**NATIONAL QUALITY FORUM**

**Moderator: Benita Kornegay Henry**
**May 15, 2019**
**5:52 pm CT**

Suzanne Theberge: Hi, and welcome to the Patient Experience and Function post comment meeting. We'll be getting started in just a moment. Hello. We'll be getting started in just a minute.

All right. I think we can go ahead and get started. It's just past the top of the hour. Welcome, everyone. Thank you for joining us today on the Patient Experience and Function Fall 2018 Cycle post comment web meeting.

We appreciate you joining you s today, and just wanted to go over a couple quick things before we dive into our content for the day. The project team is if you're on the phone, this is Suzanne Theberge, I'm the Senior Project Manager on the team. And Sam and Jordan, would you like to just say a quick hello?

Samuel Stolpe: Yes, thanks very much. This is Sam Stolpe, I'm the Senior Director on this team. And it's my pleasure to welcome you and our co-chairs will likely be doing the same, but we're delighted to have this opportunity and what is going to be our last call for the fall 2018 cycle. So I'm excited to see this come to a close and thanks, everybody, for participating.

Jordan Hirsch: Hi. And this is Jordan working as the Project Analyst for the Patient Experience and Function team. As Sam echoed, just, you know, nice to have everyone here and looking forward to the closeout of fall 2018, and if I may jump ahead, looking forward to continue working with those of you who will be on our spring 2019 committee as well.

Suzanne Theberge: Great. Before start into our agenda, I just want to go over a couple of quick housekeeping items, many of which are going to be familiar to everybody.

Please don't put the call on hold because we will hear your hold music. If you are on both the webinar and the phone, please mute your computer lines to reduce any feedback. Before you speak, please say your name. You can mute your phone line with star 6 and unmute with star 7 and we can take questions via chat and verbally.

Also for our committee members, just so you know, we need to log in on the phone, on the webinar and on the voting platform. The link which was sent out, I think yesterday afternoon or early this morning, that Jordan sent out so - and it's also on the committee SharePoint. Please let us know if you're having any trouble accessing the voting link because that's how we'll be collecting your votes later on during this call.

And with that, I will go over the agenda, so we are going to be reviewing the comments that we received on the measures under consideration for fall 2018 and then we're going to be discussing and asking you to revote on Measure 3480 which did not reach consensus on evidence at the committee's February Web meeting. And we'll close out the meeting with our member and public

comment period, go over, quickly go over some next steps and then that's it for today.

So before I do a committee roll call, I just want to ask any of our co-chairs if they would like to make any opening remarks before we do the roll call.

Gerri, Lee, Chris?

Gerri Lamb: Hi, everyone. This is Gerri Lamb. Glad you're all on. Thanks to Suzanne and Sam and Jordan for getting us organized here. And looking forward okay this discussion.

Chris Stille: Hey. This is Chris. Good afternoon, everybody. Yes, looking forward to good focused discussion today and also seeing many of you next month.

Lee Partridge: And this is Lee Partridge, echoing a welcome of Gerri and Chris; also looking forward to June where if you have taken a peek, you've probably seen that we have a pretty full agenda. So enjoy this afternoon which I think is probably going to be not, I hope, not too controversial discussion. So be prepared for June.

Chris Stille: That's a lot.

Suzanne Theberge: Yes. We're briefing the folks now what we're going to be doing in June. It's going to be a busy spring cycle. So…

Chris Stille: Yes.

Suzanne Theberge: All right, so thank you. I'll just do a quick roll call so we can confirm that we have quorum and see who's on the phone from the committee. Don Casey? Don, are you there?

Don Casey: Hi. Yes, I am. Thank you. Sorry.

Suzanne Theberge: Thank you. Ryan Coller?

Ryan Coller: I'm here. Thanks.

Suzanne Theberge: Thank you. Sharon Cross?

Sharon Cross: I'm here.

Suzanne Theberge: Thank you. Chris Dezii?

Chris Dezii: Present.

Suzanne Theberge: Thank you. Shari Erickson?

Shari Erickson: Here.

Suzanne Theberge: Thank you. Barbara Gage? Dawn Hohl?

Dawn Hohl: Here.

Suzanne Theberge: Thank you. Stephen Hoy?

Stephen Hoy: I'm here.

Suzanne Theberge: Thank you. Sherrie Kaplan? Brenda Leath?

Brenda Leath: Here.

Suzanne Theberge: Thank you. Russ Leftwich? Brian Lindberg? Linda Melillo? Lisa Morisse?

Lisa Morisse: I'm here.

Suzanne Theberge: Thank you. Charissa Pacella? Len Parisi?

Len Parisi: I'm here.

Suzanne Theberge: Thank you. Deb Saliba? And Ellen Schultz?

Ellen Schultz: I'm here.

Suzanne Theberge: Great. Thank you. And Peter Thomas let us know he won't be joining today. So, great, thanks, everybody.

