 approve the measure, close the loophole,
8 missing data. And then for the vendor and the
9 development, I don't hear anything else. I'm
10 going to summarize this in a recommendation
11 back to CMS though. But approve the measure
12 with the closing of the loophole and missing
13 data.

14 You have a pained look on your
15 face, Rob?

16 DR. ZOROWITZ: No, I'm fine.

17 CO-CHAIR GIFFORD: Okay. It's a
18 happy time. We're getting through the
19 measures. We did the pain yesterday. We got
20 that done.

21 Any abstaining?

22 (No response.)

1 CO-CHAIR GIFFORD: Any opposed?

2 (No response.)

3 CO-CHAIR GIFFORD: All in favor?

4 (Unanimous agreement.)

5 CO-CHAIR GIFFORD: Okay. The
6 recommendation to CMS again to Jean Scott and
7 everyone else is the RAPs and the F-TAGs need
8 to really be improved probably on this very
9 issue of overdiagnosis of UTI. And it needs
10 to be done in a way that empowers the medical
11 director and the nursing staff to take on my
12 colleagues who are the ones who really are
13 ordering the urinary cultures when as soon as
14 they see the bacteria they feel compelled to
15 treat.

16 DR. GRIEBLING: And it also needs
17 to harmonize to the never event in acute care.
18 So the fact that patients who are admitted to
19 us in acute care settings, if they develop an
20 iatrogenic urinary tract infection that will
21 not be covered under payment by CMS, that all
22 has to be harmonized in this.

1 CO-CHAIR GIFFORD: The big problem
2 is you need to empower the nurses to take on
3 the doctors because there's a synergy between
4 the nurses and the doctors here. The nurses
5 feel compelled to do something. The doctor
6 says we'll just order a urine. And it starts
7 a cascading event. The urine comes back
8 abnormal. The doctor says then give him an
9 antibiotic. The calls stop. Everyone's
10 happy. Except the patient's the one that's
11 harmed during the whole process.

12 So until you're in a position to
13 help break it and work with the state survey
14 agencies, the reporting and payment and
15 linking it all together, I think it would just
16 be very powerful.

17 MS. ROSENBAUM: And that plays
18 into overuse of antibiotics too in the elderly
19 population.

20 CO-CHAIR GIFFORD: Exactly.

21 All right. We finished
22 incontinence. Please know the incontinent use

1 the bathrooms.

2 (Laughter.)

3 CO-CHAIR GIFFORD: And we're back
4 here in 15 minutes.

5 Okay. I move we approve all three
6 measures as is. Everyone in favor? Okay.
7 You guys can go. We're done.

8 (Whereupon, the above-entitled
9 matter went off the record at 10:45 a.m. and
10 resumed at 11:00 a.m.)

11 CO-CHAIR GIFFORD: Okay. So what
12 we need to do now is reflect back over the
13 measures we've gotten. So reflect back over
14 the measures that we've done so far, and what
15 we've passed and haven't passed.

16 Okay. So a couple of quick
17 announcements. I was just talking to fill the
18 time in. You sit down when I talk.

19 So show of hands of people who
20 need to take the shuttle to National Airport
21 for the 2:30. In the back too. Yes. So
22 we've got to count one, two, three, four,

1 five, six -- six people. Okay. I counted
2 you. Did I miscount? Was it seven?

3 Show of hands again. I clearly
4 can't count. One, two, three, four, five,
5 six. Yes, six. Okay.

6 Why do you want to know about BWI?

7 How many people are going to BWI?

8 Is there a chance we're going to
9 end early?

10 We could always hope.

11 Okay. On the issue that Helen
12 brought up last time, the two measures that we
13 approved -- the two incontinence measures. In
14 the past, there was a recommendation from NQF
15 that those measures always be used together
16 because of the potential for gaming. Kind of
17 like what we said before. If you can put a
18 lot of catheters in a lot of people to get out
19 of the exclusion for the other. So when the
20 exclusions in one measure are used to get you
21 out, there is also a quality measure
22 elsewhere. There's usually been a

1 recommendation to pair those two.

2 So what it would be is that the
3 low-risk bowel and bladder and then the use of
4 the catheter. Those two would be paired
5 together.

6 I would ask do you think that the
7 UTIs should be paired as all three or they can
8 be done that -- the other two we didn't
9 approve. So it would just be those two.

10 Comments on whether they should be
11 continued to paired or not? They currently
12 are paired.

13 No comments or questions about it?

14 MR. BOISSONNAULT: What do you
15 think?

16 CO-CHAIR GIFFORD: I just do what
17 I'm told.

18 So I would put forth to the
19 committee that they be paired. That's what I
20 think, Bruce. They should be paired.

21 MR. BOISSONNAULT: Could we ask
22 the developer? Should they be paired?

1 MS. CONSTANTINE: Yes, we agreed
2 that they should be paired.

3 MR. BOISSONNAULT: I move that we
4 vote to pair them

5 MR. KUBAT: Just a question in
6 relation to that.

7 Not to be overly simplistic, but
8 does the paired mean just reported in
9 proximity or does it mean some explanatory
10 commentary?

11 CO-CHAIR GIFFORD: I think the
12 explanatory commentary and other stuff is up
13 to the people who would use it. But
14 essentially we're endorsing them almost as a
15 single measure that they have to be done
16 together. If someone's going to use them they
17 shouldn't just use one of them.

18 So whether it be CMS or the Rhode
19 Island Department of Health wants the report,
20 I'd have to use both of them together.

21 DR. BURSTIN: All right. So
22 essentially, you would always report them

1 together. They would not be a composite. You
2 wouldn't get a single score out of it but
3 you'd always make sure those two measures flow
4 together to be able to look at the issues
5 between them.

6 MR. BOISSONNAULT: More
7 specifically would the implication be that the
8 baseline dates -- if one of the issues is
9 squeezing the tube of toothpaste, you wouldn't
10 want someone to be able to use timing issues.

11 So is that what you mean by
12 reporting together that they would be drawn
13 from the same data set timing?

14 DR. ZOROWITZ: I think currently
15 if you look at the QMs, both of those items
16 are always on the QMs. I don't think that
17 this means that they're going to be linked and
18 there's going to be something that says you
19 have to look at both of these measures.

20 I think the point is that if one
21 of them is going to be reported, both of them
22 must be reported. Regardless of where on the

1 list of QMs they're reported, they both have
2 to appear.

3 MR. BOISSONNAULT: But we would be
4 looking at the same data set and same data
5 timing for the two different measures. Isn't
6 that part of the point is to keep someone from
7 squeezing the tube of toothpaste by playing
8 with timing or something?

9 MR. KUBAT: Do we do the same
10 thing with restraints and falls?

11 CO-CHAIR GIFFORD: I'm going to
12 the other measures as well. In fact, that's
13 why I tabled it there. I wanted to see if
14 there was other stuff. So, yes.

15 So on this one, always ask the
16 patient. So we're asking the vendor if they
17 want to do it. The recommendation before us
18 to pair it as before.

19 All abstaining?

20 (No response.)

21 CO-CHAIR GIFFORD: Favor?

22 (Unanimous agreement.)

1 CO-CHAIR GIFFORD: Against?

2 (No response.)

3 CO-CHAIR GIFFORD: Okay. It
4 passes.

5 To Bill's point, were there any
6 other measures that we did yesterday -- now
7 you've got to remember what we did yesterday
8 -- that should equally be paired?

9 Restraints or falls? Yes, Alice?

10 MS. BELL: I was just going to say
11 that that would be my recommendation is that
12 falls and restraints be paired. I don't know
13 what we did -- to be honest with you -- that
14 would fall into that.

15 We did the injurious falls. I
16 don't know if we talked -- I apologize. I'm
17 blanking on the restraint measure.

18 But yes, I would say restraints
19 and falls should definitely be paired. And if
20 we had talked about both physical and chemical
21 restraints, so psychotropics as well as
22 physical restraints that there be a pairing.

1 CO-CHAIR MUELLER: Could someone
2 remind us? I know we did not approve the two
3 A&A fall indicators. Did we approve any fall
4 indicator?

5 MS. BELL: I believe we approved
6 the injurious fall.

7 DR. MODAWAL: Major.

8 MS. BELL: Major injury. So major
9 injury fall with restraints.

10 MR. BOISSONNAULT: Could we have
11 numbers?

12 MS. THEBERGE: 008 and --

13 CO-CHAIR GIFFORD: 21.

14 MS. THEBERGE: -- and 21's the
15 restraints.

16 So it's percent of residents
17 experiencing one or more falls with major
18 injury long stay, and percent of residents who
19 are physically restrained long stay.

20 MR. BOISSONNAULT: And are they
21 both from the same data set?

22 MS. THEBERGE: Yes.

1 MR. BOISSONNAULT: Okay. Because
2 pairing if they're not from the same data set
3 makes no sense. You can still game it.

4 DR. ZOROWITZ: Just to throw a
5 little point of dissent, we know that neither
6 chemical nor physical restraints reduce falls.
7 And in fact, they probably increase them. So
8 I don't know what the necessary importance of
9 pairing them would be because if someone
10 thought that they could use restraints to
11 reduce falls, their fall rate is probably
12 going to go up or remain the same.

13 So I think it's a different issue
14 than the other one. I don't really think it's
15 necessary to pair them.

16 MS. BELL: And I agree with you
17 that statistically it does show that we -- and
18 actually the risk of injury is greater with
19 the fall when a restraint is used. I think
20 there was just some concern -- I think the
21 interests might be -- and maybe this is a
22 time-limited thing -- is that people may

1 attempt to use restraints even though the
2 result would be more injury and more fall.
3 And so the pairing might just be to see how
4 often are people attempting to solve one issue
5 with the other even though the outcome is
6 going to be more negative, I guess, if that
7 makes any sense.

8 CO-CHAIR GIFFORD: Along those
9 lines, I didn't like the fact that we even put
10 the fall measure -- I mean the restraint
11 measure in the fall section because it denotes
12 that restraints are somehow tied to falls.
13 Restraints really are quality of life issues.
14 They should be grouped as a quality of life
15 issue outside of that.

16 But that doesn't mean that pairing
17 aren't maybe important issues around quality
18 of life and other aspects. And since they are
19 -- they go together, it doesn't have to be
20 that they're squeezing a toothpaste going
21 different ways. It could be that we still
22 think that they're so important you'd want to

1 pair them together.

2 So that doesn't mean that voting
3 to pair them isn't wrong here. It doesn't
4 have to be the rationale for it.

5 MR. BOISSONNAULT: To the vendor,
6 I think -- and this may have been a more
7 limited conversation among some of us -- but
8 I think there's some evidence that restraints
9 actually lead to more harm falls. And so the
10 point I think Alice was making in pairing was
11 in fact exactly consistent with what Robert
12 was saying is to sort of highlight the linkage
13 that if you think the simple solution is to
14 just bind people in order to reduce harm to
15 them that you may see -- the literature
16 suggests the inverse. And so that would be
17 the point of pairing.

18 But do you have an opinion on
19 pairing those two?

20 MS. CONSTANTINE: I would suggest
21 pairing them because I think until we see the
22 data and falls is a new measure. So I think

1 it would be very good and also to remind us to
2 take a look at them together and see which
3 direction that they go and to be very
4 cognizant of that for us as the developers as
5 well as facilities and to monitor that. So it
6 makes sense to me to pair them.

7 MS. CONSTANTINE: And again, part
8 of the definition of pairing is that we're not
9 playing with time frames, that to the extent
10 that we can we're drawing from the same time
11 frame even though they're different measures.
12 Or do the measures not allow for that in this
13 one like they did with the last one?

