

NATIONAL QUALITY FORUM

Moderator: Jesse Pines
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12:00 pm CT

Operator: Welcome everyone. The conference is about to begin. Please note that today's call is being recorded. Please stand by.

Jesse Pines: That's great. Thank you everyone. Thank you very much for taking the time today. I'd like to introduce myself. I'm Jesse Pines. I am an emergency physician who has just recently joined NQF as a consultant in a part-time capacity and we're going to be - we have a lot of ground to cover today.

Essentially, we have 12 measures that we've got to get through before 4:00 o'clock which leaves us probably about 12 to 13 minutes on average per measure. So what I'm trying - what I'd like to do is see if we can get through the measures as quickly as possible and our hope is to get through all 12 of them today so we don't have to schedule another call. Let's go ahead and do introductions. Andrew and Jessica, you want to introduce yourselves.

Andrew Lyzenga: Sure, I'm Andrew Lyzenga. I'm a project manager for the complications project at MQF.

Jessica Weber: And I'm Jessica Weber. I'm the project analyst at MQF.

Jesse Pines: Great, and just wanted to do a quick roll call so we're first going to go through the workgroup members and I think I've written down everyone who has - who's on the call here but let's go kind of from the top to the bottom - and also at the end we have a number of our measure developers -- representatives from our major developers, so at the end if you can go ahead and introduce yourself. So Patricia.

Pat Quigley: Is that Patricia Quigley that you're asking for?

Jesse Pines: Oh, yes.

Pat Quigley: Oh, okay. I'm Pat Quigley and I'm a nurse scientist with the Department of Veterans Affairs at the Tampa VA Medical Center. I do patient safety work, Associate Chief of Nursing Research and Associate Director of our patients' safety center in (Armont) MQF on behalf of the American Nurses Association.

Jesse Pines: Thank you.

Pat Quigley: Thank you.

Jesse Pines: Mary Sieggreen.

Mary Sieggreen: My name is Mary Sieggreen. I'm from the Detroit Medical Center and I think I'm representing myself but I'm also a member of the National ((inaudible)) Advisory Panel and on their board.

Jesse Pines: Great, Jim Smith.

Jim Smith: Jim Smith - I'm a physical therapist and representing American Physical Therapy Association
- looking forward to this.

Jesse Pines: Great and I didn't hear but was that (Don) on the call yet or Tracy Wang. I don't think they're
joined in yet. Jean Deleon.

Tracy Wang: Tracy Wang is here.

Jesse Pines: Okay, hey Tracy.

Tracy Wang: Hi, I'm the public health program director for (Wellpoint, Inc.)

Jesse Pines: Great, Jean Deleon.

Jean Deleon: Jean Deleon - I'm a medical director at (Baylee Specialty) Hospital in Dallas.

Jesse Pines: Great, Jason Adelman.

Jason Adelman: Jason Adelman here - I'm a physician in general medicine. I'm the patient safety officer
at Montefiore Medical Center in the Bronx, New York.

Jesse Pines: Great. Janet Nagamine.

Janet Nagamine: Hi, I am a hospitalist at (Pizer Center) ((inaudible)), California and also a board member
for Society of Hospital Medicine.

Jesse Pines: Great. Louise Probst. Louise on the call? Okay, Iona Thraen.

Iona Thraen: Iona Thraen. I'm patient safety director of the Utah Department of Health and recently completed a PhD in Medical Informatics.

Jesse Pines: Great. Charlotte Alexander. Is Charlotte on the call. Then Saul Weingart. Okay, there are also a number of others on the call representing the measure developers. Is there anyone on for MCQA? How about for the ANA? For the Ambulatory Surgical Centers?

Donna Slosburg: Hi this is Donna Slosburg. I represent the ASC Quality Collaboration.

Jesse Pines: Thanks.

Kim Wood: This is Kim Wood. I am also representing the ASC Quality Collaboration.

Susan White: I'm Susan White and I'm in that crowd too -- Ambulatory Collaboration.

Jesse Pines: For CMS?

Deborah Deitz: Hi, there are a few of us on. This Deborah Deitz for ((inaudible)) Associates.