Samuel Stolpe: So just one note here, Suzanne. We've been diligently keeping track of how many people are on the call and what our needs are for quorum. So we have just hit it. We're exactly at 14. So please nobody leave.

Suzanne Theberge: Yes. If you have to step away let us know.

Samuel Stolpe: Yes, please just let us know if you need to step away that way when we go to voting we'll make sure we do it when everybody is around the table. Thanks so much.

Suzanne Theberge: Thank you.

Okay, so just a quick reminder of what we reviewed in the fall. We reviewed five measures; the 3455 Timely Follow-Up After Acute Exacerbations of Chronic Conditions which the committee recommended. We reviewed four Discharge to Community Members; 3477 Post Acute Care for Home Health Agencies; 3479 which was the Inpatient Rehab Facilities; and 3481 which was for Skilled Nursing Facilities. All of those were recommended. And then we also looked at 3480, the Discharge to Community for Long-Term Care Hospitals which the consensus was not reached, as mentioned earlier.

In terms of the comments that we received, we received eight comments from two NQF members; so basically two members submitted four comments each. We also received some expressions of nonsupport on three of our measures which you can see up on the slide here and that's basically our member equivalent of voting. Now we call it - voting is now expression of nonsupport.

And really all of the comments fell into one bucket which was concern over the risk adjustment model for the discharge to community measures, particularly the exclusion of the dual eligible beneficiaries.

So what we would like the committee to do is review the comments, the comments that we received which were very similar and the developer's response which was also very similar for all of the comments and then discuss and formalize a response yourself for the commenters and as part of that discussion, the committee have the option to let your recommendation to endorse those three measure stand or you can all also have the option as always to vote whether or not to reconsider those measures, the recommendation for endorsement.

So with that summary, I will turn it over to our co-chairs to facilitate the discussion.

All right, Lee, I think you are going to lead this piece. Lee?

Lee Partridge: Sorry. Can we have the slide that summarizes the comments?

Suzanne Theberge: We have a high level slide and it's also in the memo which…

Lee Partridge: Yes, I know. I just wondered what - as we started discussion, what we might have in front of us.

Suzanne Theberge: Sure. We can roll up one of the comments, if you'd give us a moment we can screen-share a full comment. But really it's - the content of the comment focus around the lack of inclusion of dual eligible status and the risk model whether that was really based on CMS policy rather than enteric evidence.

Lee Partridge: Right.

Suzanne Theberge: And, you know, whether that really causes any trouble with the reliability and political measure.

Lee Partridge: All right. And then the - our developers went on and responded to those criticisms.

Suzanne Theberge: Yes.

Lee Partridge: So I'm going to open that up for comments from our fellow members of whether or not you are comfortable with proposed response. So the floor is open.

And, Jordan, I know you told me I should be able to see hands but I'm sorry my Mac is saying no. So if you could - if you and Suzanne would just call on people, please.

Chris Dezii: This is Chris Dezii. The developer - do we need to remember back to what the developer's response was on the call or if they respond after the comment?

Suzanne Theberge: They responded in the comment that is in both the table and memo. It was unfortunately too much content to put on a slide.

Lee Partridge: Yes.

Suzanne Theberge: But there is an extensive response in the memo as in the comment table.

Chris Dezii: Okay. Let me go there. Okay. Thanks.

Chris Stille: And this is Chris. I had a comment, I just raised my hand.

Suzanne Theberge: Go ahead.

Chris Stille: From what I remember from the response, and I hope we have a methods person on the call, it seemed as though the developer actually get a ratified analysis with or without dual eligible. They didn't find a difference. That to me says it's probably okay, but I wanted to kind of double check that with one of the methods folks.

Chris Dezii: This is Chris Dezii again. I'm not - I wouldn't necessarily consider myself a methods person but I'm pretty good with logic. If I remember correctly there were over 228 variables in that model. And I suspect that any one of them is

pulled out. I suspect a significant number of that - of any one have been pulled out would not have made a difference in the outcome. Do you follow me on that?

Suzanne Theberge: Uh-huh.

Chris Dezii: And, you know, that's always been niggling (at that or not).

Gerri Lamb: Chris, this is Gerri. And I think your questions are well taken. What I understood that they had done and I thought they had reviewed well in their response, this is I'm referring to CMS and RTI and (Abt), is that they did do an analysis. They went beyond because I think the concern was that this was driven by policy and not empirically based. But they did spare the results of an association, a correlation between…

Chris Dezii: Right.

Gerri Lamb: …what measure look like with when dual eligible was included and when it wasn't included and it was a very high correlation between the two of them.

Chris Dezii: Okay.

Gerri Lamb: They also went further into looking at the proportion of dual eligible in the setting and also did not find the difference.

Chris Dezii: Okay.

Gerri Lamb: So the correlations were very high. The ICCs were right in the right range.

The question that I had with going back to our discussion from I think it was December that at that time we had asked for empirical evidence and I was really glad to see it. I just didn't know if the comment had come in before CMS and RTI and (Abt) could done this analysis.

