NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
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Lee Partridge: Sam?

Sam Stolpe: Hi there. Yes Lee, go ahead.

Lee Partridge: I was just wondering are we about ready?

Sam Stolpe: We are. We're going to give it just another moment and then we'll tee up the call.

Okay, let's go ahead and get started. Hello and welcome everyone. This is Sam Stolpe speaking and you are on the Patient Experience and Function Spring 2019 post-evaluation web meeting 3. So I'm joined today by some of my colleagues at NQF. We have Oroma Igwe, our Project Manager as well as Jordan Hirsch, our Project Analyst. Suzanne Theberge is home with the sick kid today, so we are allowing her to beg off and head into the home front. With many thanks to her for helping us put together this particular meeting. We also have one of our co-chairs on the line, Lee Partridge and I believe Chris Stille will be joining us a little bit later in the meeting.

So just a couple of things that I wanted to say before we get started, just a reminder of where we're at currently. We had our call yesterday where we evaluated two of the five measures and a little bit of the third before we got to the top of our second hour together. So we do have the remainder of our the long-term care hospital measure on functional status, our functional outcomes for change in mobility among patients requiring ventilator support.

So I believe we were - I just gotten through evidence and performance gap and we'll be moving onto continue our discussion around the Scientific Methods Panel rating of that measure. And then we'll try to get to the remaining two once we finish up with Measure 3632. We have two more comparable measures, 2635 and 2636 that we'll be discussing as well.

So just a quick check, do we have our measure developer on the line?

Ann Monroe: Yes. Hi Ann is here and Dr. (Levitt) from CMS is also on.

Sam Stolpe: (Dr. Joyce), Dr. (Levitt), thank you and welcome. And let's go ahead and go through a row call and then we'll go ahead and get started with our measure. I heard Lee Partridge on the line. And was Chris Stille able to join early by chance?

Lee Partridge: Chris is going to be joining us around 2. He is welcoming interns.

Sam Stolpe: Yes. I remember that, but just wanted to see if he had some sudden change. But Beth Averback?

Beth Averback: Yes, here and I need to leave in about 45 minutes.

Sam Stolpe: Very good. Thanks for letting us know that. Don Casey?

Don Casey: Present and not in Starbucks anymore.

Sam Stolpe: Okay, thanks Don. Ryan Coller?

Ryan Coller: I'm here.

Sam Stolpe: Thank you. Sharon Cross?

Sharon Cross: I'm here.

Sam Stolpe: Thanks Sharon. Chris Dezii? Shari Erickson?

Shari Erickson: I'm here.

Sam Stolpe: Thanks Shari. Dawn Hohl?

Dawn Hohl: Here. I do need to step out in the middle of the meeting. So I will be here at the beginning and the end.

Sam Stolpe: Okay, very good. Thanks for letting us know Dawn. Stephen Hoy?

Stephen Hoy: Here.

Sam Stolpe: Thanks Stephen. Sherrie Kaplan? I heard Brenda Leath earlier.

Brenda Leath: Yes I'm here

Sam Stolpe: Thank you Brenda. Brian Lindberg?

Brian Lindberg: Here.

Sam Stolpe: Thank you Brian. Linda Melillo? Okay, Ann Monroe? We have Lisa Morrisse earlier and Terry O'Malley, welcome to both of you.

Terry O'Malley: Yes.

Sam Stolpe: Deb Saliba? Ellen Schultz?

Ellen Schultz: I'm here.

Sam Stolpe: Thanks Ellen. Lisa Suter? And Peter Thomas?

Peter Thomas: Present.

Sam Stolpe: Thank you Peter. We're just doing a quick count. It looks like we are - let's do that, six, eight, 10, 12, 14. We're at quorum. So we are exactly at quorum. So if any of you are going to step away, please let us know. If we do lose quorum, we will be switching over to a semi-voting system.

Jordan has an emailed prepped up that has our SurveyMonkey poll available. And what we'll be doing is getting a critical mass of committee members in the wake of our call to send out both our recording and the Poll Everywhere. But you may vote in real time as we go along as you - if you wish. But once again please let us know if you're going to be stepping away during a vote and we'll probably be needing to make a switch. Although as Chris is coming on that will put us at 15, so it is pretty tight though, so thanks to everybody for being conscious about quorum. All right, that being…

Peter Thomas: I have a question.

Sam Stolpe: Go ahead.

Peter Thomas: Why is it that we're always so close to quorum? Obviously now that people are participating, but has NQF thought about increasing the number of alternates or committee members that could serve when others are not available or what?

Sam Stolpe: Yes, it's a good question. So we haven't traditionally had alternates per se for a roster. And once we establish a roster, those are the ones who were on the committee. Of course, currently we have 21 members of this committee. We can go up to 25 and it's our preference to do so. But sometimes we have people drop off. But it is something that we are conscious of and we're trying to get to a little bit of a better spot in terms of making sure that we have an adequate number of people on the committee where we can try to avoid situations like this in the future.

But some of this is an artifact of the number of measures that we as a committee took on and this third meeting in particular is a little bit challenging to get everybody together. We had a terrific turnout for our in-person meeting like I think this committee was one of the best actually and we had almost everybody here and we had…

Lee Partridge: We did Sam.

Sam Stolpe: …yes, we had everyone. So it's usually the follow up calls where it tends to be a challenge if and when it is a challenge, but thanks for your question.

Peter Thomas: All right, thank you.

Sam Stolpe: All right. Well okay, that being said, let's go ahead and move into the book of our agenda. So I'll hand it over to Lee and we were right in the middle of our discussion around the long-term care hospital functional outcome measure, change in mobility among patients requiring ventilator support. This is Measure 2632 and let's pick up the discussion around the scientific methods panel review of reliability. Lee, over to you.

Lee Partridge: Thank you Sam. And I believe Sherrie is not with us, at least not yet.

Terry O'Malley: Well, I'm here. Hello?

Lee Partridge: Sherrie Kaplan?

Terry O'Malley: Sherrie, I thought you said Terry, sorry.

Lee Partridge: Not Terry, no. I was about to say Terry is going to lead us - it's Terry is still here with us and he is the lead. So Terry, do you want to just go over the - your recommendation or comments was referred to acceptance or issues raised by the Scientific Methods Panel?

Terry O'Malley: Certainly. And so the scientific accessibility or the panel voted both reliability and validity as moderate. And they raised sort of one question, one reviewer said that there is really no test to establish this is a valid improvement score, you know, to use this quality improvement. And that the committee would have to rely on face validity.

And I think my comment on that - the comment on the question, the question will be to developers and the comment is the clinical validity from point of view of a clinician seem to me to be very strong and the methods panel felt that the data element validity was strong. So I guess my question to the

developer, they're waiting for trend data to establish this firmly as a quality measure.

Ann Monroe: Great, thanks Terry. So this is Ann and I'll get us started and pass off to (Alan), Dr. (Levitt). So, you know, we did look at the relationship between each individual item and the reading scale and discharge destinations, discharge to home and saw a strong relationship. We also looked at the overall scale score. So the sum of all the mobility scores and how that related to discharge to community and all of those were very supportive of the clinical validity of the items. And I believe that some of the methods panel actually saw some of those as good analysis to represent validity.

(Alan), was there anything you'd like to add?

(Alan Levitt): No, but again to reiterate again the fact that we agree with the comments that were made about the clinical validity of the measure and also to remind that again this was a measure that Congress also felt was an important measure to include in this program.

Terry O'Malley: Okay, that's great. Okay.

Lee Partridge: All right.

Terry O'Malley: Yes, Lee. I don't have anything else to add, maybe, you know, there're reviewers in addition.

Lee Partridge: I don't think I heard Deb Saliba on the line. Did I?

Terry O'Malley: No.

Lee Partridge: If not then I think Terry, you're the only one of your team who is on the call today. So we'll open it up for a discussion or comments from the rest of our committee and then we'll proceed to a vote. Let's just…

Don Casey: This is Don. We're on validity, correct?

Lee Partridge: We are. No, we're on reliability and…

Don Casey: Okay, thank you. I'll preserve the comments.

Lee Partridge: Okay.

Don Casey: Did we already vote on validity?

Lee Partridge: No.

Don Casey: Okay, all right, thank you.

Lee Partridge: Am I right? Reliability comes first and validity comes second?

Sam Stolpe: Yes. You've got it Lee. So we'll have the reliability discussion and vote then let's move to validity.

Lee Partridge: Yes, okay. Silence, are ready to vote?

Ann Monroe: Yes.

Sam Stolpe: Let's go.