14 DR. ZOROWITZ: I was just going to
15 say there is a difference here. Because with
16 the incontinence measure and the catheter
17 measure, if you put in a catheter you
18 eliminate one person from your incontinence
19 measure. So there really is an effect of one
20 on the other.

21 This is the opposite. You cannot
22 reduce your fall rate by putting restraints on

1 somebody. So you're not going to have the
2 adverse effect on measurement by putting a
3 restraint on somebody as you would by putting
4 a catheter in someone and eliminating them
5 from being measured as an incontinent person.

6 So I think the reasoning in
7 pairing the two is very different.

8 MR. BOISSONNAULT: I agree with
9 that. I'm not sure it goes away. But I
10 agree.

11 DR. ZOROWITZ: And the only caveat
12 that I would have is that the falls measures
13 is relatively new. And while I think it's
14 interesting to look at a restraint measure
15 with a falls measure or several falls
16 measures, I wouldn't want to say specifically
17 it should be paired necessarily with this
18 falls measure because we don't yet know how
19 this falls measure is going to work since it's
20 new and it's going to be tested.

21 So I'm convinced. So could we
22 recommend seeing if in fact there is a sort of

1 perversity of serious harm when there's an
2 excess of binding people or whatever -- yes,
3 restraints as opposed to making it a
4 requirement of passing the measure. I think
5 you're right making it.

6 DR. MODAWAL: There is some
7 relationship of course of falls and
8 restraints. But I think the type of
9 restraints and where you use it actually in
10 terms of all the restraints are not bad. I
11 mean, they're considered bad but in terms of
12 falls or injuries, perhaps there's less chance
13 to use in bed to make it more harmful than
14 those which are used in a chair.

15 So I think some qualification is
16 needed in terms of what kind of physical
17 restraints we want to look at. And we're not
18 talking about falls actually. The main issue
19 was in the outcome and the indicator was the
20 injury -- the major injury, and I think the
21 relationship with the major injury and the
22 physical restraints.

1 CO-CHAIR MUELLER: So it means
2 that there's this recommendation not to pair
3 those two?

4 MR. BOISSONNAULT: Not to require
5 it.

6 CO-CHAIR MUELLER: Not to require.
7 Right.

8 DR. MODAWAL: Just to look at but
9 not --

10 DR. ZOROWITZ: You may find that
11 higher restraints is associated with the
12 higher falls measure. Or higher harm. Right.

13 CO-CHAIR MUELLER: I don't believe
14 that requires a vote though. It's just a nice
15 friendly recommendation. Okay.

16 All right. We're going to start
17 on measures related to nutrition and other
18 functions. So item 24, residents who lose too
19 much weight.

20 DR. NIEDERT: I was the primary
21 review on this one.

22 CO-CHAIR MUELLER: But we need our

1 developer to talk about it first.

2 MS. BERNARD: I'll ask the same
3 question that Roberta asked earlier. And that
4 is there are three measures in this set. Do
5 you want me to go over all three of them or
6 one at a time?

7 CO-CHAIR MUELLER: The first one
8 seems so different than the second two.

9 MS. BERNARD: Okay. So --

10 CO-CHAIR MUELLER: So let's just
11 do the weight one.

12 MS. BERNARD: Okay. I'll do that
13 initially.

14 But the three measures -- what
15 they have in common in this set is that
16 they're longitudinal measures. And the weight
17 loss measures looks at -- well, it updates the
18 current MDS 2.0, weight loss measure, by
19 adding physician-prescribed weight loss as an
20 additional category in the underlying item,
21 and using a two quarter average for the
22 facility rather than a single quarter to

1 address concerns about seasonal variation.

2 Nursing facility residents often
3 have chronic diseases and functional
4 impairments that present a challenge for
5 proper nutrition and hydration. Residents
6 with weight loss are at higher risk for
7 functional decline, hip fracture and
8 mortality. And consequences of weight loss
9 may include muscle-wasting infections and
10 increased risk of pressure sores.

11 The prevalence estimates of poor
12 nutrition and unintentional weight loss among
13 people in institutions vary from two percent
14 to 41 percent. Using the MDS 2.0 data for
15 April to June of 2009, the national prevalence
16 of too much weight loss in nursing homes was
17 9.2 percent with a range of low from an
18 average of seven percent to a high of an
19 average of 11.4 percent.

20 So to summarize the changes in the
21 underlying items, there's a slight different
22 between MDS 2.0 and 3.0. And the MDS 3.0

1 weight loss now has a three response category
2 with the two new ones referring to physician-
3 prescribed weight loss.

4 So the response categories are no
5 or unknown, yes on physician-prescribed weight
6 loss regimen, or yes, not on physician-
7 prescribed weight loss regimen. And it's only
8 that second one that's used for this measure.

9 The improvement in measurement in
10 this is that as a result of some work that was
11 done by Vince Mor who found seasonal variation
12 in the measure, the proposed measure uses a
13 two quarter average for the facility rather
14 than a single quarter.

15 And that summarizes the changes in
16 the measure from the current one.

17 CO-CHAIR GIFFORD: Seasonal
18 variations that go up at Thanksgiving or
19 Christmas or --

20 DR. NIEDERT: I looked at this
21 measure, and obviously having my first career
22 for 35 years being a dietician and being a

1 dietician in long-term care, it is one of
2 those very close to my heart.

3 We know that the importance
4 because of all of the ramifications of poor
5 nutrition which she alluded to -- the
6 increased falls, the increased fractures,
7 certainly impaired skin. So we know that
8 unintended weight loss, it's always been a
9 quality measure, has been for some years. The
10 interest to me is that there is tons and tons
11 of research and we know about it. Yet when
12 you look at the statistics, they haven't gone
13 down any since we started keeping this
14 measure.

15 I would agree that the measure is
16 important. But I think a caveat of that
17 because I think in the verbiage it talked
18 about only one area of concern. And I would
19 like to see the consequences of not only poor
20 quality but certainly of increased mortality,
21 morbidity and high use of resources also
22 listed.

1 Some of the evidence that they
2 reviewed was over ten years old. But as all
3 of us know, the evidence is there.

4 There was mention of no formally
5 related evidence. But the American Dietetic
6 Association has done some extensive review of
7 unintended weight loss with ratings. It has
8 been measurable information where they looked
9 at different studies.

10 And I think one of the omissions
11 of this information probably was because there
12 was no registered dietician on the TEP which
13 I felt was certainly lacking when the
14 dieticians do deal with the nutrition issues
15 much more than most physicians or nurses.

16 There was also no mention of the
17 guidelines done by AMDA. I know that they
18 have those. And I would have liked to have
19 seen those included in some of the references.

20 One of the things that bothered me
21 in the review material was that one of the
22 quotes that was used was from Dr. Morely that

1 contends that there are minimal intervention
2 studies demonstrating any salutary effect on
3 weight loss. That was the quote they used.
4 But this is kind of beside the point, and I'm
5 not sure of its relevance if we're trying to
6 prevent weight loss -- when he says there's
7 nothing to do anyway. So that quote I would
8 have liked not to have been there.

9 I think from a scientific point of
10 view and the usefulness of the information, I
11 think there's some concern for facilities that
12 specialize in end-of-life or dementia because
13 their numbers are going to be statistically
14 higher because of their population. So I'm
15 wondering if that couldn't be stratified --
16 the information couldn't be stratified or
17 adjusted to be more beneficial for that
18 segment.

19 I didn't see any other problems
20 with usability. Most of us are using it as a
21 tool to help prevent weight loss or decrease
22 our unintended weight loss in our facilities.

1 And certainly the CMS surveyors and state
2 surveyors are using it to inspect our homes.

3 I didn't see any problems with
4 feasibility at this point either, but I will
5 let -- Bob was my cohort in crime on this one,
6 so I'll let him discuss anything else that I
7 left out.

8 DR. ZOROWITZ: I concur.

9 The only other point, end-of-life
10 was not an exclusion criterion. And I have
11 mixed feelings about that because while we
12 often see weight loss in our terminally ill
13 residents, it's not universal. So I wonder
14 just as a question whether that might have
15 been why it was not an exclusion factor.

16 DR. NIEDERT: The other issue we'd
17 have to look at -- this was long-term stay, so
18 it goes back to our 100 days that we talked
19 about. And there's something else I just
20 thought of and I just lost it. I think maybe
21 I have dementia. It had to do with dementia
22 too unfortunately.

1 Oh. Not marking the box because
2 you're not weighing those residents that are
3 at end of life and you have orders many times.
4 That shouldn't count against you, I don't
5 think, especially if they're in palliative
6 care and many times they might have bone
7 cancer and metastases. And so by moving them
8 you disturb them and cause them increased
9 pain, so why would you weigh them to begin
10 with? You know what the outcome is. They're
11 losing weight.

12 So I'm not one of these dieticians
13 that demands weekly weights or whatever on
14 residents in end of life.

15 DR. MODAWAL: I have the same
16 question. I don't know whether in nursing
17 homes do they classify a patient in the
18 hospice care separately?

19 DR. ZOROWITZ: There is an item on
20 the MDS 3.0 which is end of life. And I don't
21 have the -- I think it's J1400. I'm not --

22 DR. MODAWAL: And if it is

1 possible, they can be. If it possible, then
2 they can be excluded from the --

3 DR. ZOROWITZ: It's J1400.

4 But the problem I have is that not
5 all end-of-life patients need to lose weight.
6 Many of them do. And this is getting back to
7 Kathleen's point. If you know they're going
8 to lose weight and there are not effective
9 interventions, then there's no point to
10 weighing them. And therefore there would be
11 no data entered. And I think that should not
12 be held against the facility.

13 But there are many end-of-life
14 patients that given enough attention and time
15 in helping them eat, they are able to maintain
16 their weight. So that's why I'm asking
17 whether that was the reasoning behind not
18 having J1400 as an exclusion factor.

19 MS. BERNARD: That was the sense
20 of the technical expert panel -- the sort of
21 conundrum that you brought up, that because
22 someone is on hospice does not mean that they

1 necessarily have to lose weight.

2 DR. ZOROWITZ: I've seen just in
3 my own experience many Alzheimer's disease
4 victims who are nearing the end. They start
5 losing weight. We pay more attention to them.
6 And all of a sudden, they stop losing weight.

7 I would hate to see an indicator
8 exclude them and therefore the facility feels
9 they don't have to make the same effort
10 because I think it is possible -- and I think
11 this is a quality of life and comfort issue as
12 well. So I would agree with not having it an
13 exclusion factor.

14 MR. BOISSONNAULT: Robert, are
15 there significant groups of other patients for
16 whom -- here's why. Let me frame the
17 question.

18 So Diana and I both have said in
19 the absence of indications to the contrary,
20 leaving it blank should be assumed that you
21 did not comply. And what you're saying is for
22 patients at end of life who are designated in

1 MDS 3 as end of life that leaving it blank
2 should not be viewed as a negative. You
3 should drop the patient. But are there not --
4 and this is really my question -- are there
5 not other patients besides hospice as defined
6 by the MDS 3 who also you might not want to
7 move to weigh? And so my question is should
8 the issue that Diana and I have been bringing
9 up just not to apply to this measure generally
10 as opposed to only for end of life?

11 DR. ZOROWITZ: Is lack of data an
12 exclusion in this? I didn't remember. It is.

13 I would probably leave it as such
14 and give the benefit of the doubt to the
15 facilities because the flip side of this is
16 that some facilities are not very good at
17 regularly weighing patients. And on my hat is
18 sometimes doing expert review for law firms.
19 Sometimes you'll see that weights, somebody
20 just forgot to do it for six months.

21 But in this case, I think we
22 should give it the benefit of the doubt and

1 leave it as is.