Jesse Pines: Great.

(Maddy): This is (Maddy) ((inaudible)). I work with CMS and ((inaudible)).

Angela Richard: Angela Richard, University of Colorado. I work with Deborah and (Liz).

Female: ((inaudible)) from ((inaudible)).

Jesse Pines: Great. And anyone from HRQ or any other measure developers?

Pat Quigley: Is this Jesse? Is your first name Jesse?

Jesse Pines: Yes Jesse, that's right.

Pat Quigley: Okay, this is Pat Quigley's voice and I just wanted to say that in looking at the participants on our live meeting, it does look like we have someone from the American Nurses Association participating -- Darryl Roberts.

(Crosstalk)

Pat Quigley: They may have their phones on mute or something and I know I see Dr. Nancy Dunton too from the Kansas University Medical Center. She's with MDNQL. Some people just might have their phones on mute still.

Jesse Pines: Okay.

Jessica Weber: Danielle, if you could see if they're on the public line and add them to the speaking line.

Operator: Everybody that dialed in on the public line, I've opened their names or their line just so they could announce themselves.

Jesse Pines: Okay.

Pat Quigley: Thank you, Dr. Pines.

Jesse Pines: Thank you. So is there anyone who wanted to introduce themselves - anyone who has not been introduced?

Carol Kemper: Yes, this Carol Kemper. I'm actually one of the workgroup members and I'm a pediatric nurse by background and work at Children's Mercy Hospital in Kansas City. I'm the senior director for quality of safety.

Jesse Pines: Great, thank you. Any other introductions before we get into it? All right, so we have - again we have 12 measures to get through.

The way we're going to do this is go through each one of the measures one-by-one and I'm going to ask each of the workgroup members to, you know, do a little presentation for the - what the measure is and any major issues and at that point we're going to go ahead and open it up for group discussion.

So let's go ahead and get started. The first one we're going to be talking about today is 0035 which is Fall Risk Management which is - the measure developer is MCQA. So Janet, why don't you go ahead?

Janet Nagamine: Okay, so this measure looks at two things and it's clinician provider focus. Did the provider discuss fall risk with patients 75 and over or 65 to 74 with a history of walking problems or balance or fall in the past? So a little conky definition. So discussing fall risks and then managing fall risks. There are two components. So is that enough for the description?

Jesse Pines: Sure, yes.

Janet Nagamine: Okay, and then do you want me to then go into the sort of impact and importance, feasibility and all that?

Jesse Pines: So just in terms of timing probably just best to highlight any major issues with...

Janet Nagamine: Okay, so - I think in terms of the grading - you know, it looks like it's important to measure - and most of us agree on that - but it runs into trouble in terms of reliability, validity, usability and face ability. So the strengths and weaknesses I think there is data that says there is a lot more ((inaudible)) mortality related to this issue. Weaknesses relate to reliability. It's a survey - relies on patients reporting whether or not a provider discussed this and whether or not a provider intervened.

The other thing specifically is it doesn't exclude patients with dementia or who are bedridden. The setting is rather broad - not so sure it is applicable to patients on dialysis or in the ED - so it is a broad setting. And so, I think the net - I would say there are other sort of similar sort of measures and I think we should seriously think about harmonizing and getting rid of, particularly this one and looking at modifying some of the other ones to get more targeted populations addressed.

Iona Thraen: This is Iona. I support that and feel that is a truism across all the different measures that we're going to talk about related to fall that is multiple measures with some similar definitions and some different and that, you know, all of the agencies that are involved with putting these measures it seems like we need to look at what measures - how the measures could be combined or harmonized and then define according to either the target population, the setting you're trying to collect information from, the numerator, denominator and the source of data, so I would support that.

Jesse Pines: ...Jessica, you had sent out that document that had a number of the falls measures listed and so if you wanted to - you know, as we're discussing this, if you wanted to open that and kind of see what the various differences are across the measures are.

Janet Nagamine: And I was going to give specifically - I'm thinking about 1730 and 1733 which is the most similar to this one and I did have some particular sort of proposals related to how we might harmonize and modify.