Chris Dezii: Got it. Okay. Great.

Lee Partridge: Suzanne, can we answer Gerri's question? In other words, were the comment have been different?

Suzanne Theberge: These comments did come in after the committee discussion.

Lee Partridge: Okay.

Suzanne Theberge: The developer team is on the line. So if they want to speak to anything or if you want to ask them anything, you should feel free to do so, but most off those comments did come in after the committee meeting, so looking at the same material that you all have, as well as what was discussed at the meeting.

Lee Partridge: Okay. Further questions or comments?

(Mel Limberick): I'm sorry I was - this is (Mel Limberick) of RTI, I'm just wondering if that was an invitation for the developer to discuss what we had done and when we had done it?

Lee Partridge: If you would like to make a comment, yes, please go ahead.

(Mel Limberick): So (Penam), did you want to talk about when we did this analysis this, please.

(Penam): Sure. So this analysis I believe was not included in the testing form but we had conducted after the final testing form was submitted and we wanted to use the data to help respond to the public comments.

One more thing I would just add on top of the summary that they provided so nicely is that we also looked at providers that were serving the highest proportions, if you will, of this full beneficiaries, specifically for the (host). And we found that there were in some cases very high proportion of those providers that had a lot of fields that we're doing better than the national (DTC) rate. So it was telling us that providers can still do well even without field assessment.

(Mel Limberick): Thanks.

Lee Partridge: Thank you. I did notice that with great interest.

Further questions or comments or should we - do we have to take - we don't need to take a vote here, Suzanne, do we? We just - if we're willing to let our recommendations stand?

Suzanne Theberge: That's correct. If you - if somebody wanted to reconsider, you would have to vote on that, but if nobody wants to reconsider then you're good to go.

Lee Partridge: All right. So if anybody wishes to…

Don Casey: Lee, I'm sorry, you were asking for more comments. This is Don. A question.

Lee Partridge: Yes, go ahead.

Don Casey: Sorry, I was trying to digest the 94-page document data free. Can you remind me, RTI, about the collection of functional status measurement in its role in risk adjustment? Can you just remind me of that for this particular one?

(Penam): Sure. This is (Penam) from RTI. So this particular measure we used our (leaders of claim). So what we have is in the (ERF) measure we have adjustment for case-mix (scoop) which include function as part of the case-mix (scoop) definition.

So the LTAC and SNF setting does nothing parallel to case-mix (scoop) that we have used. So all of the data comes from claims so there's no patient assessment data as just from the (ERF) file (unintelligible) of that.

Don Casey: Okay. So, Lee, I just want to make an observation again that as we recalled in our discussion around evidence, you know, I'm Mr. Evidence, there was a Hodge - a mixture of data from various post-acute settings and in particular, the language was I think pretty much cut and paste to the cross settings.

And in this case, if you look back at the evidence summary, only one reference is specific to LTAC, I'm looking at the evidence summary now. And that was (Thrush), the name of the author, who examined the relationship between functional status and discharge outcomes based upon data collected from 101 LTAC patients in 138-bed LTAC over eight months beginning in - some time in 2010.

And they used a specific functional status score for the intensive care called FSS ICU and that score actually was important in the sense of noting that as you can imagine higher FSS ICU scores were significantly higher for those discharge to home compared to those discharged to a long term care hospice or expired score, you know, because usually these patients when they're

discharged they're either going to do well of they're not going to do well or short-stay hospital perhaps if they were exacerbated. This is just the summary.

And so my concern is that the one study of 101 patients in one 138-bed LTAC over eight months which showed a significant importance of functional status score for LTAC populations was not - it wasn't the expectation in the measure adjustment that functional status was addressed. The rest of the studies have no bearing on LTAC so this one study of 101 patients used as the evidence for this.

Now, you know, generally speaking, the discussion is, well, we just combined it all because it's kind of all the same, I mean, I'm being a little more simplified here but I do want to remind the committee that in fact, you know, the evidence here is (thready) in my opinion, so.

Gerri Lamb: Don, I have a question for you. It's Gerri. Is - that's an important observation, do you think that the functional status adjustment would interact with dual eligibility because the comments were specifically about the exclusion of dual eligible. Are you saying that you're concerned that there's an interaction between functional status and dual eligibility in the LTAC?

Don Casey: I'm saying I don't know the answer to that, Gerri, because I didn't read the article to see if this was actually evaluated. You know, my guess is that LTAC patients are generally pretty far down the road in terms of, you know, being sicker and probably - and again, I don't know, this probably more likely to be financially distressed because of the long illness.

So I - that's as far as I'll go. I just - it just seems to me as though we're really - we are really lacking evidence for the method that's used for functional

status. I mean, one study shows that that's useful that's better than those studies. And so all I'm trying to say is that overall risk adjustment is weak because of the fact that it appears at least by this one study that functional status improvement is a better predictor of the likelihood of staying at home it seems.