Lee Partridge: Yes, okay. Jordan, why don't you queue us up?

Jordan Hirsch: All right. Voting on reliability to uphold the Scientific Methods Panel decision for 2632 is now open. Your choices are yes or no.

Dawn Hohl: This is Dawn. My computer is showing something very odd. Can I just give you a verbal?

Sam Stolpe: You may if you wish or you may send it via chat.

Dawn Hohl: Let me just - if it's okay, I'd just like to say yes, because I don't know what's going on with my computer.

Sam Stolpe: All right, thank you.

Dawn Hohl: I'm sorry. I'm going to try to get it fixed before the next one. I'm just going to reboot.

Sam Stolpe: No worries.

Jordan Hirsch: That's all right.

Sam Stolpe: Thanks Dawn.

Jordan Hirsch: Voting is now closed. The committee has approved the method panel for reliability with yes or - sorry, 14 votes for yes, zero votes for no.

Lee Partridge: Okay. Moving on to validity, Don?

Don Casey: Do you want me to talk now or…

Lee Partridge: Yes. You said you had a question…

Don Casey: …is the - are the leads is going to say anything about it?

Man 1: No, Don, I think I've already said what I'm going to say.

Don Casey: Yes. I have a question. I'm having a little trouble with SharePoint seeing everything. So let me ask the question, because I think it fits here. I noticed in the data collection form, in the assessment of core morbidities there is one - two cardiovascular questions or documentation boxes. And one of them is the ejection fraction is less than 30%. And knowing a bit about heart failure I guess my question is there isn't any allowance for let's say active coronary artery disease and also systolic or diastolic parts, in other words preserved ejection fraction or reduced ejection fraction.

So I'm curious about this, because I think those conditions I guess - I'm assuming would affect one's ability to become less independent on a ventilator. So I guess my question is could you clarify why you're only adding in one small part of a population that I think could be substantially affected by that - whose conditions could substantially affect the outcome of that. It seems like there isn't enough emphasis on the different type of cardiovascular care ejection fraction. Less than 30% is fine, but the staging or the NYHA classification is applicable to both categories of heart, you know, the preserve EF and reduce EF?

It just seems like that's a - I'm trying to understand why those other categories of severe heart failure that is not reduced EF and also active coronary artery disease are not included in this model, because it clinically makes sense to me that they would have a big impact on this ability for some patients to get off the ventilator.

Lee Partridge: (Dr. Joyce), Dr. (Levitt)/

Ann Monroe: Yes, thank you. And I will certainly pass off to Dr. (Levitt) in a moment. So the LTCH care data set is actually used for several quality measures as part of the LTCH quality reporting program. So for the change in mobility measure that we're talking about right now, 2632, so, you know, the inclusion criteria are individuals who require ventilators to put on admission. And we do risk adjust for the primary underlying condition, so we do have cardiac as one of our risk adjusters related to that topic. And we do adjust for core morbidities. But we actually do not use that particular variables for this particular quality measure, so that's just as I said, you know, the data set is used for multiple quality measures, so there is actually a separate measure related to ventilator liberation and that actually is tied to that particular quality measure.

And I don't know Dr. (Levitt), if you'd like to add anything.

(Alan Levitt): Yes, this is (Alan). As I said before, when we take the cookies with the ingredients, you have an advantage. I think here the total question I guess - I think a lot of the items that we use are on the assessment instruments are ones that we, you know, are confident that can be collected on most stations and that the information we get back is reliable and that it can be used for multiple purposes and multiple measures.

And so could there perhaps be more specific items that could be collected? Perhaps yes. How to operationalize that and make sure that the data that we're getting back on such thing is accurate, is valid will then be - will be another issue or a concern.

But, you know, we continue to always look at all these items and saying whether or not there is a better way to define these things and certainly as - in medicine everything changes diagnostically, we may also look at that.

We do also look just in general at our risk adjustment models and, you know, different items. I mean that's something that we do on a regular basis, not just on this, but on all of our outcome measures to try to help figure out, you know, whether or not there are better items to use or within the existing items whether or not those are items we should continue to include or not.

Don Casey: I guess my point is it doesn't make clinical sense to me that you would not have - let's pick a patient, active cardiac ischemia with heart failure with preserved ejection fraction that is greater than 50% not be an influencing variable to as it relates to mobility. It just intuitively makes sense to me that that will be an important variable to include and I'm surprised it's not there. That's all I'm trying to saying, because it doesn't make sense…

((Crosstalk))

Ann Monroe: Yes, this is Ann. Sorry, just to clarify, so we do have chronic cardiac condition as a risk adjuster and the underlying, you know, condition related to being on a ventilator. So we do adjust for cardiac based on the primary diagnosis information which is actually in Section I and on the CMS Web site, there is a list of those conditions that will be - ICD codes that will be included in that.

Don Casey: Correct. And on the data collection form, there are two items from Section I. One of them is it relates to peripheral arterial disease and the other specifically relates to reduced ejection fraction less than 30%. That's all I see there. So

maybe I'm missing something, but at least in Section I, it looks like you're only collecting two items and that seems to me to be a problem.

So we're not talking about cardiac, we're talking about specific piece of population of patients with specific cardiac conditions that will be likely to be in this scenario who would also be likely to have reduced - would have restricted mobility because of those conditions, so I'm just pointing that out, that's all.

(Alan Levitt): All right. And again, to understand again from our point as I said that when we're looking at these assessment instruments and the burden that we're asking providers to have in the assessment instruments, the more we try to look at subpopulations and sub-subpopulations going off from the assessment instrument although you may feel that they may be better for an individual quality measure. You have to really to look at it to take a picture of how we're collecting these sorts of items on these assessment instruments and trying to make it a successful collection both for the measures and then also for the stakeholders when we're in a setting that, you know, their staff need to collect this information.

Don Casey: Well, I'm looking at the bigger picture too just for the record.

(Alan Levitt): Yes, okay.

Lee Partridge: Excuse me. Are there questions or comments from other members of our committee on validity? If not in the interest of time I think we should move on to a vote.

Jordan Hirsch: Voting is now open for accepting the Scientific Methods Panel of rating for validity for 2632.

Sam Stolpe: And just a point of clarification, the Scientific Methods Panel's rating on this measure was moderate for validity. Dawn, are you doing okay?

Dawn Hohl: Yes, I think it went through.

Sam Stolpe: Yes, it looks like it. Thanks very much.

Jordan Hirsch: Voting is now closed. The committee has chosen to accept the Scientific Methods Panel's rating for validity with two votes for yes and two votes for no.

Lee Partridge: Okay. Feasibility, Dr. O'Malley?

Terry O'Malley: The feasibility was rated as high and I have no further comments to that.

Lee Partridge: Anybody else? Okay, then moving along.

Sam Stolpe: Amazing.

Lee Partridge: We're in a rhythm.

Jordan Hirsch: Voting on feasibility for 2632 is now open. Your choices are A, high, B, moderate, C, low or D, insufficient. The voting is now closed. Feasibility passes with six votes for high and eight votes for moderate. We'll now be going to usability and use.

Terry O'Malley: Okay. And usability and use, it's currently - this measure is currently in - there is publicly reported in two accountability programs, the LTCH quality

reporting program and will be used in the LTCH compare in 2020. And so my feeling was that it's a pass on use and the usability is moderate.

Lee Partridge: Okay. Comments or questions from other committee members?

Ellen Schultz: This is Ellen. I do have a question about the usability given that how narrow this method is, I just question how useful it is to have like such a mix within a mix. So even within LTCH, can we have this subpopulation of those on a ventilator and then we're looking at the one aspect of their function looking at mobility rates. So I just wonder really how actionable that information is likely to be, you know, and how - yes, just how useful it is. So I wonder if the measured developers could speak to that.

Ann Monroe: Sure, I can get started and pass off to Dr. (Levitt). So basically, you know, the patient who are considered for payment under the LTCH PPS there is certain restrictions in terms of their medical conditions and ventilator is actually one of them. So this is an area of focus for long-term care hospitals in the U.S. and again there is only about 420 or so in the U.S. So this is an important diagnosis.

During the measured development phase, we actually did have an expert panel and proposed to have measures that stand across all LTCH patients that at that point in time they recommended focusing on this single diagnosis at this point in time, but I do believe that CMS is interested in addressing exactly your concerns that we want to look at the quality of care in LTCHs across all patients. So I think I'll pass off to Dr. (Levitt) to see if there is anything else you'd like to add.