Saul Weingart: This is Saul Weingart. I wonder if I can make a comment. I agree with the presentation that Pat just made and thought it was very clear and to the point. I thought there might be some virtue in, you know, patient reported measures and I didn't want to lose sight of that even though there are some very significant and logical issues that you mentioned, both in terms of exclusions but also in terms of recall by us and things like that.

There wasn't a lot of information about any efforts to validate the report, you know, the survey results or about - let's see - survey reports - or about true ((inaudible)) false positives and true negatives. So I think there's some limitations with the measure but this idea of a patient centered metric is sort of interesting.

Pat Quigley: Well, this is Pat Quigley and I'd like to say that I support keeping fall risk assessment as a separate measure rather than combining it with a care plan because, you know, this is a structure or a process measure. It's not a ((inaudible)) outcome but, you know, to me this is the first step and it's so grounded in the American Geriatric Society Guidelines and British Geriatric Society Guidelines effort and I was glad to see that they separated out patients over the age of 75.

There should be an assessment that's done and based on that assessment -- the screening for risk -- any care plan would be initiated and even, you know, we can get to the care plan one but I think that this is an important indicator for this very high risk population that they are going to look to see that there was an assessment that was done for the older population on fall risks and I'd like to hear from Jim Smith who represents physical therapy as well about your response to this indicator.

Jim Smith: I had a similar concern and it was initially described about the - when we look at the package of all of these, it is - I think it would benefit from harmonization but you're asking specifically about the discussion or the management on the fall risk?

Pat Quigley: The fall risk and keeping them separate.

Jim Smith: Well I think that what we get here is the benefit of a patient report which is going to give us some different information but it does get very cloudy trying to gather that information. For example, it says here, suggestion that patient use a cane or a walker which may indicate someone attended to mobility. It doesn't actually reduce the risk for falls to use those devices. So it's a very cloudy issue to interpret.

Iona Thraen: I think we're going to be - this is Iona again - I think we're going to be challenged all the way through this and I don't know if the pressure ulcer group also has the same kind of struggles which is looking at them in a very individualistic perspective cognitive to the setting, the target group in terms of provider, you know, the definition, et cetera, et cetera - and so you end up - I ended up voting no on most of these in terms of endorsement simply so that we could have the conversation about how does this group of measures relate to each other and should they relate to each other and if so, under what circumstances - under what conditions and if I'm voting on them individually, I have a hard time endorsing them individually.

I think the issue is huge and important and vital but this sort of mixture of all these different measures kinds of gets me really confused and I really think - I don't know where the place is in terms of this idea of harmonization and simplification and, you know, selecting the best of breed in terms of definitional issues and then mapping them -- definitional issues -- to the individual settings and provider groups, et cetera. I totally support the American Geriatrics Society recommendations. I think that's important but it shows up in some of these other measures but again, I struggled with this issue of these individual approaches.

Janet Nagamine: This is Janet and I would second that. I have the same challenge. I think when you look at this cluster of measures, I think we all agree that it's a big problem that we need a metric, that we need assess for fall risk. I think the question is how to best do that, in what setting and ultimately how the outcome and impact - and one general thing that I want to say is, you know, I think the target population needs to be streamlined.

I think assessing everybody over 65 will not have the yield that we will get from assessing everybody over 75 with Parkinson's or history of stroke or better risk stratification. That's the biggest thing for the buck and I think we'll get less push-backs about the burden of reporting that way.

Pat Quigley: Well this is Pat Quigley and I so enjoy this dialogue and part of what I saw was different about this one measure is that in talking about risk management -- risk factor management -- I do think that it's numerator - that it was calculating two different rates - that the management of people over the age of 75 and older should be different from the management of people of 64 to 74. So I thought that was one of the best benefits of this one because it did separate out the patient population.

Jesse Pines: So maybe as a point of process what we could do is try to quickly get through all of the different falls measures and then have a kind of broader discussion about harmonization right after we get through them.

Janet Nagamine: Okay.

Jesse Pines: So why don't we go ahead then and have - Jim, do you want to talk about the screening for future fall risk measure?

Jim Smith: Okay.

Jesse Pines: 0101.