Lee Partridge: Okay. I think we're back then to the question if there's any member of the committee wish to reconsider or are we willing to - that our recommendation, original recommendations for 3477, 3479 and 3481 stand?

Gerri Lamb: Lee, my two cents, this is Gerri, is, number one, I would like to acknowledge the organizations that put in their (summary) because this is being policy-driven, I'd also like to suggest that CMS RTI and (Abt) did the analysis to respond to it. And I would suggest that, you know, what I would say is let them stand. I guess I'd like to hear if anybody would like to reconsider the three measures.

Dawn Hohl: This is Dawn Hohl. And I tried to go back on all this, I did refresh myself, because much of the analysis and the references are consistent, not exact, between the measures, my only gut because I overall think there's a need for this. I do see some of these weaknesses.

My overall impression is they all need to be together or not. So either we approve them as a grouping or they'd be separated and not approved. I'm just having a hard time approving one or two and not the others because I see the methodologies as similar. That's my struggle.

Lee Partridge: Dawn, the issue before us is we're approved all three of these.

Don Casey: Right.

Lee Partridge: The question is now whether we want to go back and reconsider any one of these three or all three.

Don Casey: Right. I'm fine with letting them stand. I was a little distracted and thought we were jumping in the 3480 but I'm already said my piece with 3480 so I don't think we need to change our minds on those. Apologies.

Lee Partridge: Okay. Does anybody disagree?

Dawn Hohl: No.

Man: No.

Lee Partridge: Okay. Then we shall move on and I'm turning - I think, Chris are you leading the discussion of 3480?

Gerri Lamb: I think that was me.

Chris Stille: Yes, I thought it's going to be Gerri. Yes, you're right.

Lee Partridge: Gerri; that's right.

Gerri Lamb: Okay. Suzanne, you will see us up for 3480?

Suzanne Theberge: Sure. Actually - hang on…

Samuel Stolpe: That falls to me, this is Sam. And I'll go ahead and just walk us through a couple of slides here.

Turning over our attention to 3480, so this first slide that we see, this is reminds - it reminds where we landed. So with 3480, which is again it's the discharge to community post-acute care measure for long term care hospitals, the committee did not reach consensus on evidence specifically. And evidence is a must passed criteria so in order for us to say that we want this measure to move forward and to - with the committees move for endorsement forward, we need to first achieve consensus on that and then vote to - on the overall endorsement of the measure.

So we had one comment received here that we put inside of the report and was that the report provided limited information on why the committee did not reach consensus on this measure which intends to expand on that answer in the finalized report.

So our action items for today as I'm mentioned briefly, the community is to discuss and then revote on the evidence criteria to reach consensus and then if the measure passes the evidence vote, the committee will vote on an overall recommendation for endorsement.

Now I'm going to do a little bit of reading here just for the sake of refreshing everyone's memory, on this slide we just want to remind you where we landed. The committee voted 10 Yes and seven No for the measure as that evidence - and that's a 59 to 41 split. So we need to achieve greater than 60%, 50% (unintelligible) because they have to be, you know, 60-point, whatever, to pass our standard. So we got pretty close, not quite.

Now the draft report summarized the discussion of the committee as follows. Many of the committee's comments on this measure resembled those for the previous two measures, so the committee members noted that the literature on LTAC was quite limited and there are only 400 LTACs in the United States.

Committee members noted that people with better functional status are more likely to go home but that we also note there a few that makes a difference in this charge rates. The committee noted that per patient, it's extraordinarily important to note the rate of discharge the homing community based settings from an LTAC because this population is severely compromised and there's a large variability in the outcomes between different facilities.

Before we actually move on to the voting, there's a couple of things, one, I'm going to review with you the evidence requirements, as well as the staff's recommendation and then one of your colleagues on the committee, Peter Thomas, was not able to join but he did send an email support and I'll read his statement to you before we hand it over to our co-chairs to lead us through our discussion.

So first up, reminder on the evidence requirement. The difference between requirements for outcomes measures and process structure and intermediate outcomes measures according to NQF criteria is quite substantial. So NQF requirements are that for an outcome measure to pass evidence, empirical data to demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention or service.

If that's not available wide variation and performance can be used as evidence assuming the data are from a robust number of providers and results are not subject to systematic bias.

Now according to the developer, 83.8% of long-term care hospital had performance scores that were significantly different than the national rate with 43.7% being worse and 40.1% being better than the national rate indicating a substantial performance gap.

All right, so this next slide here is an info graphic that illustrates the difference between the evidence requirements by measure type. So on the left side with structure process and intermediate outcomes measures, NQF's criteria (unintelligible) we're looking for a clear evidence that connects the metric to an outcome and then we go through a process of evaluating the evidence as presented by the developer where we're looking for what we termed Q2C which is the Quality, Quantity and Consistency of evidence. We're expecting a fairly comprehensive review.