(Alan Levitt): Yes. Again, I agree with everything that Ann said. And after to the genesis of this measure, as I've said before, again this was mandated by Congress in

terms of the specific subpopulation of patients within the setting although we certainly do agree in the test agree that the assessment and the improvement in functional status in the ventilator population whether it's within acute care hospital or in an LTCH or really wherever they're located is core - a quality measure that's built around that is important as well.

Lee Partridge: Dr. (Levitt), this is Lee. You said your expert panel recommended concentrating on the event support with subpopulation, can you give us maybe a one sentence or if you know why they recommended that? Was there some special concern?

Ann Monroe: Well, I think it was the range of patients that were being admitted to LTCH with the time. So some LTCH admit patients who have specialized wound care needs and so there was a concern about how you would risk adjust across patients who have, you know, special - well, very complex wound in patients who are in ventilators, who are there potentially to get weaned or liberated from the ventilator and then there is also patients who have, you know, multiple organ failures. So it was the heterogeneity of the patient population and the idea that we would try and risk adjust.

And I think, you know, it will be just the range of patients, but I think Dr. (Levitt) has mentioned CMS on the payment side has actually updated some of the eligibility for the LTCH PPS. And so there has been some change since we had that expert panel. I think it was about 2014 or so where we had that ending.

Lee Partridge: Ellen, does that help.

(Alan Levitt): Yes. And this is (Alan), and again this particular subpopulation of patients is at high risk because of the bed rest and deconditioning that goes on within the

ICU or particularly for patients on a ventilator who may be more likely to be in bed to be really at a high risk for functional impairment that with appropriate treatment can show reversal and improvement.

Lee Partridge: Okay. Ellen, does that help you?

Ellen Schultz: You know, I appreciate the explanation. I will just say from my part, I find it very unsatisfying. You know, what I'm hearing is that the minutia of you know, measures of specification and development is trumping practical considerations in terms of why are we measuring in the first place and who are we able to benefit.

You all heard what I had to say on, you know, the problems that arise and we see carving out our measurement into the tiny little silos instead of looking at things holistically, so I won't repeat those comments, but I think they apply here most definitely.

((Crosstalk))

Lee Partridge: Go ahead.

Ann Monroe: Sorry, this is Ann. Just - I totally understand where you're coming from. I just want to share, you know, when I did some research about 10 years ago where we asked patients and, you know, elderly about, you know, what information will be helpful for them in terms of selecting a facility. Many did speak to - I'd like to know what they - how they - how somebody like me will do, somebody, you know, with arthritis and cardiac condition and, you know, somebody might. So there is - it is a challenging area, I totally agree with you.

Stephen Hoy: And this is Stephen. I'm sorry. I've somewhere got lost a while, the number of measures we're looking at, is this - how is this assessment different than the standard change in mobility assessment? Can you hear me now?

Lee Partridge: A little better.

Stephen Hoy: All right. I had this problem yesterday.

Lee Partridge: I'm - Peter, I mean Stephen asked where - which - are you asking on which measure we're working.

Stephen Hoy: No, I'm sorry. I'm asking how is the change in mobility score, how is this assessment different than the standard change in mobility support for all patients?

Lee Partridge: It's on different facility.

Ann Monroe: Yes, this is Ann. If I can address that, so the data elements are some of the same data elements that are in the IRF measures that we discussed on 6/20. The approach to the analysis are the same, but as Lee correctly stated, this is the LTCH setting as opposed to the IRF setting.

Stephen Hoy: Thank you.

Lee Partridge: All right. Are there other comments or are we ready to go on and vote on use - usability, excuse me?

Don Casey: Well, this is Don. It's hard to read the results from the quarters that were provided in the document. And could you just comment on the trend of the interquartile range between the five periods that were chosen for evaluation?

I'm trying to get a sense of the Delta between Q2 - Q3 '16 and Q2 '18 which I assume is the latest available information.

Lee Partridge: Ann?

Ann Monroe: So you're asking - sorry, you're asking what the change is. Yes, so the way this has to be entered into the system where we weren't able to put in a table and I'm sorry, it's not easy to read. So basically you're right that we use every available data points that we were able to use. So the mean went from 9.2 for the first rolling four quarters and it went up to I think nine point - it was yes, 9.0, 9.0, 9.1 and then 9.0, so it's been pretty stable.

Don Casey: And how about the interquartile range? It looks like it's been the same as well. Well, actually, Q2 - it's hard to read it, but…

Ann Monroe: Yes.

Don Casey: …4.1, 4.3, 4.1, 4.1, so not much change there I would say.

Ann Monroe: Correct. You know, and as we mentioned yesterday, you know, LTCH has had quite a few changes on a policy side related to payments in recent years. And so we had not anticipated that there will be a change at this point in time, but we obviously do hope that there will be some changes that we past time here.

Don Casey: So hoping for a change, but no change?

Lee Partridge: Okay. Any further comments or discussion before we move to voting? All right, I'm mindful we may lose Beth, so…

Beth Averback: Yes, I'm - I'll stay through this one.

Lee Partridge: Okay.

Jordan Hirsch: Voting on the use criteria for 2632 is now open. Your options are A, pass, B, no pass.

Shari Erickson: This is Shari. Can you clarify? This is just on the use piece, correct?

Lee Partridge: Correct.

Jordan Hirsch: That is correct. Looking for two outstanding votes.

Lee Partridge: One more. Is there anybody who hasn't voted? I wonder.

Sam Stolpe: Yes. We're not achieving quorum on this one guys, any…

Lee Partridge: Right. I wonder if Don had to dug out. Don, are you still on the line?

Sam Stolpe: Yes, Don had to step out, okay. So we don't have quorum, so we'll have to table this vote for the - for a follow up email. Jordan, did you want to go ahead and send out the voting link?

Jordan Hirsch: Yes, I'll do that right now. So everyone, check your email in the next two to three minutes and the voting link should be there for both 2632 and then the following measures that we will be discussing on this call.

Lee Partridge: Jordan, does that mean we are going off this system?

Jordan Hirsch: For now it does. If we achieve quorum later in the call then we will be going back to Poll Everywhere. It's confusing as that is and we apologize for that.

Lee Partridge: Okay.

Sam Stolpe: The reason why we do that is so that this committee doesn't need to vote again. It will just be for - or rather the committee members present don't need to vote again. It will just be for those who will be listening to the recording that would need to vote again. So we'll at least maintain the continuity of documenting the votes as we move forward. We won't be able to share the voting results until we actually have everybody who can - who has voted tally it up. So we'll be sharing those separately. But we will need to get one more vote via the poll that we're about to send out on use. So that's where we'll be requesting that you start.

Lee Partridge: All right.

Shari Erickson: Somebody re-voting on this then through some additional link, is that what's happening?

Lee Partridge: I think we should now all be switching back to our inboxes and looking for new message from NQF, am I correct?

Sam Stolpe: That's correct.

Lee Partridge: Okay.

Sam Stolpe: So that has been sent. It should be hitting your inboxes. So we need to recast the vote on use and you can do that at your leisure or you can do it now. We

recommend you to do it in real time just so that you don't have to think about it anymore.

Peter Thomas: I got a SurveyMonkey, is that what we're looking at the SurveyMonkey?

Sam Stolpe: Precisely. Yes, so we're switching last ones from Poll Everywhere to SurveyMonkey to document the reminder of the votes.

Lee Partridge: All right. And do you want to just take us through this - you want - I'm…

Sam Stolpe: Sure. Jordan, go ahead.

Jordan Hirsch: So when we send out the measure evaluation survey - preliminary survey prior to the in-person, it will follow that same format. So when you pull up the SurveyMonkey, you'll input your name and in question 1 and question 2 you will choose the measure in which you'd like to evaluate. And from there it will be following the same thing as Poll Everywhere. It will show evidence as question 3 in this case, but it will be 1A, evidence, 1B, performance gap, so on and so forth and you'll fill out each individual question starting with use for 2632 and then for all criteria for the following two measures.

Sam Stolpe: Right. Just a reminder to the committee, so the - our votes are locked at this point for all criteria for 2632 that perceives to vote for use and usability. So no need to vote on those, you may if you wish, but they won't be tallied. Where it starts counting is with use and usability and we don't need to do anything other than at this point.

Lee Partridge: So in other words, I'm doing it right now. You page down to 8, right? You first enter 20 - the number of the measure and then down to 8, the usability and use.

Jordan Hirsch: That's correct, yes.

Lee Partridge: Okay. All right, let's give everybody half a minute and then move on to…

Sam Stolpe: Usability.

Lee Partridge: Usability.

Sam Stolpe: So any discussion on usability or we can now move on?