2 DR. ORDIN: Well, I have to tell
3 you I'm a little uncomfortable with that
4 because you can make the same argument for all
5 the other things that we said. There are
6 conceivable reasons why people shouldn't. But
7 it leaves you so open to gaming. Someone
8 could say for those five months oh, you know
9 that patient was too much in pain to be
10 weighed or something.

11 So I don't know. I mean, I'm
12 really conflicted on this one.

13 DR. MODAWAL: Weight as a measure
14 is as was pointed out hard to do. And many
15 times it also variable. There's inaccurate
16 measurement of weight as well. You see the
17 nursing home chart and the weight's going all
18 over the place many times.

19 I wonder if weight loss trend
20 would be a better measure than spot readings
21 at six months or 30 days.

22 And certainly in terms of the end

1 of life patients and hospice patients, it
2 depends on the case mix. I think some of the
3 nursing homes if they have a higher case mix
4 of these end-of-life patients or patients who
5 cannot be weighed or have patients who are
6 declining despite best efforts, my concern is
7 that they may look badly.

8 MR. BOISSONNAULT: Diana, the
9 difference with this is that this field could
10 potentially cause discomfort to the patient
11 whereas the other fields if you leave them
12 blank, it's just an administrative thing.

13 So I hear you. But I think this
14 is slightly different because it has clinical
15 implications to fill it in or not fill it in.

16 DR. ORDIN: My argument would be
17 either it is perhaps to exclude it, that if we
18 think there's so much leeway in whether you
19 should fill it in or not, perhaps those people
20 likely to have it not filled in should be
21 excluded from the measure.

22 DR. ZOROWITZ: Well, keep in mind

1 that this measure has been a quality measure
2 already. And to the best of my knowledge, it
3 hasn't been a huge issue of facilities leaving
4 out the information deliberately.

5 MS. BERNARD: I would also like to
6 remind you about the definition of the measure
7 -- a loss of five percent of the resident's
8 body weight during -- or more -- during the
9 month prior to the assessment, or a loss of
10 ten percent or more in the six months prior to
11 the assessment, so that there is a window.

12 In other words, the resident could
13 miss a couple of weights and still be included
14 in this measure. You'd have to have a lot of
15 missing data in order to exclude them.

16 DR. NIEDERT: And I can say in all
17 my practice and the facility I work at right
18 now is an over 800-bed continuing care
19 retirement community, we maybe have one
20 percent -- two at the very most -- where we
21 would not be weighing that person. It's not
22 a large number of residents who are not

1 weighed.

2 It's just those people that
3 probably we do weigh weekly in the nursing
4 home where I work because that's the demands
5 that the DON and I have. So we weigh all the
6 100 people that are under SNF and nursing
7 facility care weekly.

8 The only ones that we exclude are
9 those that we know are within probably four
10 weeks of expiring, and that we know that it
11 would be very, very uncomfortable for them to
12 be weighed and moved -- the person that's got
13 4-plus edema and CHF and can barely breathe
14 let alone get them to move.

15 DR. ZOROWITZ: And your
16 denominator is large. There's not that many
17 exclusions. So in order to have a significant
18 number of data exclusions meaning that you
19 couldn't have weighed them for over six
20 months, that would not reflect well on the
21 home. And I suspect that after submitting
22 that material, probably the state would ask

1 some questions.

2 CO-CHAIR MUELLER: Are we ready to
3 vote?

4 I think the only condition would
5 be the 100-day issue, but it seems like we are
6 agreeing that we would want to keep the
7 exclusions. Okay?

8 All those in favor, raise your
9 hand.

10 No? Abstain?

11 (Unanimous agreement.)

12 CO-CHAIR MUELLER: Okay. We'll
13 move on to 22, percent of residents who need
14 help with activities of daily living has
15 increased. This is a long-stay measure.

16 And would this one make sense to
17 do the second one also? That would be 23?

18 MS. BERNARD: Yes, it would
19 because any changes to the MDS are consistent.

20 So the two measures, they're both
21 long-stay measures. They're both longitudinal
22 measures.

1 The percent of residents whose
2 need for help with activities of daily living
3 has increased updates the current quality
4 measure by using the slightly revised ADL
5 items in the MDS 3.0.

6 The underlying data items in the
7 MDS 2.0 and 3.0 are the same with minor
8 clarifications. The minor clarifications are
9 the inclusion of two categories -- activity
10 occurred only once or twice, or activity did
11 not occur. But they get re-coded into total
12 dependence. So essentially it makes no
13 difference in terms of the measurement.

14 These two measures address an
15 important area in the care for older adults in
16 nursing homes -- I mean, for the residents of
17 nursing facilities. These residents are at
18 risk for functional decline which is
19 associated with a decreased quality of life.
20 Greater dependency in activities of daily
21 living is a risk factor for negative outcomes
22 including pressure ulcers and hospitalizations

1 and their associated costs.

2 Using the MDS 2.0 data for April
3 to June of 2008, the national prevalence of
4 increasing need for help with ADLs in nursing
5 facilities was 16.1 with a range from a low of
6 an average of 10.6 to a high of an average of
7 24.2. So there's indeed variation.

8 As far as the percent of residents
9 whose ability to move in and around their
10 rooms and adjacent corridors got worse. There
11 are the same changes to the MDS 2.0 as with
12 the ADLs with the inclusion of those two
13 categories. And the importance is similar in
14 that immobility increases the risk for
15 unwanted sequelae and an impact on quality of
16 life.

17 And the prevalence for this
18 measure in terms of mobility decline, the
19 national prevalence was 15.7 with a range of
20 10.2 in one state and a high of 25.7 in
21 another state.

22 So these are the changes to the

1 measure from the one that's in current use.

2 And I'll be glad to address any other
3 questions.

4 CO-CHAIR MUELLER: For 22 -- there
5 we go. Bill, you're the primary.

6 MR. KUBAT: Yes. Thank you. And
7 Sister Mary Rose was the secondary.

8 And I think we're broadly in
9 agreement on this. This is obviously a
10 continuation measure, just moving it into the
11 3.0 platform.

12 I think as we reviewed the
13 materials on each of the points on importance,
14 scientific, usability, feasibility, in all of
15 those areas if not complete, partial or
16 somewhere in between, what was significant I
17 think or just of note is that what's
18 consistently noted throughout any or all of
19 those areas is that there broad consensus
20 about the importance of the measure and the
21 issue. But there are consistently limitations
22 that aren't compelling enough to not advance

1 it.

2 One relates to the sensitivity of
3 it in terms of Medicaid payment policies or
4 practices within states. So it's not just
5 measurement that drives behavior, but it's
6 reimbursement that drives behavior. So naming
7 and acknowledging that limitation in terms of
8 the quality improvement side or the use of the
9 measure as a CQI tool by facilities because of
10 what's consistently acknowledged or named, the
11 inability just on the basis of the measure to
12 be able to differentiate decline due to
13 inadequate care as opposed to just unavoidable
14 decline.

15 And then the third, the issue of
16 cognitive impairment and the relationship of
17 that and the challenge or the difficulty of
18 being able to risk adjust in relation to that.

19 So those things are all named.
20 They're not necessarily mitigated. But the
21 overarching consideration is that the measure
22 still stands even in the context or in the

1 midst of those limitations.

2 So I'll turn it over to Sister for
3 any other additional comments she might have.

4 SISTER HEERY: Yes. Bill and I
5 both agreed on that.

6 The only issue that I had was that
7 hospice residents are excluded. And my
8 concern with that was that we have a large
9 population of cognitively-impaired residents
10 in our home, and we do see the trend of
11 hospice now starting to come in and be
12 involved with those residents. And just
13 because someone's on hospice doesn't mean
14 they're quality of life should shift and we
15 should lose late-loss ADLs.

16 I respect hospice. I think they
17 have a big part to play in nursing homes. But
18 when we're looking at this, I think we need to
19 be careful that we don't start excluding that
20 large population. That could be a problem.
21 So that was my one concern.

22 And I think we discussed hospice

1 with weight loss and things. It's not
2 necessarily the end so we need to promote and
3 be proactive even with our hospice residents.

4 But I concur with Bill.

5 CO-CHAIR MUELLER: Any questions
6 or comments?

7 MR. BOISSONNAULT: I have more
8 angst about this than Bill or Sister Mary Rose
9 as it relates to pay-for-performance. And the
10 problem for me is we cannot endorse and say
11 but don't use it for pay-for-performance.
12 That's outside of the scope of what the NQF
13 can do.

14 Not having delved into the sort of
15 details -- just looking at what's written in
16 blue on the memory stick that we have -- I
17 don't see anything that makes me comfortable
18 that the ability to stratify for nursing homes
19 that have patients who are going to be
20 immobile and might have a higher percentage of
21 them -- maybe you don't need to talk anybody
22 else down, but if you want to, could you try

1 and talk me down that some overzealous
2 administrator isn't going to say we've got to
3 find eight percent in the budget, let's use --
4 if you know there's a patient who's
5 legitimately going to be immobile, or if you
6 know that a nursing home has a high percentage
7 of patients that are going to be immobile, is
8 it fair to compare absolute results on this
9 measure from nursing home to nursing home and
10 to pay different using that? That is my
11 question.

12 MS. BERNARD: Okay. I was going
13 to ask you to clarify your question because I
14 was having trouble understanding.

15 So you're asking whether the
16 measure is reliable enough to be able to
17 compare the performance of one facility versus
18 another facility?

19 MR. BOISSONNAULT: If you take
20 this sample from the MDS 3 or 2 -- and I sort
21 of look over to my CMS colleagues -- I'm not
22 inclined to say let's keep this secret. But

1 I really think this one brings out the issue
2 of risk stratification or some way to make
3 sure because we have some on the hospital side
4 that we're going to be dealing with that we
5 loved having them out there but I think we're
6 going to hate initially having them on pay-
7 for-performance.

8 And so let me add one other thing
9 because it's a larger issue. I would love to
10 know how the World Health Organization
11 countries who also are measuring this stuff
12 deal with this and some of the other measures.
13 I really wish we would not be quite so myopic
14 in our perspective when we look at how others
15 measures. We should try and harmonize with
16 the World Health Organization. But that's a
17 separate issue.

18 On this one -- and maybe Robert
19 can comment on it -- but if this was a pay-
20 for-performance measure, do you start to get
21 cold sweats at night?

22 DR. ZOROWITZ: Well, I'm looking

1 at some of the information here. And you
2 would expect there to be variability among
3 institutions.

4 According to the University of
5 Colorado study, it says that there was
6 variability -- a reasonable degree of
7 variability. But I would think that -- I
8 mean, we're not looking for zero here.
9 There's going to be variability among
10 institutions. And you won't flag until you're
11 significantly higher than other institutions.
12 I think that will be somewhat of a bell curve.

13 But according to this, they looked
14 at that and felt that there was some
15 variability. But I don't think that's going
16 to affect the value of the measure. I mean,
17 you may get one or two facilities here and
18 there that take a particularly vulnerable
19 population susceptible to functional decline.
20 But they don't seem to have found that that --
21 that was more the exception rather than the
22 rule.

1 MR. BOISSONNAULT: So you don't
2 think there's going to be a ton of outliers
3 who cannot control the fact that they're
4 outliers based on the way the measure is done?

5 DR. ZOROWITZ: No, I think there
6 will be some variability. You're always going
7 to have patients -- residents who have
8 functional decline. That's to be expected to
9 some extent. But I don't think you're going
10 to have an enormous number of outliers unless
11 you have a facility really specializing in
12 very clinically complex residents.