With outcome son the other hand, what we are looking for is the demonstration that the - that there are some things that the measured entity can do to modify their performance according to that outcome. This doesn't necessarily need to be comprehensive. What we say inside of the criteria is at least one structure process intervention or service that can be offered or implemented by the measured entity to assess the outcome.

Our assumption is that the outcome is good. Like there's no need to prove that, but there is the (unintelligible), the developer as much as possible to look for things that can lead to a performance improvement. If that's not available and we've never actually seen a submission where (unintelligible), if that's not available, we can still patients the measure under the assumption that there's something that if there's a large performance gap, excuse me, if there's a large performance gap, the assumption is that there's something that these facilities would be doing differently that might be leading to differences in performance and if those same things were adopted by other facilities that they would also perform as well.

When staff did our review, we noted that there were several things that were pointed out inside of the evidence that indicated that there was some things

that the measured entities could do in terms of identifying interventions or services, processes, structures that would improve their performance.

And so this is just passed, not passed. We don't actually grade the evidence as high, low - or excuse me, high, moderate, low or insufficient. It's simply just passed or not passed and so we - the staff before the recommendation to pass the measure. Okay, hopefully that explanation is helpful to you.

Lastly, I will read the comment from Peter Thomas who asked me to convey his apologies that he wasn't able to attend to some unexpected event. So Peter writes, "I am a strong supporter of the discharge to the community measure on which the patients experience and function committee failed to achieve consensus during our previous deliberations.

If voting today, I would vote to approve the measure. Discharge to community is a key measure of how successfully a rehabilitation plan of care is designed and executed in any post-acute care setting. The entire goal of rehabilitation is to return the patient to his or her previous level of health function and independent living to the maximum extent possible. The discharge and committee measure is an acute surrogate for this process."

With that, I will turn it over to our co-chairs to lead the discussion and voting.

Gerri Lamb: Thanks, Sam. This is Gerri.

Sam, would you go back to Slide 6.

Samuel Stolpe: Hi. Did you say 16? Is this the slide that you had in mind, Gerri?

((Crosstalk))

Gerri Lamb: Yes, it is.

Samuel Stolpe: All right. Very good.

Gerri Lamb: Okay. We are specifically looking at 3480 which is discharge to community post-acute care measure for LTAC. Remember it's part of a foursome of discharge to community members. We have recommended homecare, excuse me, (ERF) and SNF for endorsement. Okay? So we are focusing specifically on the LTAC measure and we're looking at the evidence requirement.

So where we're heading here is discussion and then a revote on evidence. And so a couple of comments specifically and I think that Don and Dawn and Peter teed us up very well for this discussion is like the other measures, the other three in this grouping, is if you go back to our discussions from December, we said they were important, they were complex measures.

There is a performance gap that Sam just went through and we talked about the risk adjustment issues for the dual eligible. The issue here is the lack of evidence related to specific empirical data.

So in bullet point number one, as Don was saying before, there's less evidence in LTAC. And we have the other option of wide variation of performance gap which you also have here.

And I would just like to add, Don, you may want to speak to this again, is the issues related to all four measures acting together. However, we are only going to be voting on evidence for 3480. And just to prepare everybody is once we vote after the discussion, if it passes the 60% mark, then we will vote on the overall recommendation.

Sam, did I get that right?

Samuel Stolpe: You did indeed. Thank you.

Gerri Lamb: Okie-dokie. All right, so evidence requirement for 3480. Would anybody like to open that discussion?

Chris Dezii: Can I jump in? Chris Dezii. We were informed of Peter's opinion. Peter, I think, that was the name. Peter's opinion. Did you share that with us because he's not here or because he changed his vote?

Samuel Stolpe: Yes, sorry if I wasn't clear on that point, Chris. This is Sam.

Yes, Peter Thomas was not able to join today and…

Chris Dezii: Okay.

Samuel Stolpe: …he sends his apologies and just wish to convey that he would vote to approve this where he able to join.

Chris Dezii: Oh, okay. All right.

Stephen Hoy: This is Stephen Hoy. I would agree with Peter's comments. Peter have been - agreed to some - both coming from that patient perspective. The empirical data demonstrated the relationship between the outcome and at least one healthcare structure process or intervention.

I think it's there. I would hope to have it that going home from an LTAC is related to more than one healthcare structural process and we'd be looking for

those sector measures and, you know, then moving down that second piece of evidence that's assuming that there is a wide variation if 40% of this 168 of them are not even performing at the national average rate, I would think there's a large opportunity for improvement there and maybe something we can learn from the 138 that are over the national average.

Chris Stille: And this is Chris Stille. I wonder if any of the NQF staff or (unintelligible) listen to the recording, were there any other issues that we had discussed that reporting to other than not much empirical data being available?

Samuel Stolpe: This is Sam. Thanks for the question.

There wasn't - we reviewed the transcripts when we were writing up the initial report, the overwhelming majority of the discussion focused on that specific issue.