Lee Partridge: Terry, any comments on usability?

Terry O'Malley: No. I think Don's comments were fine and the previous ones about words in use now.

Lee Partridge: All right. Then if you're on SurveyMonkey and want to vote, we should vote.

Sam Stolpe: And then the last of course is the overall suitability which you may enter your vote for that now as well and then we go ahead and move on to our discussion of the next measure.

Don Casey: Sam, I did that and - this is Don and then I think I hit the back button and I think it makes me go in and put my name back in again and sort of start over choosing the next measure in the dropdown. I hope that's correct.

Brian Lindberg: Yes, if you hit done, it closes out and you got to go back and open it again and go to the next measure.

Don Casey: Yes. I just hit the back button and after I was done and then I got to where I started, but it was blank again, so I just redid it.

Brian Lindberg: Yes.

Beth Averback: And this is Beth. I am going to need to drop off now. So I will save the link and go back and do the other measures when that opportunity is available.

Lee Partridge: Thank you Beth.

Beth Averback: Yes, thank you.

Deb Saliba: And this is Deb. I'm kind of going to replace Beth.

Sam Stolpe: Welcome Deb.

Deb Saliba: Excellent.

Shari Erickson: This is Shari. I was not able to be on the call yesterday to hear the discussion of evidence. Can you tell me where the vote landed on that phase?

Sam Stolpe: Yes, you got it, just one moment. Do you have a vote telling?

Lee Partridge: Yes.

Sam Stolpe: Yes. So we're pulling it up just now.

Jordan Hirsch: Evidence passed with 14 votes for pass, one vote for no pass.

Shari Erickson: Okay, thank you.

Peter Thomas: May I ask a question? This is Peter. I just went through the whole measures - all the measures questions and I voted and I submitted. So now I'm at a stop in the SurveyMonkey where there is no prompting for a new measure. Will that be coming up or do we have to reenter something?

Jordan Hirsch: You can go back to the first page that you were on with all of the dropdown options and then you will click for the next measure which in case will be 2635.

Peter Thomas: I see. Okay, thank you.

Lee Partridge: So we are - I think we are still at 13. Am I correct Sam?

Sam Stolpe: Yes, I believe so with…

Lee Partridge: If Chris joins us in the course of this discussion, then we may be able to switch back, but…

Jordan Hirsch: That will be correct. We'll be back to 14 if the current 13 still hold.

Lee Partridge: All right. So let's move on to the pair of measures, 2635 and 2636, we're going to discuss them separately although they are I think the same. Some of the same questions will come up. And we'll begin with 2635, discharge self-care score for patients in an IRF. And we are returning back to (Dr. Joyce) and Dr. (Levitt). Do you want to start us off?

Ann Monroe: Great. And I will give basically an overview of both measures together for efficiency. So these are impact act quality measures that are using the standardized data elements that we have been talking about over several

measures now. So again seven top tier activities for the self-care measure and again we're - in this case we're looking at the discharge score. So with seven data elements the range is seven to 42 for the discharge score.

And then for mobility there is 15 data elements. And so when you looked at some of the analysis we get related to the district mobility score, you saw a range of 15 to (90). So these measures have the usual numerator, denominator format and so basically the measure is the percent of patients within an IRF that meet or exceed an expected discharge score.

So in order to calculate the measure in our documentation we described how we calculate the observed score and then our expected score based on our risk adjustment approach.

In terms of gaps, we did see some disparities. So on the self-care measure we saw that individuals who are Black, Asian, Native American of Pacific Islander had lower scores on the quality measure, so they had a lower percent meet or exceed the expected scores compared to White. On the mobility score, we saw that people who are dual eligible had worst outcome in terms of function for mobility and also individuals who're Black had worst outcomes than White.

In terms of comparing the data across time, the way this particular measure is designed, we're always updating the benchmark. And so, you know, in general we wouldn't expect to see the QM score actually increase over time, because the QM is designed to basically always strive to have the national average as kind of the expected score.

In terms of feasibility, the data began data collection for these measures in October 2016 and both measures are scheduled for public reporting on the IRF

(unintelligible) in 2020 using data from 2019. This is - both measures have a timeframe of 12 months.

So I think those are the highlights I wanted to mention. I'll pass of to Dr. (Levitt).

(Alan Levitt): Thank you Ann. Just to add, again, you know, these are measures as you know. It's really different selection of ways to looking at a functional status outcome measure than just the change in. This is really meeting anticipated score, so this is important in the IRF programs.

And then particularly as we move across, I mean obviously that's not part of the endorsement today, but just to get a feeling as to kind of where we're really going with this, you know, I see the same items are now being collected in other settings that as we continue on measure development, these will be very important measures for example in home health where, you know, at home health agencies that take care of patients that for example may have limited improvement expected or they're essentially maintaining or may even getting worse because of their diagnosis.

Again, these are measures that are really looking at risk adjusted of what we would anticipate the discharge score will be and whether they meet or not and so it's particularly helpful for those types of providers in those settings as well. That's it from me.

Lee Partridge: Thank you. Deb, you are the lead discussion on the self-care measure. Do you want to start us off?

Deb Saliba: Okay, yes.

Sam Stolpe: Just a quick note, sorry to interrupt you Deb. This is Sam Stolpe. It appears with step - with Don coming back and Deb stepping in, we just lost one with that. So that puts us back at quorum. We feel pretty strongly there is better process to actually document the votes in real time if we can. So with apologies for the confusion, once we get through the discussion of evidence let's go back to the Poll Everywhere approach and see if we can't maintain quorum with Chris anticipated to join, we should be good. So let's just vote through the standard initial approach if we may.

Lisa Morrisse: This is Lisa Morrisse. I need to leave in 10 minutes, I'm sorry.

Sam Stolpe: Okay. So that ends up being a little sticky and hopefully Chris will come in just as you're going out. So that would again balance us and put us back in quorum and we've got a - we're dancing on a razor edge and I appreciate everybody helping us as we're trying to work around quorum and sorry for the added confusion.

Lisa Morrisse: Okay.

Lee Partridge: So I think are we now ready to - Deb to start our discussion of 2635.

Sam Stolpe: Yes. Deb, we're ready to go.

Deb Saliba: Okay. And I can go pretty quick Lee. So basically this is an important target population that LTCHs traditionally serve which is ventilator patients. So understanding - I'm specifically discussing 2635, but, you know, understanding their outcomes is particularly I think an important area.

The preliminary reviews, you know, they felt that it passed on evidence and I agree with that that there was significant opportunity for improvement which

is Ann, you know, discussed. You know, there is a huge range in performance on this measure as well as the other measure across providers.

The reliability measurement that the scientific panel reviewed the reliability and validity of the item - I mean as a measure excuse me, and the measure, it passed both reliability and validity. For reliability, there were two votes for high, four votes for moderate, no for low and no for insufficient. For validity, two high, three moderate, no low and one insufficient. For usability, these measures are based on the standardized assessment that is already collected. So there is no added burden from the measure you can talk about that (unintelligible). But there is no added burden from the measure.

So that's sort of my summary of the measure. Did you want more detail than that, I can certainly go into more detail if needed?

Lee Partridge: Well, why don't we move on to Brian who is also a reviewer? Brian?

Brian Lindberg: Yes. I have no - Deb, sorry, I have no comments.

Lee Partridge: And Dawn was also a reviewer I think. Is she back on?

Dawn Hohl: Yes. I don't have any comments. Thank you.

Lee Partridge: Okay. Then comments and questions from the rest of the committee, 2635.

Don Casey: Don, just a general comment. I mean it is really hard NQF for us to evaluate these so called annotated bibliographic summaries of articles without any real evidence synthesis that's or scientific. I'll just say that and leave it at that. I mean I'm fine with the evidence, but the way it's presented is totally unusable in terms of making judgments in my opinion.

Lee Partridge: All right. If there're no further comments or discussions, we I think are now back on voting live. Are we? Sam?

Sam Stolpe: Yes.

Jordan Hirsch: (Unintelligible) Poll Everywhere.

Lee Partridge: Okay, all right.

Sam Stolpe: Sorry, we did go back to being live.

Jordan Hirsch: Yes, that's correct.

Sam Stolpe: Okay.

Lee Partridge: So everybody…

Peter Thomas: So do we have to sign in or can we still use this - okay, never mind, I see them online.

Jordan Hirsch: Voting for the evidence criteria for 2635 is now open. Your options are A, pass, B, no pass.

Peter Thomas: Moving out for a pass please. I'm not - here I'm, very good.

Lee Partridge: Great.