13 DR. KOREN: I think that the point
14 that Robert is making is that the ideal number
15 is not zero, and that there will be a
16 baseline, that all facilities will probably
17 have a certain number of these people because
18 they do have end-stage dementia. They will
19 have hospice patients.

20 So it's not like you're saying if
21 you're not zero, you're not good. What you're
22 saying is you don't want to be outlier on the

1 top. And there aren't a lot of places that
2 sort of specialize in just these people.

3 MS. BERNARD: I think if I could
4 just add one more comment to that that when
5 you have a rate-based measure, you're looking
6 at the variation in rates by facilities. And
7 you know I think as Dr. Koren said that
8 they're not going to be zero. It's not as if
9 you're not going to have people whose mobility
10 changes.

11 And in this particular measure --
12 these two measures -- we've not found a risk
13 adjustment model that has been useful.

14 MR. BOISSONNAULT: Yes, I'm pretty
15 deep in the weeds on the statistics. I'm not
16 looking for zero. I'm looking to avoid what
17 Demming called the red beads experiment where
18 you are doing all these things but there are
19 factors that are either random -- which is the
20 red beads -- or completely out of your control
21 as it relates to your population.

22 But as long as the folks who run

1 these centers say no, we don't think there's
2 going to be a lot of outliers who for some
3 reason have 30 percent patients right off the
4 top, then that's you guys.

5 MR. KUBAT: One other factor with
6 that -- and just hearing the conversation
7 prompts me to think about it -- there's more
8 than one element or aspect to Medicaid payment
9 policies that potentially have an impact on
10 this, and will continue to have an impact on
11 this.

12 It's not just reimbursement to the
13 SNF that people document in relation to you.
14 But where you have those variations in payment
15 practices within states or across states, you
16 also have variation in the development of
17 alternative services. So the extent to which
18 there's more of a focus on assisted living on
19 home- and community-based services -- which is
20 a function of Medicaid dollars and so forth --
21 that's going to impact the population that is
22 then served generally in the skilled

1 facilities in that state. I think that's also
2 a function of the variation. And that's going
3 to be reflected in ADL decline.

4 MR. BOISSONNAULT: What you're
5 saying is there's going to be a systematic
6 impact on that.

7 My experience in this -- and I
8 waver a little bit on whether I should name
9 names, so I won't -- when evaluating one of
10 the world famous heart center open-heart
11 surgery rates, by most risk adjustment
12 methodologies, this one center looks
13 wonderful. But when you sort of dig under the
14 hood, you discover that more than close to two
15 thirds of their open-heart surgery patients
16 are traveling from all over the country to get
17 there. So the patients -- the one third of MI
18 patients whose first symptom is death or
19 trauma -- are out of the sample in risk
20 adjustment -- at least early risk adjustment
21 wasn't fully capturing that.

22 I just think at a minimum we

1 should on this measure say there's some real
2 cautionary issues about including it in a
3 bundle that goes toward reimbursement. But I
4 know we can't do that. That's enough for now.

5 DR. GRIEBLING: One of the points
6 that I think is important in terms of
7 especially looking at outliers and expected
8 functional loss is that the way you've
9 structured this it focuses on four specific
10 ADLs. It's not all ADLs. So it doesn't
11 include mobility. And it's looking
12 specifically at the ones that tend to be lost
13 last -- so the ones that are preserved.

14 And so I think that that focus
15 helps to narrow that gap somewhat, and I think
16 that will help with this measure. I think
17 it's strengthens it.

18 And I'd also strongly support
19 Sister Mary Rose's point. I think hospice
20 needs to be included.

21 SISTER HEERY: And I'm sorry. The
22 other thing is that most people that are in a

1 proactive program are preventing these late
2 loss. So there's payment on the other end
3 that you're getting. So it's a wash across
4 the board. So a good facility should be not
5 here. Yes, it should not be here.

6 CO-CHAIR GIFFORD: Let's see if I
7 can summarize that.

8 I think it's approve measure as is
9 except for the 100 day and remove the hospice
10 exclusion.

11 Is that a condition or a
12 recommendation? Recommendation. To look at
13 what it would mean to that and the pros and
14 cons of that. Okay.

15 So condition, close the 100-day
16 loophole and recommendation to look at the
17 hospice removing.

18 All in favor?

19 Abstaining?

20 Opposed?

21 (Unanimous agreement.)

22 CO-CHAIR GIFFORD: Okay. On to

1 number 23.

2 MS. THOMPSON: Yes. Under the
3 measure specifications, first of all I have a
4 lot of issues with this particular measure.
5 The measure reads "percent of residents whose
6 ability to move in and around their room and
7 adjacent corridors got worse." However, the
8 numerator that they're looking at is
9 locomotion on unit, which reads "how resident
10 moves between locations in his or her room and
11 adjacent corridor on the same floor, if in a
12 wheelchair, self-sufficiency once in the
13 chair."

14 So the part of the title of the
15 measure that talks about the ability to move
16 in and around the room isn't even addressed
17 because that's a different question on the MDS
18 3.0 altogether.

19 Secondly, with regard to this, the
20 issue that I have with regard -- and I was
21 kind of hoping it would be fixed in the 3.0
22 but apparently it was not something that was

1 meant to be. If it looks at equally if the
2 resident can do this ambulatory or in a
3 wheelchair, it's for self-sufficiency. So if
4 you have a resident who is extensive
5 assistance in locomotion on the unit
6 ambulating with extensive assistance, and the
7 next assessment they are now extensive
8 assistance but they are in a wheelchair,
9 theirs is no change to this code. So that
10 decline is never captured on this issue of the
11 MDS.

12 And of course the reverse is true
13 as well. If the resident required extensive
14 assistance in a wheelchair and improved to the
15 point of being extensive assistance
16 ambulating, and as far as -- what I learned in
17 nursing school is walking is always better
18 than riding except when you're going to town
19 -- that incline itself is also not recognized
20 in this so that you have a lot of -- I just
21 found that to be a big issue that this
22 particular numerator gets very, very messy.

1 Also as was stated by CMS, it did
2 add the number 8 on number 7 as it happened
3 one or two times. The 7 and the 8 get rolled
4 into the 4 which is extensive assistance for
5 the intent of this measure. However, in the
6 eyes of PPS, the 7 and the 8 equals an
7 independent. So there will be disparities
8 between any public reporting of the quality
9 measure as it relates to this and that
10 information as it relates to when they post
11 any PPS statistics.

12 The other issue I have is that it
13 talks about just a one-level decline. So if
14 a resident is independent and three times in
15 over a 24-hour period times seven days they
16 required cuing, that is a decline.

17 In the late loss one that was
18 talked about earlier, the nice thing they did
19 is they talked about a two-level decline and
20 one late loss ADL, or one-level decline and
21 multiple ADLs. It would have been nice if
22 they would have looked at the independent and

1 supervision like maybe a decline from a zero
2 to a 1 to a 2 or a decline from a 2 to a 3, or
3 something like that, to take into respect.
4 Because I tell you what, if you did an MDS on
5 me today, I would have declined on my
6 locomotion on unit-based and cuing over the
7 last seven days on where my room was.

8 (Laughter.)

9 MS. THOMPSON: I have been in so
10 many hotels and tried to get in so many wrong
11 rooms. It's just unreal.

12 The other thing that is -- and we
13 do talk about -- they do exclude residents who
14 are already at a level of total dependence
15 because they can't really decline any further
16 than that, adding the 7 and the 8. They also
17 do exclude residents who are comatose, life
18 expectancy of less than six months or
19 receiving hospice.

20 Again, I think that because it's a
21 one-level decline that constitutes decline, I
22 think we have a problem with -- I don't know

1 what the current term is. We used to call
2 them the old old -- the residents that are in
3 their 90s, and that you're going to see that
4 slight decline just as part of aging -- mine
5 happens to have it in the 50s, but most other
6 people it's in the 90s -- that there's
7 exclusion for that. So I felt that this was
8 minimally met at best with regard to the
9 scientific area.

10 As it relates to usability,
11 because there is so much noise in that
12 particular number of not knowing residents who
13 improved or declined based on the appliance
14 they're using as part of their self-
15 sufficiency, and also in the measure itself
16 they just basically in this area talked about
17 the fact that well, we already have one. So
18 there wasn't any proof as to how this by
19 itself -- this measure by itself -- is very
20 usable. I don't see it's usable because you
21 have to dig through it too much to find the
22 noise -- get rid of the noise to find the meat

1 of what you want. Although I do believe that
2 the idea of being able to somehow identify a
3 resident's change in their mobility is very
4 important. I don't believe that this measure
5 in the way that it is written what with data
6 we can get out of there is meeting that point.

7 With regards to feasibility, the
8 fact it is feasible. It's in the 3.0. We
9 have a way of sending the data. It's just
10 that it's not very usable and the fact that
11 they did identify that there would be so many
12 inconsistencies and errors based on that.

13 So as far as me personally, I
14 don't propose this measure be continued. I do
15 remember you talked yesterday -- someone
16 talked about the fact there's going to be some
17 functional -- there's going to be some kind of
18 a group that's going to be looking at
19 functional. And I think that this needs to go
20 there. We need a group that looks at how to
21 handle those kinds of things. I don't
22 recommend this measure.

1 Diana was my co-reviewer, so I'll
2 turn it over to her.

3 DR. ORDIN: It was just really
4 painful to see their validity and reliability
5 testing of this measure. I mean, not that
6 they did it, they did it very well. But the
7 results because this is a very highly risk-
8 adjusted measure. And basically the people
9 who did it did it pretty well.

10 And I will quote what they said.
11 This is their R-squared, which is sort of a
12 portion of the variance that -- yes, that's
13 attributable to what they're taking into
14 account. And their risk adjustment was like
15 .11. So basically --

16 MR. BOISSONNAULT: .11 percent or
17 11 percent?

18 DR. ORDIN: .011.

19 MR. BOISSONNAULT: So 1.1 percent
20 R-squared?

21 DR. ORDIN: Right.

22 MR. BOISSONNAULT: Is that

1 accurate?

2 MS. BERNARD: It did not explain
3 the variance.

4 MR. BOISSONNAULT: What?

5 MS. BERNARD: The risk model did
6 not adequately explain the variance.

7 DR. ORDIN: Right. And the C
8 statistic showed that it was -- if it was .5,
9 it would say little better than chance. And
10 I think the C statistic here -- I can't
11 remember -- it was very low. It was certainly
12 below chance. So just the risk adjustment
13 methodology alone I think makes this a
14 totally, unfortunately unacceptable measure.

15 And I also look forward to having
16 some standardized cross setting ways of
17 looking at functional status.

18 Yes, the C statistic was --

19 CO-CHAIR GIFFORD: So the two
20 reviewers have recommended that the vote be to
21 not pass the measure. Anyone want to ask
22 questions as to how to elevate it to a higher

1 level?

2 So we have before us --

3 MR. BOISSONNAULT: No. Is R
4 squared of the risk adjustment the
5 effectiveness of the measure or of the risk
6 adjustment portion of the measure? I mean,
7 looking at CMS, do you guys -- do you guys do
8 this now? You don't report this. Do you
9 report this measure now in 2.0?

10 MS. BERNARD: It is part of the
11 current measure. I don't know if it's
12 publicly --

13 DR. ORDIN: It looks like the
14 testing hadn't been done.

15 MS. BERNARD: The testing had not
16 been done on the MDS 3.0 with the exception of
17 what Saliba & Buchanan did in developing the
18 3.0.

19 There was a desire in the 3.0 to
20 change some of the function measures. But
21 that presented an issue for the states that
22 depend on these data for their payment.

1 So the measures are essentially
2 the same -- I mean, the items are essentially
3 the same between 2.0 and 3.0. So even there's
4 not been testing on the 3.0, we don't
5 anticipate that there would be much difference
6 because the items are essentially the same.