Chris Stille: Okay.

Stephen Hoy: And could somebody just for my own knowledge and I think maybe for the rest of the patient care team who's on the call, explain a little bit more about the exclusion discussion around the dual eligible piece. It would make sense to me that they'd be included in this but I don't - I think it got lost on those methods discussions.

Gerri Lamb: Okay, Chris, Chris, was that you asking that question?

Stephen Hoy: Sorry that was Stephen.

Gerri Lamb: Stephen, okay. So…

((Crosstalk))

Stephen Hoy: I know that - I saw that as a…

((Crosstalk))

Gerri Lamb: …evidence to…

((Crosstalk))

Stephen Hoy: …to some of that that was testing…

Gerri Lamb: Okay, I'm trying to clarify your question. The - your question about risk adjustment for dual eligible as related to the evidence requirement. Is that right?

Stephen Hoy: Yes.

Gerri Lamb: Okay. Sam, can we invite our measure developer to respond to that?

Samuel Stolpe: Yes, absolutely.

Don Casey: Gerri, can - this is Don. Can I jump in and remind the committee that the evidence - -the analysis is on Page 80 of the big document, tables 15 and 16 and the text, which might be useful to people - for people to pull up.

Stephen Hoy: Thank you for the reminder.

Gerri Lamb: Page 80. Thanks, Don.

Don Casey: And beyond.

(Penam): This is (Penam). So should I answer right now?

Gerri Lamb: Yes, please go ahead, (Penam).

(Penam): Okay. So if I understood the question correctly, it was asking whether we include or exclude dual. So we just want to clarify that we do include dual eligible beneficiaries in the measure sample. The discussion earlier was about risk adjustment and whether or not we risk (to go) with the old status.

So we do include them in the measure but risk adjustment model does not include dual eligibility as the (unintelligible). Does that answer your question?

Gerri Lamb: Thanks, (Penam).

Stephen, did that answer your question?

Stephen Hoy: Yes, I'm going to repeat it back to you just so I make sure I understand is that the risk is not tied to dual eligible status.

(Penam): So I guess you can say that. There's no risk adjustments so there's no estimate for dual eligibility in the model.

Stephen Hoy: Thank you. (Unintelligible) speaking. I think I got it. Thank you so much.

Gerri Lamb: Good. Thanks, (Penam).

Others comments about evidence?

Don Casey: Gerri, can I just - this is Don. Can I just dovetail - I mean, the researchers found that the only indicator for dual eligible with full Medicaid is strongly and significantly associated with lower odds and successful discharge to community. And as I understand, (Penam), that was not adjusted for in the model. So, am I right?

(Penam): Yes. And so in the response to the public comment, we provided additional information as to why we believe that it was appropriate to not adjust for it.

Samuel Stolpe: Just as a point of clarification, this is Sam once again, the risk adjustment is not part of the evidence portion of the submission?

Don Casey: Right.

Samuel Stolpe: So at this point we should probably be focusing strictly on the discussion around evidence until we come to the conclusion and vote on it.

Gerri Lamb: Thanks, Sam. That was my question. So I'm glad you clarified that.

So sticking with evidence and you have the criteria in front of you, other comments?

Don Casey: Well, Gerri, Don, I guess I should cut and paste my comment from my mistake in the last discussion to this one. But I do see on Pages 66 and 67 that there was at least an evaluation of functional - of self-care functional ability and also mobility functional ability at discharge.

It appears this was just for patients who were successfully discharged to the community setting for LTAC, the LTAC population. So I don't know if this

is helpful, but, you know, a study of one LTAC over eight months of 109 patients thereby forming the conclusion that, you know, there is good evidence for this measure is in my mind incorrect.

Now I didn't do the surveillance evaluation of the entire body of evidence that's available internationally on this but if you just think about the LTAC population, I mean, the number of subjects here is 158 roughly, 58,000. So even though it's a small study, it is the only point of evidence we have to indicate that functional status is an important potential predictor of successful discharge to the community.

So I just think it's a small issue but from my standpoint, I don't see full evidence justification for this. I understand that, you know, the so-called differences is evidence but in terms of this being used for comparative purposes and public reporting and probably payment policy, it just seems to me like it's not ready for primetime. That's all I want to say.

Gerri Lamb: Thanks, Don. And I'm glad you revisited it from your previous comment. That's important to get on the table.

Other comments about evidence? Okay, not hearing any. So let's just wait a moment and then we're going to go to vote. I hope everybody has their voting screen up.

Samuel Stolpe: Here let me see.

Gerri Lamb: Any other comments because we will then do a revote on the evidence requirement.

Samuel Stolpe: All right.

Gerri Lamb: All right, Sam, let's go to a vote.

Samuel Stolpe: Very good. Before we actually take the vote, was there anyone that joined the call after roll call that we should be aware of?

Okay, hearing none, let's all go ahead and read this off, we're voting on NQF number 3480, Discharge to Community Post Acute Care Measure for Long Term Care Hospitals importance to measure and report.