Jordan Hirsch: Voting for evidence for 2635 is now closed. The committee has passed evidence unanimously with 14 votes for pass.

Lee Partridge: Okay. Moving on to Deb. Deb, any specific comments here that you want to make?

Deb Saliba: I commented in my summary comments, but there were significant performance gaps.

Lee Partridge: Brian, anybody else, any comments or questions?

Brian Lindberg: I agree.

Lee Partridge: Okay. Then it sounds to me so we're ready to vote and I see people already are.

Jordan Hirsch: Voting for performance gap for NQF 2635 is now open. Your options are A, high, B, moderate, C, low or D, insufficient. Voting for performance gap for 2635 is now closed. Performance gap passes with five votes for high and nine votes for moderate.

Lee Partridge: All right.

Deb Saliba: And so just to summarize quickly the scientific panel rating for reliability was passed and I thought that was - I agreed with their assessment.

Sam Stolpe: Any other comments related to the Scientific Methods Panel rating or shall we move to the vote?

Lee Partridge: I think the silence as you're ready to vote.

Sam Stolpe: Implies vote. So voting is now open for NQF 2635, Scientific Method Panel rating of reliability. Go ahead and enter your votes now.

Don Casey: What was their rating Sam again?

Sam Stolpe: Well, thanks. They rated this as high.

Don Casey: Thank you.

Sam Stolpe: And validity was rated as moderate.

Jordan Hirsch: Voting for accepting the Scientific Methods Panel rating for reliability for 2635 is now closed. The committee has unanimously upheld the Scientific Methods Panel rating for reliability with 14 votes.

Lee Partridge: Moving on to whether or not we accept the scientific methods panel rating for validity and here it was moderate.

Jordan Hirsch: Voting for accepting scientific methods panel's rating for validity for 2635 is open.

(John): Could I make a comment please?

Jordan Hirsch: Yes, please.

Lee Partridge: Yes. Sorry, (John).

(John): Again the same phenomenon here. Only five quarters of data, the most recent Q4 '17; not sure why '18 wasn't included. Mean scores and interquartile range is for the 12-month periods are pretty much exactly the same. And then

the decile scores don't change a whole lot and that - and obviously there's a wide dispersion, so there is variation, but it makes the question in my mind whether without movement, whether risk adjustment is adequate or not.

So from that standpoint, I think there's - I have some serious concerns about face validity given the evaluation data that's presented.

Deb Saliba: So I think - let me ask this question. I think I heard and read that their - update the benchmarks and therefore you would sort of expect that it would stay - there wouldn't be as much change over time given the updating of the benchmarks.

So now you may be concerned about the validity of updating the benchmark and whether that's an acceptable approach, but you would expect if you're going to use that to see some stability, I think. Do the developers - can they - I think that the - one of the big issues for the validity, before I ask if anyone wanted to comment, was the number of - the percent of incomplete stays. It was like 37% incomplete stays which I think those needed to be excluded but are - that maybe argues for, you know, some kind of other measure that looks at the number of readmissions to the (unintelligible) little bit.

Anyway, I don't know if you want to comment about the benchmark again.

(Anne Deutsche): Sure. This is (Anne). So, Deb, you're exactly right, you know, the benchmarks does get updated with the idea that we want to have the most current practice and outcomes used. And so you're exactly right that we're not expecting that the actual percentage of patients, meaning benchmarks, is going to change over time.

And so, you know, we have looked at the discharge scores and they were barely stable, you know, across the time period of the data that we have so far. In terms of the - do that - (John), did that help?

(John): Well, I guess, my only point is that as we're talking about validity in the context of how it's - you know, its purpose which is to distinguish between in a month facilities but also to use the measure - you know, I guess I'm bleeding in the usability but it's to be related.

The ability of this measure to achieve its goal for public reporting and payment is uncertain in my mind. So it's less a matter of whether the measure is good or wrong. It's more a matter of whether it's appropriate for, this time, for what your future intended use is.

So again it's kind of between both legs but that's where I'm really coming from. So…

(Anne Deutsche): Okay.

(John): …I don't see any impact, is what I'm getting at.

(Anne Deutsche): Okay. So to the second issues, Deb, that you brought up in terms of the incomplete stay; so I think for these particular measures that 11% for the (Earth) setting and as you indicated, we do agree that the discharge community measure is a nice balance, complementary measure, because that ticks up on individuals who were discharged due to an incomplete stay.

Lee Partridge: Voting is still open, I think, on validity. We haven't closed it out yet. I think we just - go ahead. (Sam)?

Jordan Hirsch: For scientific methods panel's rating of moderate for validity is now closed. The committee has upheld the scientific methods panel's rating for validity with 13 votes for yes and one vote for no.

Lee Partridge: Okay. Moving on to, excuse me, feasibility. Deb, any comments or further comments here?

Deb Saliba: No, I've included them in my summary comments.

Lee Partridge: Uh-huh.

Deb Saliba: I felt that it was feasible given that it's based on the standardized, required standardized assessment.

Lee Partridge: Brian, anybody else?

Brian Lindberg: No.

Ellen Schultz: Nothing to add; no.

Lee Partridge: Great. If not…

Sam Stolpe: Did we happen to have (Chris) join? He must ask I guess. Well he's - presumably he needs to make his way back from a meeting with his residents. But with (Don) stepping off and (Chris) not having yet joined, we don't have quorum.

So why don't we move on to the discussion of usability and use and see if we're able to get (Chris) on and we can go back and vote on feasibility.

Given that we had such a limited discussion, I don't think there'll be much of a need for a recap.

Lee Partridge: All right. Moving on without voting yet to usability and use.

Woman: Yes, for usability, again it's - again can be publicly reported and it is - it can be used for accountability. The preliminary rating was passed and I agree with that for use. For usability the preliminary rating was moderate. And whether or not it can be used for performance improvement and accountability and the preliminary vote was moderate and, you know, consistent with the earlier comment about, you know, the resetting of the benchmarks, you know, you could argue for moderate.

I will say, you know, that the evidence for ventilator management just changes exponentially every year. So I think the fact that you need to rebenchmark as performance improves or outcomes improve, it is in some way not necessarily surprising given how much we are learning about good ventilator management on a pretty regular basis.

But, anyway, I'm willing to go with the panel's vote of moderate instead of high on that one.

Lee Partridge: Other comments?

(Carrie): This is (Carrie). Just a question for CMS to the developers. It might be interesting to actually present the change in benchmark data over time. I think what we're all hoping to see is an improving trend line, but if there's not going to be a trend line there ought to be at least an improving benchmark.

Does that make sense?

Deb Saliba: Yes, (Carrie), that's an excellent suggestion, yes. And right now we - you know, this data started being collected in 2016 so the most recent data we have is 2018. So we have looked at that a little bit, but I agree we should definitely share that information.

Lee Partridge: (Sam), we have not heard from (Chris), right?

Sam Stolpe: Nothing from (Chris). So let's go ahead and - if we've completed our discussion around usability and use, then we don't need to vote on those because we don't have quorum and obviously would not vote on the overall endorsement either. So we can go ahead and move on to the discussion of the next measure.

Man: So no SurveryMonkey on this one, (Sam)?

Sam Stolpe: Certainly like it would be the (route) for voting on those but you're welcome to log your votes now for both feasibility and usability and use and your overall endorsement vote. If you want to take a moment and do that, that's fine or we can move directly into having the measure developer present the overview of their measure.

Peter Thomas: You know, why don't we just move to the next one and go back and do all the votes at once?

Lee Partridge: It sounds like Peter Thomas.

Peter Thomas: It was me.

Lee Partridge: Okay. I agree. So, (Anne) and Dr. (Levitt), you did talk a little bit about both of these measures together at the beginning as we started these two. Is there anything further you want to add as an overview before we turn to Peter and his colleagues for detailed discussion?

(Anne Deutsche): I don't have anything to add. Dr. (Levitt)?

Dr. (Levitt): No, nothing. It's just to thank Dr. (Umali) for his suggestion.

Lee Partridge: All right. Peter, the floor is yours.

Peter Thomas: Okay. This is Measure 2636, it's In-Patients Rehab Facility or IRF Functional Outcome Measure: Discharge Mobility score for medical Rehabilitation Patients. It's a maintenance measure. The most recent approval was in 2015. The outcome measure, the developer and steward is CMS RTI and it's administered at the facility level.

This is not measure the change between admission and discharge in functional status of patients as some measures do. This measure is the functional status at discharge of patients compared to patients that meet or exceed a risk adjusted expected target.