Jim Smith: Screening for future fall risk is data that comes from PQRI -- the physician quality reporting initiative -- and is measuring the percentage of patients 65 years and older who are screened for falls. So this is a process measure that is identifying the screening for falls among the population with that 65-year-old cutoff and it does clarify that individuals with two or more falls in the past year would benefit from intervention. It is supported through a number of guidelines or standards that have been endorsed and I'd leave that now for our discussion.

Jesse Pines: Jim, were there any major issues with - that you found with any of the testing that you want to bring up?

Jim Smith: Not that I identified.

Jesse Pines: Okay.

Saul Weingart: I have a question about this one that I'm a little confused about. This is Saul again - which is - it looks like the calculation is based on CPT codes and I wasn't sure to what extent there's auditing or some other sort of validation that the codes correspond to the delivered care.

Iona Thraen: This is Iona. I did take the opportunity to look up the CPT codes and the CPT codes in general that are identified here are general evaluation codes, not necessarily specific to falls and then the variety of codes that are present depends on the setting whether you're in physical therapy or you're in a physician's office or you're in a skilled nurses facility or you're in an acute care setting but that's the variability of the codes but I did not find and if someone found it differently, please correct me. I did not find that it was specific to falls.

Jesse Pines: I think we may have some representatives from MCQA on the line. We have somebody on the webinar I believe - Erin Giovannetti. Erin, are you on?

Erin Giovannetti: Erin, can you guys hear me now?

Jesse Pines: Yes we can. It sounds like there's some questions about whether there's been any validation work related to the CPT codes and...

Erin Giovannetti: Yes. I wanted to just clarify that there are two sets of CPT codes in this measure. The set that are for the numerator to identify whether or not someone was screened for future fall risks or actually the CPT codes and those are listed there - those are specific to patient screen for future fall risks.

The second set of CPT codes are used to identify the denominator which is patients who had an ambulatory care visit. So that's why you see some CPT codes which are not related to falls at all because those are used to identify simply the denominator not the numerator head which is whether or not you were screened for falls.

In terms of validation, if you look at I believe in the validity section - we talk about the testing. That was done. That was a comparison between CPT codes and medical records review. That was done by the PQRI and that data is available in the section on the validity.

Male: Is that the ((inaudible))...

Male: Sorry, go ahead.

Male: I'm trying to figure out where that is. Is that 25...

Erin Giovannetti: I'm sorry. That's in the section on testing reliabilities -- section 2a 2.2.

Male: So page 10 to 11.

Jesse Pines: So did that answer the question about CPT codes?

Iona Thraen: Well it says that the 98% agreement is on the numerator, correct - 98.53% agreement?

Erin Giovannetti: Yes.

Iona Thraen: With a confidence of ((inaudible)). Thank you for that clarification by the way.

Jesse Pines: Great. Thank you, any other comments on this specific measure or any other questions for MCQA?

Pat Quigley: Well, this is Pat Quigley. I'd just like to say that I was particularly supportive of this specific measure because this really separated out I thought, you know, those patients who are really vulnerable, who really need to have action that's on the more vulnerable side of the AGS guidelines - those people who have had more than one fall in the last year or an injury or ((inaudible)) and the Department of Veterans Affairs, in our primary settings - these are the patients that we actually go after because they need to really be worked up. So I really was very pleased to see this in the report and the indicator and was very supportive of it.

Iona Thraen: This is Iona. I have a quick question. I guess I'm not familiar with category two coding.

Could you tell me what that CPT category two coding - what is that? Is that a billing system that's currently in place?

Erin Giovannetti: No, these are codes that are created for quality measurement. So basically when a -
and these are codes that are part of the PQRF reporting systems -- that's physicians that
reported - the PQRF can choose which measures they want to report on and when they report on
these measures they select a CPT two code for each one of the measures.

Iona Thraen: Okay, so this is a separate reporting system that is manually uploaded with information
from the provider and then the denominator -- the CPT codes -- is that pulled off of the electronic
record system or the billing system or did they also hand enter that?