7 MR. BOISSONNAULT: So there are
8 two issues that came up, both of which are
9 unclear to me at least.

10 One was a sort of a potential
11 definitional mismatch between the numerator
12 and denominator. Did I get that right? The
13 wording is slightly different even though it's
14 implied that it's the same.

15 And the other that I actually
16 think may be less of an issue is that risk
17 adjustment doesn't help.

18 MS. BERNARD: Risk adjustment does
19 not help.

20 MR. BOISSONNAULT: But that
21 doesn't mean the measure doesn't work. It
22 just means risk adjustment proved superfluous

1 or ineffective at increasing the precision of
2 the measure.

3 MS. BERNARD: Yes.

4 MR. BOISSONNAULT: But what I
5 don't understand from this -- and I think we
6 have to look to you because we're not
7 technical experts on the measure -- is what is
8 it in the underlying measure without risk
9 adjustment that is compelling?

10 MS. BERNARD: You mean in terms of
11 --

12 MR. BOISSONNAULT: You don't like
13 the way I ask questions. I can tell.

14 (Laughter.)

15 CO-CHAIR GIFFORD: Is there
16 anything salvageable out of this measure? If
17 you drop risk adjustment, does the measure
18 still work?

19 MS. BERNARD: If you drop risk
20 adjustment, it works or it doesn't work just
21 as well as it works or it doesn't work
22 currently.

1 This is a difficult --

2 MR. BOISSONNAULT: What the
3 Colorado study said is risk adjustment did not
4 make the measure better.

5 MS. BERNARD: That's right.

6 MR. BOISSONNAULT: But that
7 doesn't I think talk to the underlying measure
8 --

9 MS. BELL: If I could -- just the
10 underlying measure -- you asked about
11 elevating this measure. I think the issue is
12 that the percentage of residents for whom the
13 primary mode of mobility was ambulation who
14 lose that ability. So that the problem is
15 we're comparing mobility, ambulation and
16 wheelchair mobility again on an equal
17 leveling.

18 And in point of fact, Darlene, if
19 you go back to what you said, it's even worse
20 because if they go from walking with assist to
21 being in a wheelchair independent, that's an
22 improvement in this measure. So to me, the

1 means by which you look at this is those
2 individuals for whom primary mode of mobility
3 was ambulation who see a change in that,
4 either more assist or to an assistive device
5 in the form of a wheelchair.

6 MR. BOISSONNAULT: I'm not
7 concerned about risk adjustment. I'm
8 concerned about a mismatch which is
9 essentially what you just described -- a
10 mismatch between the definitions and -- the
11 sort of finding things that are happening in
12 the numerators and denominators.

13 MS. BERNARD: You mean the
14 inclusion of both wheelchair and self-
15 ambulation?

16 MR. BOISSONNAULT: -- percent
17 would move from walking to wheelchair being a
18 good thing.

19 MS. TRIPP: Could I ask a
20 painfully simple question? I think.

21 Is there any evidence that this
22 measure works?

1 MS. BERNARD: Well, it works in
2 what way? Works to --

3 MR. BOISSONNAULT: Any way.

4 CO-CHAIR GIFFORD: Is there a way
5 to salvage this measure? It's going down in
6 flames.

7 MS. BERNARD: I will make one last
8 --

9 CO-CHAIR GIFFORD: We are pulling
10 the plug. The family meeting is in ICU right
11 now. Do we pull the plug or not?

12 MS. BERNARD: Here's the struggle.
13 And in some ways it somewhat analogous, but
14 perhaps not as good as the ADL, that mobility
15 is an important issue. Loss of mobility, loss
16 of any kind of autonomy and independence in
17 long-term facilities is an issue.

18 These are the items we have. And
19 so we are trying to propose a way of measuring
20 mobility given the items that we currently
21 have.

22 Is it ideal? No. Is there

1 another way that we would like to measure
2 mobility? Yes.

3 These are the data. There is an
4 area that's of importance. And we laid out
5 very frankly this is why it's important, this
6 is the data we're using. And these are the
7 issues that have emerged when this measure has
8 been looked at. We have uncovered as much as
9 we can.

10 Are we concerned about this
11 measure? Definitely. Do we appreciate this
12 discussion? Absolutely.

13 And that's as far as I can try to
14 salvage your pulling the plug as I go down in
15 flames.

16 (Laughter.)

17 MR. BOISSONNAULT: I hope you do
18 two things. I hope you fix the MDS 4 so that
19 --

20 MS. BERNARD: Well, you've got the
21 right people in the room to do that.

22 MR. BOISSONNAULT: -- so if there

1 is -- if we're understanding what I think the
2 experts have conveyed, there may be a sort of
3 a mismatch in the numerator and denominator
4 that could lead to unintended consequences of
5 rewarding people from walking to wheelchair
6 and some other mismatch issues that have more
7 to do with the validity.

8 So I hope you don't like stop
9 reporting it. On the other hand, I don't know
10 what the vote will be.

11 MS. BELL: And I'll just say in
12 the interest of CPR that I don't like it, but
13 if we go to just the issue of from a quality
14 of life standpoint does an individual have the
15 means by which to get themselves from point A
16 to point B independently, whatever that means
17 is, there is some merit in the fact that the
18 individual continues to remain at whatever
19 level of independence. Because sometimes
20 being in a chair independent is better than
21 walking dependently. Those situations
22 definitely arise.

1 So if we look at it just from that
2 quality measure, does the individual possess
3 the autonomy to move in the most independent
4 way, then I can see some utility. But at the
5 same time, I feel very strongly that this
6 comparison of level of mobility is wrong and
7 distorted.

8 DR. ZOROWITZ: And I agree with
9 that. But also keep in mind that this is
10 looking at a population. It's unlikely that
11 a lot of residents that we're looking at and
12 the number will have changed from walking with
13 assistance to independence in a wheelchair.
14 So I think there's some wiggle room within
15 that percentage not to get too all wrapped up
16 with -- you think it's going to happen
17 frequently?

18 MS. BELL: I think the potential
19 is for it to happen frequently. And
20 particularly when that change demonstrates
21 improvement. So yes, I think the potential is
22 there.

1 I believe today that there are too
2 many people in wheelchairs in nursing homes.
3 And so I think the potential definitely is
4 there to overutilize wheelchairs as we see it
5 today.

6 MS. GIL: I guess my points were
7 going to be the same that regardless of
8 functional status, residents are given a
9 wheelchair upon the time that they're moving
10 in. And so how do we really look at this
11 indicator in a way that we prevent that from
12 happening, as well as in a way that we can
13 reward and recognize and look at ways that
14 organizations are trying to get residents out
15 of wheelchairs today?

16 DR. ZOROWITZ: I mean, personally
17 I don't think -- I mean, this measure has been
18 with us for some time now. I don't think that
19 it has been a cause of putting residents into
20 wheelchairs. And I don't think its absence
21 will cause residents to come out of
22 wheelchairs.

1 MS. BELL: I agree with you.

2 DR. ZOROWITZ: I understand the
3 flaws to the measure. But at this point I
4 think it's been fairly workable up to this
5 point, and the changes are not all that
6 significant with MDS 3. I think it's still a
7 flawed but usable measure.

8 MS. BELL: And I don't disagree
9 with that. I think what might change getting
10 residents out of wheelchairs is a different
11 measure that says if their primary mode of
12 mobility was ambulation that their primary
13 mode of mobility continues to be ambulation or
14 that we move them toward that.

15 So I'm just saying I think a
16 different measure could influence it. I agree
17 that this measure one way or the other
18 probably won't.

19 DR. ORDIN: I just want to point
20 out something.

21 We talked about the risk
22 adjustment. But there are really reliability

1 problems with this measure too. I mean, after
2 their tests they said a ten percent
3 discrepancy rate would be good. And they had
4 an over 30 percent discrepancy rate.

5 So I totally agree. I think we
6 absolutely need a measure that addresses this.
7 But I think it's probably worth working very
8 vigorously toward a better measure.

9 MR. BOISSONNAULT: I'm going to go
10 further.

11 If you say look, if you don't
12 approve it, we're going to stop putting it out
13 there, then I'm going to vote for it. So I
14 would rather you continue until you have a
15 better measure.

16 But do you guys think this meets
17 the gold standard of what we want to do for
18 ambulation? Because if we approve this one,
19 the chances that we'll look at another
20 ambulation measure -- you know what I mean?
21 There's an either/or effect at the National
22 Quality Forum that I don't how it plays in.

1 CO-CHAIR GIFFORD: Before CMS
2 answers that, just so you realize, you can
3 criticize Bill and I for being asleep at the
4 switch at the last nursing home steering
5 committee meeting. I think we can only chew
6 on the previous panel, right?

7 As was pointed out, we didn't have
8 all the depth reliability and validity testing
9 at that time. So a lot of the votes were
10 based on the merit of the topic. We now have
11 the luxury of knowing more about the validity
12 and reliability.

13 I think this sounds very similar
14 to the staffing. We all desperately want to
15 see a staffing measure, but we just didn't
16 feel comfortable with what we saw in the
17 staffing measure. I think Dede is pointing
18 out that now that we've seen some reliability
19 just because it's out there, whether you're
20 going to drop it or not, the reliability
21 testing that was done is very similar on the
22 items that exist out there now.

1 Am I wrong, Dede, on this?

2 So what you're saying is if you're
3 going to vote to keep the existing measure,
4 you might as well vote to pass this measure
5 because the existing measure is just as flawed
6 as this measure.

7 MR. BOISSONNAULT: Yes. I
8 personally think we're better with this
9 measure than the absence of any measure based
10 on what Robert I believe said that they
11 actually look at the measure, they dig in, and
12 they say well, was this our fault or not our
13 fault.

14 I think the question for me is --
15 so I hope CMS continues to put it out there --
16 but the question for me is is this the gold
17 standard that we want to set potentially
18 because the tail is going to wag -- I think
19 nursing homes are the tail that are going to
20 wag the dog on this measure for the rest of
21 health care. Is this the measure that we want
22 to hang our hat on?

1 CO-CHAIR GIFFORD: I believe CMS
2 will answer this question. But I believe when
3 MDS switches over to 3.0, the 2.0 measures
4 will be sunset unless those that immediately
5 crosswalk over with minor changes that don't
6 have to come back for review as new measures.
7 So this has come back as a new measure for
8 review and approval here. So that probably
9 would mean that the existing measure would
10 sunset and go away.

11 MR. BOISSONNAULT: They publish
12 things that aren't -- CMS.

13 CO-CHAIR GIFFORD: Oh, they can
14 still use --

15 MR. BOISSONNAULT: It just won't
16 have the endorsement or the gold standard.

17 CO-CHAIR GIFFORD: Yes.

18 PARTICIPANT: They won't have any
19 data though. Isn't that the issue?

20 CO-CHAIR GIFFORD: No. There are
21 hundreds -- not hundreds -- lots of measures
22 that are used in the survey process. There's

1 lots of measures used elsewhere. There's all
2 sorts of stuff.

3 But if they want to put something
4 in this to compare, they essentially --
5 there's loopholes as always -- they
6 essentially needs consensus endorsement. NQF
7 is the most convenient, broadest consensus
8 endorsement process.

9 DR. MODAWAL: I just want to make
10 a comment.

11 The main issue of independence and
12 dependence and I think it was point out
13 actually, if the denominator can be refined in
14 terms taking people who can walk on their own
15 or who have the ability to self-propel the
16 wheelchair, that could be one kind of
17 denominator. And then the rest would be
18 obviously dependence in terms of whether it's
19 assist or propelled.