So I took a look at the - that's kind of an overview of kind of the opening of it. In terms of evidence, I took a look at the exclusions. I thought I found the exclusions to be reasonable. At first I questioned whether people with quadriplegia and some of the conditions there should be eliminated from the calculus. But frankly those patients are extraordinarily compromised and might be difficult to include those and not have them skew the data.

So on evidence, the preliminary rating was a pass. And new evidence had been submitted since the last review of this measure.

Lee Partridge: Okay. (Steven Hoi), are you - you were also one of the reviewers on this measure. You have anything to add?

(Steven Hoi): I am still here for core account. But nothing to add yet.

(Chris): Hi. It's (Chris). So I just joined.

Lee Partridge: Oh, (Chris). Wonderful. I think you just made us a quorum again.

(Chris): Sounds good. Tell me what we're talking about.

Lee Partridge: We are - all right.

Peter Thomas: We're talking about Measure 2636, the IRF Discharge Mobility Score. And I just got finished providing a bit of an overview about the measure and mention that the evidence preliminary rating was passed and that there had been new evidence submitted to (unintelligible) measure and was last reviewed in 2015.

(Chris): Awesome. Great. Thanks, Peter.

Lee Partridge: (Steven Hoi), comments? Additions?

(Steven Hoi): Nothing yet to break into it.

Lee Partridge: Ellen?

Ellen Schultz: I don't have anything to add to the evidence either.

Lee Partridge: And if - (Lisa Thomas), is she - I don't recall whether she was - or, (Lisa), are you on the phone? No, I think she's not without us today.

All right, then comments from the rest of the committee before we move to vote? And, (Sam), am I right, we are now back to voting online?

Sam Stolpe: Yes.

Lee Partridge: Not on SurveyMonkey. (Chris), you haven't been with us. We've been moving in now depending upon whether we had quorum at that moment.

(Chris): Okay.

Sam Stolpe: Yes, so we can go ahead and vote using the Poll Everywhere platform, which the link has included inside of the calendar invite. So polling is now open for Measure Number 2636; voting on evidence. And your options are A. Pass; or B. No Pass.

Jordan Hirsch: All right, voting for evidence for 2635 is now closed. The committee has passed evidence with 14 votes for pass; zero votes for no pass.

Lee Partridge: Twenty-six thirty-six, Jordan, just for the record.

Jordan Hirsch: My apology.

Lee Partridge: Okay. Then moving on to…

Peter Thomas: So, (GAP). (GAP) was preliminarily rated as moderate with respect to disparities, the research clearly showed differences in mobility outcomes by geographic region, facility characteristics, length of stay, race ethnicity after adjusting for patient demographic characteristics and admission clinic status.

The risk adjustment factors, there are five of them: dual eligibility: living alone: urbanicity; socioeconomic status; and race ethnicity. And I found all those to be quite relevant for risk adjustment and I agreed that with the moderate rating for (GAP).

I was thinking of actually I might have rated it high had I not seen what the preliminary rating score was. So I think it's at moderate.

Lee Partridge: Further comments?

(Chris): So this is (Chris).

Ellen Schultz: This is Ellen.

(Chris): Oh sorry. Go ahead.

Ellen Schultz: Well this is Ellen. One question I flagged in reviewing this was that it seems that there - that lowers with the economic status and living alone are both associated with higher discharge and mobility score. So (unintelligible) if the developers have thought about that. It's not necessarily the direction we would expect.

(Anne Deutsche): Yes, actually - so you obviously review things carefully. That's true. And there is actually literature that in the (Earth) settings that patient who may be at risk for (hope) discharge, you know, readmission, et cetera, sometimes have

longer length to stay so we actually were not surprised by that finding and we did find that in some of the other (Earth) measures also.

Deb Saliba: Can I jump in as a provider? So this is Deb. So basically I think to hang on to patients depending on whether they've got a supportive environment to go home to or not.

So if I think a patient's going to be going home on their home, I may keep them a day or two more and that my (hustle) administrator may not like that but I may keep them a day or two more to give them a little bit more rehab, a little bit more time for recovery so that they're going to be safer to go home without any kind of caregiver support.

Does that make sense?

Ellen Schultz: Yes, that helps. Thank you.

(Chris): Yes, that makes sense. And, Deb, this is (Chris). In the child health world it's the same type of thing. We want to make sure that they're really tuned up if they have any potential for problems once they get home. That's a really interesting finding.

The question right before that and the same thing, I don't know if, Ellen, that was also yours, but the change overtime obviously is small because it was only a 15-month period. Given the measure was first endorsed four years ago, is there any evidence of larger changes during that time or do we just not have the data for that?

Deb Saliba: (Anne)?

(Anne Deutsche): Yes. We presented all the data that we had access to when we submitted. And you're right, we have not seen movement in this particular area. One of the things we talked about with 2635 which is the similar measure is that for these measures we're looking at a benchmark.

And so the benchmark actually can move. We keep that kind of with the current data. So the benchmark for 2017 data, with 2017 the benchmark for 2018 data is based on 2018 data. So the benchmark could potentially move in the future and (Carrie) had suggested maybe providing that in the future.

(Chris): Aha. Yes, that sounds great. I'm sorry I was no ton for the last measure. Okay.

Ellen Schultz: So can you clarify, is this measure risk adjusted for these social drivers at health?

Lee Partridge: So these particular disparities section in that part of the document are not risk adjusters. We examined whether…

Ellen Schultz: Okay.

Lee Partridge: …was that a (unintelligible), you know. Because, you know, I would actually be a little bit concerned if it were. So I'm glad to hear that it isn't. Okay, thank you. Thank you.

(Chris): Let me clarify, Dr. (Deutsche). I just want to make sure I understand it. The score that you're comparing these individual scores, individual patient scores too, that is risk adjusted. Is it not?

(Anne Deutsche): Yes. And we risk adjust for things like age, primary diagnosis, co-morbidity, but we don't adjust for race, ethnicity, living alone, et cetera.

(Chris): Very good. Thanks.

Man: And that's how you come up with the expected mobility score?

(Anne Deutsche): The expected mobility score is based on the risk adjustment model, yes, which was age, primary diagnosis, co-morbidities, et cetera.

(Chris): And I raised the question about this during the in-person meeting about how, you know, another measure that's similar that measures the difference between admission functional level scores and discharge for each individual patient rather than some kind of risk adjusted target.

What do you think - I mean, are those just two measures that are used for different things and they each have kind of their place or do you feel that one of those is less or more kind of important or reliable than the other?

(Anne Deutsche): Great question. So the reason that we ended up with two sets of measures is basically because providers are used to seeing kind of the granular change in function where every unit of healthcare or mobility is really tracked carefully and, you know, any improvement that can be gained, you know, can be measured and they're very interested in use of that type of data for individuals who are normal consumers or, you know, might be interested in looking at an (Earth) or family member. They're more used to numerator, denominator so percent met benchmark is more digestible for them.

We did see in the study that I think I've mentioned before, you know, where we make report cards and chose people social improvement presented two

different ways. There were some consumers who like the granular level data but others really didn't quite know what to think about it and how to interpret it. But they were able to interpret a percentage meeting benchmark and that was much more intuitive to them.

So I think the idea is that there are different audiences out there and different levels of comfort with data. For quality improvement I think knowing the more granular data is really, really important I think for consumers who maybe just want to know do people do well in this facility, this percentage, 2635, 2636 measures make it a little bit easier for them to interpret.

Does that help?

(Chris): It does. Thank you. I think we're ready to vote.

Jordan Hirsch: Voting for performance (GAP) for N2S 2636 is now open. Your options are A. high; B. moderate; C. low; or D. insufficient.

Voting for performance (GAP) for 2636 is now closed. Performance (GAP) passes with five votes for high; nine votes for moderate. Thank you.

Sam Stolpe: Okay. So on reliability and validity, the scientific methods panel voted, it was quite high. The preliminary ratings; not number one vote didn't pass. The preliminary rating for reliability was high. The preliminary rating for validity was moderate. In terms of the votes themselves there were no low or insufficient votes. There we four high and two moderate for reliability and two high and four moderate for validity.

I guess in terms of the consistency and the repeatability of the measure in terms of reliability was proven by what I read at least and certainly in the view

of the scientific methods panel. I only had one question though about this and that is the issue of gaming.

We've heard a lot from the Medicare payment advisory commission in the context of creation of a post-acute care uniform payment system that they may not even wind out using functionality as a factor in that payment system because of the concern about gaming the functional scores.

Can you talk just a little bit, Dr. (Deutsche), about that phenomenon in the context of reliability and consistency of the data collected under this measure?