The voting is now open, please log your votes.

We're looking for one more vote. And we just got it. Okay, very good. Voting results are in. We have 11 votes for pass, three votes for do not pass. To break it down into percentages, that is 79% pass, 21% do not pass. The measure passes evidence. Gerri, back to you.

Gerri Lamb: Okay, so with that, Sam, clarify for me, I thought if we pass evidence then we need to go on to a vote for the overall recommendation. Is that correct?

Samuel Stolpe: That's correct. Perhaps I would have jumped the gun. I guess if there's any discussion afterwards, we would want to have that…

Gerri Lamb: Okay.

Samuel Stolpe: …overall endorsement and then vote for overall endorsement.

Gerri Lamb: So we're calling for just overall comments on the pass right now before we go to overall endorsement?

Samuel Stolpe: Overall discussion of the measure if there's anything else that wants to be brought out initially for the discussion…

((Crosstalk))

Gerri Lamb: Before we do that, got it, already got it. All right. So we are going to move forward then to discussion of overall endorsement. This in our lasts review remember the evidence was where we did not have consensus, we had consensus on the rest.

So let me open it up for any other comments about 3480 before we move to overall endorsement.

Suzanne Theberge: And, Gerri, this is Suzanne, I'll just jump in and remind the committee of your previous vote. For gap it was four high, nine moderate, zero low and four insufficient. So pass - it did pass gap.

So reliability it was four high, 11 moderate, zero low and one insufficient. Validity two high, 14 moderate, zero low and one insufficient; passing both of those. Feasibility high nine, moderate five, low and insufficient each received zero. Use and usability for use, it was 13 pass, one no pass and usability high one, 18 moderate - eight moderate, three low and two insufficient. So generally received moderate votes across the board on the other criteria.

Gerri Lamb: Thanks, Suzanne.

Comments? Discussion?

Chris Dezii: Yes, this is Chris still one more time. I don't know if we can - you know, is there any way that we can vote to pass and put a note to say really the

evidence wasn't great. We'd like to come back in a shorter time as we can and relook at the data? Or is that just pretty much a standard look at the data every X years?

Samuel Stolpe: Hi, this is Sam.

Gerri Lamb: Sam, you want to answer that?

Samuel Stolpe: Yes, this is Sam. We will of course as part of our normal maintenance process be revisiting this measure in approximately three years and it is something that we can note to the developer that we'd like to see more evidence in that area if that's something that the committee wants us to put forward.

Chris Dezii: Yes, and I'd say that.

Gerri Lamb: Sorry. Could you repeat that again?

Chris Dezii: Just the idea that because the data - the empirical data for evidence are pretty weak that as soon as possible we'd like to see some empirical data in that way.

Gerri Lamb: Oh I see. Thank you.

Chris Dezii: Okay.

Gerri Lamb: Chris, I would take issue with them being weak.

Chris Dezii: Okay, maybe not weak. Maybe just a - yes, not as much as we normally like to see.

Gerri Lamb: Yes because I think the - in my view, the measure developers went back and they did provide data on the measures gaps. Certainly we want to see more but our previous review was based on moderate in the areas not weak except the evidence.

Chris Dezii: Okay. Yes, no, I'm totally sold on the performance gap. I have no trouble there.

Gerri Lamb: Okay, cool.

I was wondering, Don, I don't know whether you would care to comment - I was really intrigued with your earlier comment about the importance of treating these as a set. I wanted to understand more about that. What were you thinking?

Dawn Hohl: Well, you know, my thought is I look at the post-acute care continuum as patients move from one to the other quite often and I think as much as we can standardize and have these metrics across the continuum, I think the better we're able to respond to the health system.

Now of course we're going to have, you know, more discharges with goals met coming out of homing health then we are, you know, that's the community from long term care because long term care for many that is the final spot.

But I just feel we need these consistent measures and then that will help us at some point go back and better learn what patients should be at what levels of care. If this is a true outcome measure, they should help us place patients better.

Gerri Lamb: Thank you. That's very helpful to me.

Samuel Stolpe: Sure.

Gerri Lamb: Other comments about suitability for endorsement?

Sherrie Kaplan: So this is Sherrie. Just thinking about what was just raised with regard to the measures that is set. I mean, I understand the point, I guess, my concern would be whether or not that would be - I mean, if you - if one were considering not voting for the measure, if that's an adequate or appropriate sort of argument for them to endorse it? Because when I view, you know, the endorsement, it really says the CMS they can be used in payment program versus the measure that can just be used or do we feel as or is it because the measure wouldn't be used if it weren't a payment program.

I mean, the measure exists and could be used for the types of comparisons that are being mentioned, but I mean, to me in some ways an endorsement really the measure is strong enough to really be able to be used within payment program, not that that's the only reason for endorsement but it is one of the key things that, you know, measure - endorsed measures are used for.