20 I mean, I think if the denominator
21 can be refined, I guess a very important
22 question to address that would be a good

1 quality indicator straight away knowing that
2 how many functional people or mobile persons
3 are there in a nursing home.

4 CO-CHAIR GIFFORD: CMS, the
5 parents of the child on life support, would
6 you like to make a comment?

7 DR. LING: So where do I start
8 with this response?

9 I think let me start by saying
10 even given the caveat that one of the criteria
11 that NQF sets before us is that the measure be
12 publicly reportable.

13 We recognize the limitations of
14 the measure that's before you. So I don't
15 know what wiggle room you have to consider
16 this measure on its merit as it stands before
17 you because we recognize this is not the
18 measure -- this is not the measure that we
19 would like to hang our hats on to report
20 change that is meaningful for the nursing home
21 residents. But we will need the opportunity
22 to go ahead and test the MDS data -- the 3.0

1 data -- and given your feedback, construct a
2 measure that actually may achieve what we're
3 hoping to convey.

4 And take that for what it's worth.
5 But that's my response.

6 DR. ORDIN: So do you need the
7 limited NQF endorsement to do that testing?

8 DR. LING: I suppose we can
9 proceed even without -- I mean, we would bring
10 it forward -- bring a new measure forward in
11 the next go around. Helen, would we be able
12 to bring a new measure forward in the next go
13 around? Not the next go around, but when the
14 MDS data are available.

15 DR. BURSTIN: It sounds like
16 there's going to be a need to do that. We'll
17 actually be doing a lot of testing on the MDS
18 3.0 anyway. I just think that in general you
19 guys are welcome to iterate on this measure as
20 long as you'd like and get it right and bring
21 it back in. I mean, it sounds like you're not
22 ready to publicly report this measure anyway.

1 So why seek endorsement if it's not ready for
2 prime time I guess would be my take.

3 MR. BOISSONNAULT: Was it your
4 intention to put it on Compare?

5 DR. LING: The intent for the gold
6 standard measure that we will create would be
7 to publicly report it.

8 Now would we? I believe this
9 measure is being publicly reported as part of
10 Nursing Home --

11 MR. BOISSONNAULT: Yes. In 2.0,
12 it is is my understanding.

13 DR. LING: Right. So then I would
14 say that we would not need the time-limited
15 endorsement to proceed with the testing.

16 CO-CHAIR GIFFORD: I don't know
17 how to salvage this. It's going to be an
18 interesting vote.

19 Given the discussion in sort of
20 following the NQF sort of standards for how
21 and what we've talked about for the measures,
22 I would say that -- at least I will put out

1 for vote that this measure not pass. And if
2 we decide that that doesn't pass the vote --
3 people want to see it pass -- then we'll have
4 to frame another dialogue on how to make it
5 pass.

6 MS. TRIPP: Can I just ask a quick
7 process-type question?

8 Assume it goes down. CMS re-works
9 it. When could they get something NQF-
10 approved that looks -- when is the earliest
11 that can happen?

12 DR. BURSTIN: It's not exactly
13 clear. But I think part of it depends how
14 long it's going to take to re-work this
15 measure. It's not clear to me.

16 And the other possibility is is
17 this something you could give conditional
18 approval and over next month or so, they bring
19 it back. Because I just don't know how much
20 life support this is on -- to continue your
21 analogy -- and how much it could be tweaked to
22 make it work for the cycle while they work

1 towards a better -- it sounds like the better
2 measure isn't even this one necessarily. So
3 the question is can they tweak this one enough
4 to make it acceptable in the short term while
5 they develop the better measure in a year or
6 two.

7 MR. BOISSONNAULT: Two choices.
8 One would be to vote a yes/no on the proposal,
9 and then a yes/no on a 12-month limited which
10 I'm still -- I really don't want to see the
11 measure completely go away personally -- while
12 they work it out because I think they will.
13 That's a needless gap.

14 There's another option if CMS
15 wants it which is when we do our conference
16 call, as opposed to waiting -- would anything
17 change enough between now and when we do our
18 conference calls in the next three months that
19 would allow you to bring the measure back
20 because you may want to go for the full three-
21 year endorsement as opposed to some 12-month
22 thing we could get out of here now.

1 DR. NIEDERT: My concern is if we
2 do this, why didn't we do something like this
3 in staffing yesterday because we nixed
4 staffing because of the same issues. And we
5 did not say staffing was any less important.
6 We knew it was.

7 And to me, this is saying this is
8 not apples and apples. And I think it is. I
9 don't think it's apples and oranges. I think
10 we've got apples and we've got apples. Today
11 we've got Delicious and we've got Jonathan but
12 we've still got apples.

13 Otherwise, we're saying that this
14 issue is so much different than staffing. And
15 truly in my heart, I don't think so.

16 MR. BOISSONNAULT: Well, to my
17 earlier comments about the importance of the
18 data source, there was a law passed that I
19 think changed the staffing question
20 fundamentally for me. I'm not going to speak
21 for everyone on the panel.

22 But when the federal government

1 said CMS, you will collect and report data on
2 staffing, that made the issue very different
3 for me than this one.

4 MS. TRIPP: There is no federal
5 law. I mean, with the staffing there is a
6 federal law that's going to mandate the most
7 comprehensive staffing data we've ever had.
8 And CMS has been working on that since the
9 '90s.

10 So there is no parallel here.
11 There is no federal law that mandates data of
12 this sort be reported, which is why I think
13 you're seeing a different reaction.

14 But I do think there's a real
15 urgency that NQF have a staffing measure for
16 sure. That's the reason I think the two are
17 getting different treatment, not because
18 they're different issues, just because there's
19 that federal law out there.

20 CO-CHAIR GIFFORD: So our vote is
21 not on the importance. Yesterday, we conceded
22 that everything is really important. It's

1 clear that this is a really important topic
2 like staffing and many other topics.

3 We could equally vote on nursing
4 home caps. I think all of us would vote that
5 nursing home caps is an important thing. We
6 could vote to pass it right now without even
7 looking at it.

8 So I guess NQF does have a
9 process. We have criteria here. We sort of
10 wiggled away from a lot of the criteria here,
11 and we haven't gone through each of the
12 things. We've got four conditions -- the
13 scientific aspect, the importance of it, the
14 usability and the feasibility.

15 And I think we need to sort of
16 somewhat adhere to that process and try to
17 figure out how to vote on this as a measure up
18 and down because it's not just about how NQF
19 is going to use this measure. Remember, in
20 Rhode Island we publicly report measures
21 independent of CMS. And we rely on NQF
22 measures.

1 So NQF is not an endorsement for
2 CMS and what it is. And also once the
3 measure's endorsed by NQF, we lose control of
4 it. We can do whatever we want with it. And
5 we do. We don't play with the specifications
6 or anything, but we play with how we compare.
7 We can play with how we frame it and discuss
8 it in Rhode Island different from CMS because
9 I disagree how CMS does it. So we do that.
10 But that's not part of the approval process
11 here.

12 DR. BURSTIN: I just think one
13 suggestion, given the amount of discussion
14 going on in that back row, it sounds like it's
15 not clear what the next step is. And one
16 option would be to just defer this. Don't
17 vote on this today. They've heard all the
18 comments about this measure. Let them see
19 what is doable to bring back to you on
20 conference calling, just not vote on it today.

21 And I would actually make the same

22 --

1 MR. BOISSONNAULT: That's my
2 recommendation.

3 CO-CHAIR GIFFORD: Would you like
4 to withdraw this measure for our review?

5 MR. BOISSONNAULT: No, no. They
6 just have to --

7 CO-CHAIR GIFFORD: I know. Are
8 you willing to defer it?

9 DR. BURSTIN: That's not
10 necessary. It's purely that the committee can
11 vote to defer it until clearly CMS has heard
12 and RTI has heard the issues. Can they try to
13 build a better mouse trap to address some of
14 these issues and bring it back to you? And
15 frankly, if you wanted to do the same thing on
16 staffing, that's an option as well.

17 CO-CHAIR GIFFORD: All in favor of
18 deferring the measure until some future date
19 -- kick the can down the road? Okay.

20 Anyone abstaining? Anyone
21 opposed?

22 (Unanimous agreement.)

1 CO-CHAIR GIFFORD: Okay. Thank
2 you.

3 MS. NAIERMAN: May I ask a
4 question then?

5 CO-CHAIR GIFFORD: Yes.

6 MS. NAIERMAN: I'm thinking of the
7 pain measures and the opportunity to review
8 those completely different --

9 CO-CHAIR GIFFORD: I think the
10 pain measures fall very close in this
11 category. They got a little bit higher. But
12 if you read our recommendations, the tone and
13 effort was very similar with the pain
14 measures.

15 And I think there's other sets of
16 measures. I think it's clear that we would
17 like to see other measures -- other stuff and
18 continued effort -- a vote of not passing or
19 even the limitation is set. This should not
20 stop. We strongly encourage pursuing. We
21 strongly encourage CMS to continue to support
22 measure development and expansion of the

1 measures that are out there.

2 MR. BOISSONNAULT: Yes. The CMS
3 pain or the other?

4 CO-CHAIR GIFFORD: The pain's
5 passed. They were time limited with about
6 five conditions. No public reporting and five
7 conditions listed on there.

8 MR. BOISSONNAULT: Yes, but we
9 can't actually --

10 CO-CHAIR GIFFORD: Yes. We'll
11 follow up. It's be an interesting CSAC. It's
12 not over yet. We still have some more time on
13 this.

14 So that concludes going through
15 all the measures. I want to thank you all for
16 a robust discussion on the last one. A lot of
17 energy for a day and a half.

18 I wanted to take -- what time is
19 it? We still have a little time -- just a
20 quick moment to go around the table again and
21 hear from you now that you've had a chance to
22 reflect overnight any additional measures to

1 the comments that you wanted to added in
2 before from yesterday.

3 You don't have to reiterate
4 everything you said yesterday. We already got
5 that. If you have something new, it is fully
6 appropriate to say pass, I don't have anything
7 and it doesn't make you look bad. You don't
8 have to feel compelled that you have to speak
9 at the mic.

10 You're saying to add something if
11 you want, or some different. If it's
12 something to add, I'm just going to go around.
13 You'll get your chance.

14 MS. TRIPP: I think I have to
15 leave in a moment.

16 CO-CHAIR GIFFORD: Okay.

17 MS. TRIPP: And I was just going
18 to announce that I'm passing around something.

19 Yesterday I talked about anti-
20 psychotics and I sent around a White Paper,
21 but emailed everyone. These are the talking
22 points that I wrote. These will give you a

1 quick summary of the White Paper.

2 Any improperly stated items are
3 attributable to me only. And the White Paper
4 is by Stephen Crystal and Judy Lucas. They're
5 both at Rutgers.

6 And so just very briefly, the high
7 points of this are there's evidence that
8 indicates that more than half of the anti-
9 psychotic use in nursing homes is contrary to
10 CMS guidelines. There is apparently a strong
11 correlation between especially long-term anti-
12 psychotic use and mortality.

13 There's a UK study that showed
14 that residents taking APs for 24 months had a
15 survival rate of 46 percent as compared to a
16 survival rate of 71 percent for residents who
17 were taking a placebo. So this is a very,
18 very significant issue.

19 There have been two black box
20 warnings, one in 2005 and one in 2008. They
21 have not significantly decreased the use of
22 anti-psychotics in this population.

1 So this is just sort of an
2 awareness raising. And I do believe that
3 Stephen and Judy are going to try to work on
4 developing a measure for NQF approval at some
5 date.