(Anne Deutsche): Sure, I can get started and I think Dr. (Levitt) might have something to add. So the data elements were designed to provide clear instructions on collection of data at admission which is the data actually that is used for payment and I think that (LPax) was particularly mentioning so that is something that was considered when the items were developed and also for implementation obviously and training. CMS does has looked at the data on a regular basis then we look for trends. So CMS I know is definitely interested in looking at any particular shift in the data and any potential changes.

And I'll pass that to Dr. (Levitt) to answer that.

Dr. (Levitt): Okay. Thanks, (Anne). Okay. In one of the - first of all, you're absolutely right that concerns of data, particularly when data reported and trying to validate that data that is a concern of the agency. And we historically have done exactly what (Anne) had said but one of the (beauties) of the standardized assessment data elements (unintelligible) that are interoperable now between setting is that we're now going to be able to look at same data that should be reported the same exact way.

There's no difference between how it's reported in admission in one setting and discharge and another setting. We'll be able to look at this actually across settings and to start to help in terms of looking at data accuracy. Discrepancy isn't - rates of discrepancy is between dissipation is discharge to a different setting or different pack setting between the scoring that is being done in that time in full because it should be within reason the same score.

And so this is actually giving us an opportunity to improve on that, for whatever reason the information is used, whether it's used for payment, it's talked about for quality or even for longitudinal care for the patient.

Man: So in other words if a patient is discharged from an IRF with a relatively moderate to high functional level as it enters the (SNF) because they're referred there and wind up at admission being a relatively moderate to low level, you got to wonder who is doing the…

Dr. (Levitt): Exactly.

Man: Doing the…

Dr. (Levitt): And we haven't been able to do that because these - unfortunately, even though everybody is collecting data as you know in all these settings it's not collected the same way and that's going to be one of the advantages that we'll be able to use. But your concern is our concern as well.

Man: Well let me just go on record since I have you on the phone, make it a personal privilege and say that please don't confuse my question with a lack of endorsement in some way of the importance of measuring function. That is the ballgame in post-acute care and if function is not included in a unified post-acute care payment system.

I don't know what it is exactly we're paying for. So I would strongly endorse refining whatever measures need to be refined so that the gaming can be called out of the system so that function can continue to be a vital measurement tool in post-acute care.

Man: Thank you. Thank you for that comment.

Man: I think I'm certainly ready to vote. If anyone else has comments, please make them.

Man: Can this be on both reliability and (unintelligible)?

Man: I've been treating it that way so I would say yes.

Man: Well, I mean, I think this is done the exact same phenomenon that we noted for the last two measures is in place for these. I'm also bit bewildered why we don't have 2018 data at this point, but I'll leave it at that. Just no change in the measure and hoping that it will doesn't seem to me to be a good thing yet.

Lee Partridge: Okay. So are we ready to vote on reliability 2636?

Man: That silence sounds like a resounding yes to me. So, Jordan, go ahead and open it up.

Jordan Hirsch: Voting to accept the scientific methods panel's rating for reliability for 2636 is open. Your options are yes or no.

Voting to accept the scientific methods panel's rating for reliability for 2636 is now closed. The committee has unanimously voted yes for maintaining any scientific method panel's rating for reliability.

Man: Lee, would you like to move directly into the validity vote or is there more discussion?

Lee Partridge: Is there further discussion on validity? If not?

Man: Not for me.

Lee Partridge: Okay. Anybody else? If not then I…

Jordan Hirsch: Voting for accepting the scientific methods panel's rating for validity for 2636 is now open. Your options are yes or no.

Voting for scientific methods panel's rating for validity for 2636 is now closed. The committee has voted to accept the scientific methods panel's rating for validity with 13 votes for yes, one vote for no.

Lee Partridge: Feasibility.

Man: Okay, feasibility, the preliminary rating was high. This already is obviously in process. This is stays being collected. There's no significant feasibility challenges according to the preliminary review and this is a fairly well established measure and I don't have much more to say about feasibility other than that.

Lee Partridge: Okay. (Allen), (Steven), anybody else?

Woman: There'd be none.

Man: Yes, none here.

Lee Partridge: Great.

Jordan Hirsch: Hearing no comment…

Lee Partridge: I think we're ready to vote.

Jordan Hirsch: Feasibility for 2636 is now open. Your options are A. high; B. moderate; C. low; or D. insufficient.

Feasibility for 2636 passes with nine votes for high, five votes for moderate.

Man: Moving on to the discussion of the use.

Man: Okay, use, let's see. When you've got a measure like this when we're deferring on impart reliability and validity. The use and usability obviously has a greater emphasis. This is a publicly reported measure. It's currently in use for the IRF quality reporting program and the IRF compare.

The preliminary rating on this was a pass for use and I agree.

Lee Partridge: Further discussion?

Ellen Schultz: This is Ellen. I did have a question on usability. Do you want to get in to that now or vote on sue first?

Lee Partridge: Let's vote on use first.

Ellen Schultz: Okay.

Jordan Hirsch: Criteria of use for 2636 is now open for vote. Your options are A. pass; B. no pass.

We're awaiting one more vote.

Voting for use for 2636 is now closed. Use passes with 12 votes for pass and two votes for no pass.

Lee Partridge: Okay. Now usability. Was that, Deb?

Ellen Schultz: This is Ellen. I got a question.

Lee Partridge: Ellen; sorry.

Ellen Schultz: So I'm just interested to hear from the developer's perspective like I'm wondering how potential for confusion be seen as measure and the sister measure, as I understand it is using the same data but it's calculating the rate in a different way at looking at the change overtime rather than comparing to an expected.

Or I mean, I don't know if you've looked at the association between those two. I'm just wondering about potential for confusion, you know, the one measure is publicly reported but then the other is being used for quality reporting program. So I'd like to hear your thoughts about that.

Woman: Sure. That's a great question. So there definitely is an association across the two self-care measures and the two mobility measures. And just to clarify, all

four measures are actually in the (Earth) quality reporting program and all four, you know, are slated for public reporting in 2020.

So basically somebody can choose to look at one piece of information or the other depending on their comfort level. I would say that the provider like the (Earth) are much more used to looking at change and function and so I think they focused on that particular one because they've done it a little bit more granular because each unit function that changes is documented. Does that address your question, Ellen?

Ellen Schultz: To some extent. I mean, to my mind it's still a little confusing to break them out as two different matters that it leaves the impression that it's looking at different aspects of quality or somehow using different data when in fact it's more about the packaging in a way.

But I mean, I guess, so another way to ask my question is like how do you receive feedback at all about confusion over the difference between the two measures.

Woman: We have not - you know, I think you, you know, bring up a good point when it's publicly reported we will definitely look out for that feedback. I think that, you know, we, as I said, we generally do things the same association. So if you look at on one of the self-care measures, you're very likely to look good on the other measure but in the - for these last two measures, 2636, 2636 - 35 and 36, you know, you do have to either meet the benchmark or not so it is a little bit more challenging to actually get passed or meet or get passed the benchmark. So it does define change a little bit more.

Ellen Schultz: Okay, thank you.

Lee Partridge: Further questions or comments? If not, let's move on to vote on usability.

Jordan Hirsch: Voting for usability for 2636 is now open. Your options are A. high; B. moderate; C. low; or D. insufficient.

Voting on usability for 2636 is now closed. Usability passes with one vote for high, 12 votes for moderate and 1 vote for insufficient.

Man: Discussion on overall endorsement.

Lee Partridge: Moving in to the home stretch.

Man: Any discussion at this time or should we move to the vote?

Man: We can move to the vote from my perspective.

Man: Yes, very good.

Jordan Hirsch: Voting for overall suitability for endorsement for 2636 is now open. Your options are A. yes or B. no.

Voting for overall suitability for 2636 is now closed. The committee recommends Measure 2636 for maintenance of endorsement with 13 votes for yes, one vote for no.

Sam Stolpe: Very good. Thanks very much, Jordan.

All right, well, this is Sam Stolpe speaking. We do have some time remaining, so what I would recommend and put forth as a suggestion to our

two co-chairs to weigh it on is that we use the available time for us to go back and revisit the remaining criteria that we weren't able to complete.

Some of these depends on (Chris') comfort level. If he'd prefer to listen to the entire discussion, (Chris), then we can do that separately. If you do feel like you have sufficient familiarity with the measures, then go ahead and move forward with a vote. We can go ahead and do that as well.

The nice thing is that we had limited discussion on usability and use for Measure number - sorry, I guess with the - 2632. And then for 2635 when we did feasibility and usability use, we had limited discussion there as well. If that - if the co-chairs will (unintelligible) all that, let's go ahead and go back and reinitiate the voting process.