Erin Giovannetti: That is set in most different ways - physicians can choose different ways to do it. If
they've got an electronic system, they can pull out electronically. Some CPT two codes are also
coded electronically, it's just the physician or the practice chooses to do so.

Iona Thraen: Okay, but it's a separate reporting mechanism?

Erin Giovannetti: It is a separate reporting mechanism.

Iona Thraen: Okay, thank you.

Jesse Pines: Any additional comments on that just to - and let's go ahead and if not let's go ahead and
move forward then.

Pat Quigley: Well this is Pat Quigley. I just would like to make one more comment that is probably a little
bit - I think really relevant to patient care - as I was hoping that these patients that have the repeat
falls and the fall related injuries that you would find this on their problem list - so, an electronic
medical records - it would rise to that level of awareness but thank you.

Jesse Pines: Great. Let's go ahead and move then to measure 1730 -- Risk Assessment for Falls -- which is another MPQA measure and Louise ((inaudible)) is going to be presenting this. Go ahead Louise.

Andrew Lyzenga: I think Louise is not actually on the call. So maybe if - does anybody else on the committee who took a look at this measure have any thoughts about it?

Janet Nagamine: This is Janet. The thought that I have - this takes the higher risk because you're already starting with those with a history with falls so I thought that was a plus. And 1733 integrates all of that, so did you assess for a fall and do something about it? So I kind of like that feature. There are lumpers and splitters and I'm not sure which one makes the most sense but if ultimately your goal is to reduce falls and improve patient outcomes, my thought was that this was a good package if you're going to choose one metric but I'm open to what others who audit this think.

Jim Smith: This is Jim and I just - there seems to be some confusion about PQRI which this is part of. I hope I represent it correctly that PQRI is a voluntary system but through participation there is the opportunity for some financial benefits for reaching higher levels of performance with quality indicators. So this would be another one of those that is a - at this time - optional measure but is also in some ways leveraging changes in practices and the direction that we would want to see.

Jesse Pines: Any additional comments about this measure in particular in the group?

Janet Nagamine: Janet again - on 1730, the other thought I had was that ASC and urgent care are included in the setting and I didn't think that was realistic that they're going to do a revision and home assessment and orthostatic vital in those settings. I think again - looking at the yield and targeting the right setting for the right risks will - is important.

Jim Smith: And that was - those were areas that I have a lot of notes to myself. I believe what they're saying is there are a range of assessments that might be appropriate, not that all of them would have to be done on a given individual but...

Janet Nagamine: But that is - I may have misread the criteria and my - the way I read it, I was - in order to get credit for having done all the stuff is that they did do all of these things -- the assessed or the statics -- they assess their - they ask them about their home and I just didn't think that would be very operational in some settings.

Male: We may need clarification on that. My understanding was that any one of these might qualify as part of the assessment for the individuals -- the patients.

Pat Quigley: This is Pat Quigley and yes, that would be correct because if you look at the risk assessment that was comprised of and/or more of the following - so it could be any component of that. That's what in the AFG guidelines under the assessment protocol. But part of what I saw was a little confusing to me for this one compared to the other fall risk screening for those of future falls -- the 0101, you know, that was for patients who had more than one fall or injury fall. These guidelines here are really for anybody who has a positive fall history in the last year. It's not just two or more falls. So I - but I still think that this is important because it really does help to indicate the multi factual risk assessment that it's not just a screening -- people have to do assessments. So I still supported this one.

Male: Yes, the only weak side will be they have to do a assessment. It might not be the right assessment or the optimal assessment for that individual.

Jessica Weber: And I think MCQA would like to clarify. Danielle, does MCQA have an open line?

Operator: Everybody's line is open.

Jessica Weber: Okay.

Female: Hi, this is MCQA. Just to clarify - these three measures -- 0101, 1730 and 1733 -- all kind of work together as a set. So in order to be in the denominator for 1730 -- the risk assessment -- you need to have screened positive on 0101. So this is saying that patients who had a positive screen for future fall risks using 0101 are then in the denominator for 1730 and these are the patients that should have a risk assessment. Does that clarify that?

Female: And then the plan follows?

Female: And then the plan follows with the same denominator of those who showed positive of 0101.