6 So I appreciate the time, and I
7 appreciate you letting me go out of turn.

8 CO-CHAIR GIFFORD: Tom, I'll start
9 with you going this way.

10 DR. GRIEBLING: The only other
11 thing that I'm thinking about and again in
12 terms of global quality of life that we really
13 never look at in this population is sexual
14 health.

15 CO-CHAIR GIFFORD: What was that?
16 Sexual health?

17 DR. GRIEBLING: Sexual health.

18 CO-CHAIR GIFFORD: I just wanted
19 to make sure I heard it right.

20 DR. GRIEBLING: It's a topic -- as
21 a urologist, we deal with that a lot. It's a
22 topic that we just really always kind of

1 ignore in nursing home residents.

2 CO-CHAIR GIFFORD: Bruce?

3 MR. BOISSONNAULT: A global
4 comment to NQF not specifically related to
5 this panel which is I don't think we need to
6 harmonize with the rest of the world. But it
7 would be nice if we could pick a half a dozen
8 key things that we want to measure in
9 collaboration with the World Health
10 Organization because I think part of the pain
11 of the debate we just went through was the
12 sort of unwillingness to acknowledge where we
13 are weak compared to the rest of the world and
14 the inability to get access to data that
15 everyone agrees is measured the same way vis
16 a vis the rest of the world.

17 Plus I think they know a lot of
18 stuff we don't know because they have better
19 data bases in some instances.

20 MS. ROSENBAUM: I think I'd like
21 to see -- this just occurred to me as we've
22 been discussing things -- some emphasis on the

1 use of pharmaceuticals in many areas, for
2 instance, controlling incontinence or
3 stimulating appetite or antibiotic use, the
4 anti-psychotic use. It's not mentioned in a
5 lot of the measures.

6 MS. GIL: Just in terms of efforts
7 to harmonize, in looking at some of the
8 proposals that came forward, the process in
9 terms of really engaging the dialogue in a way
10 that really fits the environment. I think it
11 was a little frustrating I think for all of us
12 because I think they were really important
13 measures as we all agreed.

14 So I don't know if there's
15 anything that we can do to strengthen that
16 process in collaboration with those
17 organizations. But I think that the issue of
18 harmonization is just so important.

19 DR. KOREN: I have nothing new to
20 add.

21 Helen, do you want me to mention
22 that that you have on the screen there?

1 DR. BURSTIN: I'll just preface it
2 by saying that yesterday there was a specific
3 mention of this measure that's already NQF
4 endorsed called the care transitions measure
5 developed by Eric Coleman with support from
6 the Commonwealth Fund.

7 And it turns out the measure's
8 already endorsed at the facility level. It
9 doesn't say specifically hospital. It
10 specifically says facility. So it would be
11 something that could be very appropriate for
12 nursing homes. And we talked about how we
13 could talk with Eric to maybe obviously modify
14 the wording slightly on some of those
15 questions so when I left the nursing home
16 particularly for the short stays. I just
17 wanted to get people's input.

18 Mary Jane, if there's anything
19 else you want to add?

20 DR. KOREN: I would just add one
21 thing which is as nursing homes become more
22 and more post-acute care settings in which the

1 ability to prepare patients to go back into
2 their homes in the community and not then
3 bounced back into the hospital is really
4 critically important. And Eric's work sort of
5 has boiled down the predictors of re-
6 hospitalization to three items. And what's
7 interesting about them is they're items that
8 are answered by the patient, not by a care
9 provider.

10 So I would urge us to sort of
11 start to think about those as a way to look at
12 the quality of the preparation that the post-
13 acute care nursing home does to prepare people
14 to be in the community and not bounced back at
15 some point.

16 CO-CHAIR GIFFORD: Helen, can we
17 ask Eric to fill out one of these things so we
18 can talk about it at a future call meeting and
19 get some feedback on it relative to nursing
20 home?

21 DR. BURSTIN: Yes, we can actually

22 --

1 CO-CHAIR GIFFORD: The questions
2 up there do say hospital.

3 DR. BURSTIN: Sure. Yes. It just
4 went back through our care coordination
5 committee and was just re-endorsed. So we'll
6 just take that form and have him just do an
7 addendum of if there are any specific thoughts
8 about nursing homes, we'll bring that to you
9 in your follow-up call because I think it's a
10 really good opportunity for CMS and others to
11 view something in the public space that's got
12 such a good track record.

13 CO-CHAIR GIFFORD: Thank you,
14 Lisa, for everything. Very helpful. Good
15 comments.

16 DR. MODAWAL: I just had questions
17 about communication. And I think CTM is a
18 good way for hospital communication, but
19 actually the communication within the
20 interdisciplinary team in the nursing homes
21 and communication of physicians with the
22 different levels across the --

1 DR. ZOROWITZ: I've enjoyed the
2 meeting a lot.

3 I would like to see a more formal
4 structure in the voting so that if we see
5 items that are --

6 CO-CHAIR GIFFORD: I'm going to
7 come back and talk in a second and get your
8 feedback on the process.

9 DR. ZOROWITZ: Oh, am I out of
10 line here?

11 CO-CHAIR GIFFORD: Yes, you're out
12 of line.

13 (Laughter.)

14 DR. ZOROWITZ: You know you're all
15 great people, and I'm really having a great
16 time.

17 (Laughter.)

18 CO-CHAIR GIFFORD: I'm looking for
19 a new measures reviewer and stuff. You're
20 going to get -- we're going to go around and
21 give a chance to give comments on the process
22 here and some feedback on the measure --

1 DR. ZOROWITZ: I'm sorry.

2 CO-CHAIR GIFFORD: That's okay. I
3 didn't tell you that's what was coming. So
4 you didn't want to miss the opportunity.

5 MS. BELL: I apologize. I'm going
6 to be running too.

7 But I don't have anything to add
8 other than what I've already contributed
9 today.

10 MS. NAIERMAN: I'd like to add one
11 more measure for consideration which is timely
12 and appropriate referrals to hospice.

13 CO-CHAIR GIFFORD: Bill?

14 MR. KUBAT: I think what I would
15 add is not a particular measure, but thinking
16 about the things that were described and
17 mentioned last year -- or I mean last night.
18 Yesterday was such a much more robust addition
19 to where we left off four years ago. And
20 that's tremendously, tremendously helpful.

21 But one of the things that occurs
22 to me is that -- and I continue to like the

1 use of the word harmonization and that concept
2 -- but harmonization is in the eye of the
3 beholder. And so what harmonizes for NQF,
4 what harmonizes for CMS, what harmonizes for
5 public policy and regulators, what harmonizes
6 for the consumer are different things.

7 And so there really needs to be I
8 think almost a preferential bias in skilled
9 nursing and long-term care to advance those
10 issues and measures that relate to quality of
11 life, culture change and so forth.

12 DR. ORDIN: I don't think I have
13 any new measure to add. But once again, I
14 think just in this process, I've been struck
15 by how little information or how poor the
16 information has been on usability by the
17 public. And since public reporting is one of
18 the mainstays of our evaluation criteria, I
19 think we may want to figure out how to beef up
20 the evaluation criteria and how that submitter
21 -- beef that up.

22 CO-CHAIR GIFFORD: You did not

1 listen tow hat I just said to Bob.

2 (Laughter.)

3 DR. ORDIN: But you didn't stop me
4 soon enough.

5 SISTER HEERY: I have nothing to
6 add. Thank you.

7 CO-CHAIR GIFFORD: Christine?

8 CO-CHAIR MUELLER: We had a
9 measure today about toileting -- behavioral
10 interventions for people who were able to get
11 themselves to the toilet. I'd like to see for
12 a future measure looking at toileting programs
13 for incontinent residents in general or any
14 resident in nursing homes who have
15 incontinence, and also to take advantage of
16 some of the new items on the MDS that might
17 help with that.

18 CO-CHAIR GIFFORD: So now the same
19 thing. I'll start in the middle with Bob. Go
20 around. But some of you gave it at the
21 beginning -- some feedback on just the NQF has
22 continued to revise and improve I believe the

1 review process. And I think it's my fourth
2 panel I've been through. And each one has
3 been slightly different but gotten better.
4 And so any opportunity to give some feedback
5 on that broader process would be helpful and
6 appreciated.

7 And so I'll just quickly go around
8 and get that feedback. So Bob, go ahead.

9 I think all of us getting the
10 measures earlier and all the measures taken
11 off the table, we got that. I heard that.
12 Sorry, Bob.

13 DR. ZOROWITZ: I would like to see
14 some formalization of other options to just
15 voting up or down with and without
16 recommendations. That is tabling an item that
17 needs improvement, directing a work group to
18 come up with a better measure -- something
19 that would keep the measure in the process.

20 The staffing issue, I think, is a
21 perfect example. I think we all felt that was
22 important. We don't want it to go away. But

1 I'm not sure whether right now there's going
2 to be an effort to bring back a better
3 staffing measure. But I think that really
4 should be -- we should be able to vote on
5 important, not ready for prime time, but go
6 back, come back in three months with a better
7 measure as a formal part of voting.

8 MS. NAIERMAN: I would assume that
9 most of us are more content-oriented and less
10 scientifically-oriented. And it would be
11 helpful for me in another round to have a
12 scientist statistician in the room who would
13 actually explain to us and also be an advocate
14 on our behalf rather than on the measure
15 developers or anybody else -- kind of a
16 consultant that we can talk with about the
17 scientific merit of these measures.

18 DR. BURSTIN: I just want to
19 follow up to that.

20 We actually for the outcomes
21 project for the first time had a consultant
22 statistician who did reviews on every measure.

1 We didn't do it for this because
2 they seemed like ones we sort of knew a fair
3 amount about. But it may be something we'll
4 do for all projects in the future.

5 CO-CHAIR GIFFORD: Alternate back
6 and forth.

7 Arvind? Process?

8 DR. MODAWAL: I thought this went
9 very well. This is my first time. And it was
10 an experience and some of the things can be
11 improved.

12 I thought should be a one-pager
13 like rules in terms of -- not more than one
14 page -- in terms of our evaluation and voting
15 just to explain the process because we are
16 learning as we were doing these. That would
17 be helpful.

18 CO-CHAIR GIFFORD: Bill?

19 MR. KUBAT: I think the other
20 thing that I'd add is that it wasn't -- at
21 least for me -- it wasn't always clear in
22 terms of all the 25 things that we looked at

1 what was the concise feedback from the TEP.

2 And to have that more clear would have been
3 helpful in my own discernment.

4 DR. KOREN: This may have been
5 said. I'm not sure. But I would have found
6 the conference call that we had with the
7 slideshow preparing us for this meeting to
8 have been much more helpful after I had
9 received the materials than before we got the
10 materials because it was very hard to track.
11 And it didn't really mean anything. Once we
12 got the materials, it would have meant a lot.

13 DR. ORDIN: Well, I only had one
14 idea anyway.

15 I think being able to write -- to
16 sort of follow up on what Mary Jane said -- to
17 be able to make comments on the form instead
18 of going back.

19 MS. ROSENBAUM: I've really
20 enjoyed this. This has been my first time
21 here. But I kind of felt I had to learn as I
22 went on some of this. And I think a little

1 more preparation with some of the forms --
2 maybe getting them ahead of time would help
3 because I think it's really very stimulating
4 and I've learned a lot. Very good.

5 SISTER HEERY: I have to agree.
6 It was my first time and learned as I went
7 along. The information would have been a
8 little more helpful.

9 And I agreed on the voting that if
10 we knew that, we could have done maybe some
11 other things and kept proposals there.

12 DR. SCHUMACHER: Just a couple of
13 comments.

14 One is that it might have been
15 helpful if instead of up on the screen trying
16 to scroll through everything, and it was
17 really small and we could barely read it
18 anyway. If there's some way to sort of
19 summarize what the reviewer said and put that
20 up there. And even maybe to think about
21 summarizing some of the data from the
22 technical expert panel -- something like that.