(Chris): Okay. This is (Chris). I'll just weigh in because I wasn't here. I think that'\s fine. I'd like to know if there were any sort of major points or things that Lee or other's (thoughts) were significant in terms of the discussion that I need to know about. If not, I trust you completely.

Lee Partridge: I think we had discussed some pretty thoroughly, (Chris). I think you'd be comfortable.

(Chris): Okay.

Lee Partridge: So, (Sam), take us back to where we should be here.

Sam Stolpe: Very good. So let's go back to Measure Number 2632. The - we need to complete the votes for use and usability. Now, (Chris), there was one concern that was raised on usability, also the concern that the measure is lacking in some practical considerations and the measure is very specific and applies to a

narrow population. Other than that there weren't other additional concerns raised.

(Chris): Okay. I'll go back and look at that while you're keying things up.

(Anne Deutsche): And it's - this is (Anne). If I could pitch in, Dr. (Levitt) highlighted that this particular measure was part of one of the laws that was passed by Congress and it required specifically this population within the (LPax) setting.

(Chris): Uh-huh, okay.

Lee Partridge: Is it possible to put that slide back up on the screen for 2632? That might help.

Sam Stolpe: So 2632 should be up. Okay.

Lee Partridge: Excellent.

(Chris): So it's a usability concern?

Sam Stolpe: Correct. Okay.

Lee Partridge: Yes, it's - (Chris), the issue is the (unintelligible) support population is a sub-population.

(Chris): Yes, sure.

Deb Saliba: So, (Chris), my comment - this is Deb. In my comments I just noted that, you know, it's actually a pretty major target population for (LPax).

(Chris): Uh-huh, sure.

Deb Saliba: So even though the (assets) saying - and I looked at the numbers and it seems like there's a fair number of folks that this measure affects.

(Chris): And those are really compromised patients. I mean…

Sam Stolpe: Yes.

(Chris): …very difficult to treat.

(Carrie): Yes. This is (Carrie). I think the numbers were 13% of (LPax) did missions and some like 18,000 patients that fell into this category.

(Anne Deutsche): This is (Anne). It's changed overtime. I think it's about 20% right now.

Man: Yes, (Carrie). It's likely slowly increasing because of the changes in payment with site neutral payment in (LPax), while the percentage of (LPax) admissions that are on the ventilator or going up.

(Carrie): It's making it more relevant.

Lee Partridge: (Chris), if you're comfortable, I think the vote.

(Chris): Uh-huh, yes. Yes.

Lee Partridge: Okay, go ahead? All right. So, Jordan, do you want to tee us up?

Jordan Hirsch: I am - voting for the use criteria for 2632 is now open. Your options are A. pass; B. no pass.

(Chris): Sorry I lost the link. I need to get it back. I'll just be a second to get that back.

Sam Stolpe: No worries.

(Chris): Got it.

Jordan Hirsch: Voting on use for 2632 is now closed. The committee has passed use with 13 votes for pass, 1 vote for no pass.

Lee Partridge: And moving on - go ahead.

Jordan Hirsch: Voting for usability for 2632is now open. Your options are A. high; B. moderate; C. low; or D. insufficient.

Waiting for one more vote.

Voting for usability for 2632 is now closed. Usability passes with 10 votes for moderate, three votes for low, one vote for insufficient.

Voting for overall suitability for endorsement for Measure 2632 is now open. Your options are A. yes; B. no.

Voting for overall suitability for 2632 is now closed. The committee has voted to recommend maintenance of endorsement for Measure 2632 with 12 votes for yes, two votes for no.

Man: All right. Very good. Let's go ahead and pull up the voting for feasibility on Measure Number 2635. IRF Functional Outcome Discharge Self-Care Score.

So the feasibility of discussion was actually extremely limited so we can either - actually this is (unintelligible) vote for that.

Jordan Hirsch: Voting for feasibility for 2635 is now open. Your options are A. high; B. moderate; C. low; and D. insufficient.

Voting for feasibility for 2635 is now closed. Feasibility passes with four votes for high, 10 votes for moderate.

Man: All right, we always chose discretion on how you want to approach any for the discussion on use and usability on this one.

((Crosstalk))

Lee Partridge: Unless anyone has - yes, unless anyone has burning comments or (Chris) has questions, I'd proceed to voting.

Man: Yes, that seems fine to me.

Jordan Hirsch: Voting for use for 2635 is now open. Your options are A. pass; or B. no pass.

We're waiting on one more vote.

Voting for use for 2635 is now closed. Use passes with 13 votes for pass; 1 vote for no pass.

Lee Partridge: Usability.

Jordan Hirsch: Voting for usability for 2635 is now open. Your options are A. high; B. moderate; C. low; or D. insufficient.

We're awaiting two votes. One vote remaining.

Man: Did we lose somebody or is somebody - oh sounds like we got it. Thank you.

Jordan Hirsch: Voting for usability for 2635 is now closed. Usability passes with 13 votes for moderate, one vote for insufficient.

Voting for overall suitability for endorsement for Measure 2635 is now open. Your options are A. yes; or B. no. Waiting on two more votes. Waiting for one more vote.

Voting on overall suitability for endorsement for Measure 2530 - 2635 is now closed. The committee recommends Measure 2635 for a maintenance of endorsement with 13 votes for yes and 1 vote for no.

Sam Stolpe: Thank you very much, Jordan. And a big thanks to the committee for bearing with us as we all struggled with quorum, but it look like we were able to both have a robust discussion and notwithstanding some of the procedural hiccups. We're able to get everything completed. So thank you for bearing with us.

Let's just move ahead and go directly to public comment at this time. So any members of the public who wish to make a comment or members of the NQF membership are welcome to say - to contribute their comment at this point.

We also have the chat open through the platform if you wish to have any NQF staff to read your comment, feel free to enter it directly into the chat.

Very good, hearing none, let's go ahead and move forward with next steps.

Upcoming, the report will be posted for public comment for a 30-day public commenting period on August 1st until August 30th. Following that, the draft report post comment call for the committee will be on September 25, 2019 from 1 to 3 and following that we will have (CSAC) review recommendation and an appeals period.

Would once again want to thank everyone for bearing with the changing from Poll Everywhere back to SurveyMonkey back to Poll Everywhere and it is greatly appreciated that you all were able to stay on with us and assist us through a 15-measure cycle.

Moving forward, if you need to contact us, please email the (patientexperienceandfunction@qualityform.org) project box or call NQF at 202-7831300.

Peter Thomas: I'm sorry. This is Peter Thomas. Could you please repeat the timeline for what happens next? I was writing. I didn't get it all.

Sam Stolpe: Oh yes, of course, and I've also gone back to the slides so you can see it in front of you. So the month of July the Patient Experience and Function team will be drafting the report for a 30-day public commenting period beginning August 1st ending August 30th. And at the end of September, on September 25th, the committee will be reconvened for the post comment call for the draft report.

Peter Thomas: Okay. And just to let you know, I'm drafting the rationale for - on the competing measures and we'll have that over to you as soon as possible.

Man: Thank you, Peter.

Man: Great. Thanks, Peter.

Sam Stolpe: Wonderful. So on behalf of the staff, this is Sam Stolpe speaking. I just wanted to say once again how appreciative we are of all the work that this committee has done. Our co-chairs have just been absolutely fantastic and there's really meaningful body of measures for us to consider and we are more appreciative than you realize for all the amount of effort that you have put in over the last several months to get to these very robust discussions completed. It truly, truly means a lot.

Also big thanks for our measure developers for bearing with us and staying on the line and helping us to understand your measures. That also is a really important part okay four process. So thanks to Dr. (Deutsche) and to Dr. (Levitt) for taking the time with us this afternoon.

I'll hand it over to our two co-chairs for any closing remarks.

Lee Partridge: I just want to echo your comments and to all my colleagues, this has been probably the most - I've been doing NQF work for a long time but I think this is perhaps the most difficult set of measures and meetings that I've ever been involved in.

And a special thank you also to (Anne Deutsche) and Dr. (Levitt). We put you through a good many hours of questions.

(Chris)?

(Chris): Yes. I just - you know, thanks to all. It's been huge but people's staying power has been remarkable. So thanks again and we'll see you on the phone in the future.

Lee Partridge: And have a wonderful holiday.

Man: Happy holidays, everybody.

Lee Partridge: Back to you.

Man: Take care, everybody. Bye now.

Lee Partridge: Yes, bye-bye.

END