Don Casey: Well not - this is Don. I'll add that public reporting from the standpoint of so-called consumer choice is the other factor here.

Sherrie Kaplan: Yes, good point. Thank you.

Gerri Lamb: And also, Sherrie and Don, good point. Just to remind everybody that we are voting on one measure, 3480. And we're voting on it on the merits of that measure. I asked Dawn because I was interested in how she was thinking about the measure set would work but we are only voting on the suitability of

this measure based on our previous review and our endorsement or recommendation for endorsement related to evidence. So just to clarify that. Other comments on suitability? All right, you're ready for a vote? It should be up on the screen.

Samuel Stolpe: All right. We'll go ahead and pull it up. Just one moment. So we're voting on NQF number 3480, Discharge to Community Post-Acute Care Measure for Long Term Care Hospitals Overall Suitability for Endorsement. That's the measure we need NQF criteria for endorsement please. Submit your vote now.

Thanks very much. Voting results are in. We have votes for 12 yes, two for no and the percentage breakdown for that is the same as the previous - I guess it's not, it's 86% for yes, 14% for no. So measure passes and will be moved forward for the next stage.

Gerri Lamb: Thank you, everybody. Good discussion.

Samuel Stolpe: All right. And thanks for leading us through it. I'll hand it back over to Suzanne.

Suzanne Theberge: All right, thanks, everybody. So next stop is our NQF member and public comment period. So at this time we'd like to open the lines for anybody who's snot on the committee to make a comment either phone or via the chat. If you'd like to make a comment, raise your hand or just submit via chat.

Okay, it looks like we don't have any comment or chat so I think we're good to move on to our next stop.

So for the fall cycle we are just about done. We will be bringing these measures to (CSAC), all five measures will go to (CSAC) as recommended and (CSAC) will make their ratification of the endorsement. And then the measures will go out for a 30-day appeal period starting shortly after (CSAC) and then the final work on our end will be just releasing a final report.

So you all are done with the fall cycle except for the co-chairs who will be representing the committee at (CSAC). Of course everyone is welcome to listen in, but the rest of the committee doesn't need to participate.

Very shortly we will be starting our spring cycle work. For those of you that are joining us for the spring cycle, many of you are, our orientation call is on May 30th and our in-person meeting in DC at our offices is June 20. It'll be great to see everyone in person in just over a month.

We, as mentioned earlier, have a really full bucket this cycle. We will be looking at maintenance of endorsement for the (caps) measures. We will also be looking at several functional data measures. We will be - from CMS and from (UDSMR). I know that those of you who are on the patient experience concur the formally (CFCC) committee they remember some of these measures which we looked at a few years ago.

And then we also have two new measures, the collaborate share decision-making measure. You all heard a presentation from that developer team a couple of years ago now and they are now ready for endorsement review and then we also have a functional status measure for patients with neck impairment. That's another new measure.

So 13 maintenance measures, two new measures and a fleet of related and competing measures that we will have to discuss. So promises to be very full.

Jordan will be reaching out to you in the next few days with a poll about scheduling a second meeting, close meeting webinar. We're concerned we're not going to get through everything at the in-person meeting and the one follow up webinar that we have scheduled. So we're going to be scheduling a second follow up webinar. So keep an eye out for that.

We just have a couple of other quick reminders for folks on the spring committee, so yes, I think actually Jordan has already sent out that (duty call). I apologize. So please just fill that out if you haven't already. And we also are looking for disclosure of interest (lens) from many of you and then if you have an update to your bio - on our roster, please let us know so we can finalize that and get that up on the Web site.

So we will be in touch with you in a couple of weeks with the materials for the May 30th call and you can expect to receive all the measure information, including the (fact) preliminary analysis by May 31st. So that's all coming your way in just a couple of weeks. You can start thinking about spring.

I would just - and with that, here's our contact information and I'll just pause before we close the call and see if anybody has any questions?

Chris Stille: Suzanne, this is Chris Stille. If you guys can send out the travel information soon, that would be great. I always have a hard time getting flights international and the sooner I can try that, the better.

Suzanne Theberge: Absolutely. I'll check in with our meeting's team this afternoon and see if they can get that out. We have - we'll have them get in touch with folks as soon as they can.

Chris Stille: Thank you.

Suzanne Theberge: Other - and so that will come from NQF meeting, not from the project box. Just so you know.

Chris Stille: Sure. Did you send the slides from today's presentation or not?

Suzanne Theberge: They are posted on the committee SharePoint.

Chris Stille: Okay. Great. Thanks.

Suzanne Theberge: Any other questions, concerns? All right, well with that, we can close out the call and give you all an hour back of your afternoon. I'm sure everyone can use it. Thank you so much for your time today and for your effort and time on the fall cycle.

Samuel Stolpe: Thank you.

Dawn Hohl: Thank you.

Gerri Lamb: Bye.

Chris Stille: Thanks, everybody.

Suzanne Theberge: Goodbye.

END