1 There's just too much to try to put up on the
2 screen. So if there's any way to shorten that
3 and put something up that's more meaningful.

4 As far as other components of the
5 process, I agree with what Dr. Koren said
6 about the conference call that it would have
7 been more useful if we had received some of
8 the information first because we really didn't
9 know what you were talking about for those of
10 us who were new to this. And just some
11 suggestions for that call would be maybe to
12 sort of number one, give us a better idea for
13 the big picture. What is it we're trying to
14 do here? Who are we going to be sitting in
15 front of? Who are we going to be hearing from
16 in terms of the presenters? I didn't
17 understand any of that until I got here and
18 saw it for myself. And also maybe even to
19 just on that call kind of walk us through an
20 example of how a primary reviewer should
21 present the information, what that should look
22 like, what points should be made, and give us

1 more by example rather than just presenting a
2 bunch of data to us.

3 DR. GRIEBLING: I just echo that
4 comment. I think a model review presented
5 during the conference call would have been
6 helpful.

7 MR. BOISSONNAULT: And I go back
8 to Ken Kaizer days in my involvement on and
9 off with NQF.

10 I think the results suggest that
11 things went pretty well. I actually am
12 leaving Washington feeling very, very good
13 about even where there was not sort of
14 unanimity and even with some of the things
15 with which I did not agree, I think the issues
16 were actually explored quite well.

17 And so I would not want the
18 process to become constricting or a barrier to
19 the flexibility we sometimes need to for
20 example table things or whatever. So I was
21 actually more comfortable with the ambiguity
22 than some of what I heard today.

1 If I were going to sort of offer a
2 suggestion, you can work us harder. I think
3 the indication that I perceived in the past
4 was expect to spend between one and three
5 hours on each review that you're not a primary
6 for, and that you're going to spend maybe more
7 than that if you're going to check the
8 references for the ones that you are primary
9 on. Because it is our job to check the
10 references.

11 Now we know there were some
12 barriers to that that I'm not going to get
13 into although I think for the ones we were
14 primary on, it was a nonissue. And so I
15 wasn't even particularly disturbed by that.

16 But I think when you've set out
17 the expectations -- we're setting national
18 policy. This is extraordinary work. And I'm
19 honored to be here. And I think we should go
20 home feeling pretty good. And when I get my
21 next letter, I would not be upset if somebody
22 said it looks like it's going to be about 40

1 hours work to prepare for this. Are you
2 willing? Because that's what I enjoy doing.

3 MS. THOMPSON: The only thing I
4 would like to add is I think that especially
5 it would have been nice if we would have had
6 copies of the MDS 3.0 form and at least a
7 reference manual to -- I mean, I actually had
8 a copy. I gave it to him. I don't want to
9 take it home with me. But I think for those
10 that are not as intimately involved with that
11 form to be able to look at it to see where is
12 this data coming from. And when we are
13 looking at measures that are not related to
14 the MDS 3.0, if some of that reference
15 material could be available for those that
16 don't know where that source document is and
17 what it means.

18 DR. KOREN: David, I know that
19 we're off of the measures. But I just thought
20 of one. And I don't know quite how you would
21 use it -- but to think about, which is use of
22 safe lift practices in nursing homes. I think

1 it has huge impact not only for the quality of
2 care for the residents, but I think it also
3 has impact on staff. We know it's a pretty
4 dangerous job. Back injuries and workers'
5 comp are really big issues. And there are
6 starting to be some really well-defined
7 criteria for what safe lift practices are.
8 And I think we should start to look at that.

9 CO-CHAIR MUELLER: Well, I echo a
10 number of these things. And I'm very grateful
11 to a co-chair who had four times practice at
12 this. And this is my first time also. So the
13 prepping for this was a challenge with limited
14 time. But anyway, very grateful to have the
15 opportunity to work with you.

16 I have to only imagine that NQF
17 has worked tirelessly on coming up with this
18 form for people to fill in. And boy, I don't
19 have any suggestions for how to make it
20 better. But I still found it hard to read
21 that tiny little print. I wanted to get rid
22 of the balloons so I could expand it but you

1 had locked it, I think. So I couldn't get rid
2 of the balloons. You know how to accept the
3 changes? Yes. I couldn't accept the changes.
4 But maybe it is an age difference, but we just
5 really need things a little bigger these days.

6 So anyway, just a suggestion about
7 any continuing to improve the forms.

8 MS. NAIERMAN: I just wanted to
9 take the opportunity to take you both, David
10 and Christine. I thought it was very, very
11 well done. Smooth coordination and a
12 wonderful sense of humor. Thank you very
13 much.

14 CO-CHAIR GIFFORD: Well, I too
15 want to thank you all. But actually, we're
16 still not done.

17 Sandy, you probably have a public
18 comment? If I don't know you, I don't --

19 MS. FITZLER: I do. You don't
20 know me.

21 CO-CHAIR GIFFORD: Were you going
22 to give a public comment?

1 MS. FITZLER: I have a few, and
2 this is from this morning's discussion.

3 I am concerned that we're not
4 looking at UTI for the short-stay population,
5 only the long-stay. And I'll tell you why.
6 The inappropriate or misdiagnosis of UTI is a
7 problem, not just for long-term care but for
8 other settings of care. And this is a
9 transition of care issue because we see a lot
10 of patients coming in who have been put on an
11 antibiotic in the hospital for a UTI, but
12 we're seeing a lot of folks who are having
13 hips and knees.

14 And the post-op protocols for the
15 administration of an anti-coagulant. And we
16 know that we have problems between a drug-to-
17 drug interaction between the antibiotic and
18 the anti-coagulant. And we should be picking
19 this up earlier. So I would like to see some
20 kind of measure that forces our attention on
21 this in the short-stay population.

22 My second issue is with a measure

1 just discussed not too long ago. And that's
2 the percent of residents whose need for help
3 with daily activities has increased. I think
4 this is important but I really don't think
5 that this means anything to the consumer
6 because this is why they're putting patients
7 into a long-term care facility in the first
8 place. They know. They are watching a
9 decline in their family member. They know
10 that decline is there. So to me, this is
11 confusing to them.

12 Now, if we flipped this measure so
13 now we're looking at the residents whose need
14 for help with daily activities has maintained
15 or improved, that would mean something to the
16 public. And this is what we are talking about
17 when we're talking about measures that are
18 stated in the positive.

19 So I do have a request that we ask
20 CMS when they're testing these measures to see
21 how many of these measures can be flipped, to
22 see if they're still valid and reliable when

1 they're flipped, and I'm doing so only because
2 I have been assured by numerous sources that
3 they would try to do this.

4 Thank you.

5 CO-CHAIR GIFFORD: Anyone on the
6 phone for comments or questions?

7 (No response.)

8 CO-CHAIR GIFFORD: Other public
9 members?

10 MR. GRUHN: Thank you. I'm Peter
11 Gruhn with the American Health Care
12 Association.

13 There was discussion earlier about
14 outliers and risk adjustment with respect to
15 the ADLs. And one thing that troubled me a
16 little bit was -- at least my take -- was that
17 facilities that may be specializing up to your
18 type of your patient or so forth, we can
19 overlook that in terms of the measure because
20 there's not that many of them, and it may not
21 be all that critical in terms of the measure
22 and how we evaluate that facility.

1 But I just submit to you that if
2 this is an -- and then what's a sufficient
3 number? Is it maybe 50? One in each state
4 that might be the premier center for treating
5 traumatic brain injury folks or rehabbing
6 them? Whether when one looks at the QM for
7 that but they get skewered on it, how is the
8 public to distinguish that facility from a
9 facility that is not doing so well or not of
10 a high quality and so forth?

11 So I'd urge the panel and
12 researchers to keep that mind. Look for
13 appropriate risk adjustment for particular
14 measures.

15 And then a second piece on there
16 was some discussion on a number of the
17 measures on seasonal adjustment and going from
18 one quarters worth of information to two
19 quarters of information, doing a moving
20 average as I understood it. In looking at the
21 QM information on a quarterly basis that CMS
22 publishes where the nursing home compare, for

1 many of the measures one can clearly see
2 seasonality. Measures will go up. Measures
3 go down. Performance will look worse, let's
4 say, in the first and second quarter depending
5 on a particular measure, and then decline
6 dramatically through the year and then bump up
7 again the following year in the first and
8 second quarter. A two quarter average might
9 help mitigate some of that variability. But
10 it's not going to get down to the underlying
11 issue, I don't feel, of smoothing out and
12 adequately adjusting for the seasonality.

13 Really, you might want to consider
14 looking at a four-quarter average or some
15 other methodology for making that type of
16 adjustment.

17 Thank you.

18 CO-CHAIR GIFFORD: Any other
19 comments from the public?

20 (No response.)

21 CO-CHAIR GIFFORD: CMS?

22 (No response.)

1 CO-CHAIR GIFFORD: Okay. Well, I
2 too want to thank the NQF staff who put a lot
3 of effort into this in assembling all the
4 material, and particularly Suzanne, Del, Emma
5 and Helen. Really it was very helpful. So
6 thank you.

7 (Applause.)

8 CO-CHAIR GIFFORD: The Court
9 Reporter in the corner is taking everything
10 down for us.

11 And the sound, I have to say I
12 have been in many, many meetings, and the
13 sound and the power strips and everything else
14 really have been wonderful. It's one of the
15 better ones I've ever been to. So I want to
16 thank you for that.

17 (Applause.)

18 CO-CHAIR GIFFORD: And then
19 lastly, I'd like to thank you all because you
20 do have day jobs. And despite Bruce wanting
21 to spend even more time doing it, I think you
22 all did really spend a lot of time and were

1 very thoughtful and took your role very
2 seriously. And so I want to thank you and the
3 feedback you gave.

4 I enjoyed it a great deal. So
5 thank you a great deal. I want to thank all
6 of you for your effort.

7 And our work is not done. We will
8 continue to meet by email and calls. So we
9 still have some other work to do. And I think
10 we set a really good tone. And it is exciting
11 to set some national policy and everything.

12 Christine, do you want to say
13 anything?

14 CO-CHAIR MUELLER: I think I said
15 earlier thank you and I look forward to
16 continuing to work with you.

17 CO-CHAIR GIFFORD: And I believe
18 lunch is out there. We're not going to have
19 a working lunch. We're not going to come back
20 after this because I knew if I released you
21 for lunch, none of you would come back.

22 So we did finish early. So thank

1 you guys very much.

2 MS. THEBERGE: Just a couple of
3 quick things. I just wanted to let you all
4 know that next steps we will be setting up a
5 conference call early in May to discuss some
6 of the conditional recommendations. We're
7 going to take all that back to the developers,
8 talk to them, come up with a report. So we'll
9 be in touch with you early next week about
10 getting that call scheduled. And we'll also
11 be sending around the report for your review.

12 MR. BOISSONNAULT: Are we still in
13 terms of the evaluation materials that we
14 received and so forth still not at liberty to
15 share those?

16 DR. BURSTIN: Once the information
17 is posted on the NQF website for comment, it's
18 public information. At this point, it's not
19 yet. It's still deliberations with the
20 measure developer. So I would use those
21 appropriately.

22 CO-CHAIR GIFFORD: And I will

1 recommend to NQF that you all get double bonus
2 payments for your work. So thank you. And
3 you can double it.

4 (Laughter.)

5 MS. THEBERGE: Thank you very
6 much, everyone.

7 (Whereupon, the above-entitled
8 matter went off the record at 12:53 p.m.)

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