Female: Okay.

Jesse Pines: Great, thanks for clarifying that.

Female: This is just for future consideration. So I'm thoroughly ((inaudible)), so when I was going through these measures, I did not aggregate them in this fashion that you just described. So you've got a screening and assessment and a plan. I just went through them individually as they were on the list. In the future it might be helpful if there is that relationship inherent in the measures that maybe staff you could queue it to that so that we can then screen them in their clusters and then maybe it would make a little more sense to us. Does that make sense?

Jesse Pines: Sure.

Female: I didn't catch it. I apologize upfront.

Jesse Pines: Sure, I think that sounds like a really good idea and maybe you'd want to do the in-person meeting because we could do it that way.

Female: Yes.

Male: Just a question for the MCQA. Are these measures meant to be paired and always reported together?

Female: 1730 and 1733 are paired and always meant to be reported together and I think that is noted in the form -- when we filled out the form. We did pair those two measures. 0101 is not paired because it is still a measure which - because of the history of MPQRI - can be reported alone without 1730 and 1733.

Male: Okay, thank you.

Female: But they are related to each other. I think they're clustered - maybe - even if they're not paired, what you described is a clustering of those measures.

Female: Yes.

Female: There's an inherent order in relationship to them.

Female: Yes, they are all listed in the PQRF, PQRI measurement system together.

Female: Okay.

Jesse Pines: Any additional comments on 1730? Okay, why don't we - Pat, why don't you move on to 1733 and if you could talk a little bit about plan of care for falls.

Pat Quigley: Sure, thank you so much Jesse. 1733 is a process measure as well and this is for those people who do have the positive on history of falls, would have an actual care plan. So anyone whose had a history of falls in the last year that they would have a documented care plan -- the numerator associations at risk for future falls, so from the discussion we just had for our measure ((inaudible)) and MCQA that these could be patients that had more than one fall or injury of a fall in the last year. You see that in the numerator discussion. And then the plan of care is defined as appropriate assistance devices and balance and strength and gate measures.

So when I reviewed all the submissions from our colleagues on our workgroup, it seems like most people are supportive of the indicator. There were a couple of people who said no, that they wanted to have some discussion. And you have the evidence review that has indicated and it still is based on the American Geriatrics Society guide list of course as we mentioned before. And let me say, there was one other comment that I wanted to make about this is, although the evidence has been graded - so they have graded this based on the AGS guidelines as Grade A and Grade B and there's also the ninth Grade A, there's plenty of evidence of why we need to have a care plan in place.

The only comment I had related to the plan of care is I thought that it was really limited to having the plan of care defined as having an assistive device and/or balance, strength and gait training and because there has been further discussion in the prior risk assessment indicators related to the ASG guidelines, I would think that the intent of the plan of care is that you would try to mitigate or eliminate any of the fall risk factors on the ASG guidelines so, if a patient had ((inaudible)) hypertension, we treat that. You know, the patient has a ((inaudible)) problem, we would treat those. So I just thought the care plan part of this needed to be expanded a bit but I fully support this and know that other people wanted to have an opportunity to be able to discuss it Jesse.

Jesse Pines: Great. Thanks Pat. Any discussion or any - maybe any clarification from MCQA about expanding the care plan?

Iona Thraen: This is Iona. I was the one that put needs discussion and so I think we had that discussion where at least you're aware of what my concerns are so I don't need to say anymore.

Jesse Pines: Okay, any other additional discussion on this measure and again, we're going to be going through these measures quickly and once we get to 0537 -- and get through 0537 -- we're going to be having a more general discussion about harmonization and how we could potentially put all these together. And so, let's go ahead and move on to 0266 which is patient fall and is Charlotte on the call or someone from ASC.

Andrew Lyzenga: I don't believe Charlotte called in today but we do have some AFC quality collaboration wrapped on the phone. And I should not something which is we had actually - we're supposed to correct a typo in this measure where it lists exclusions for the measure. And I believe it says AFC admissions experiencing a fall outside ambulatory surgery center and that should be deleted.

There actually should be no exclusions. Is that correct Donna?

Donna: That is correct Andrew.

Andrew Lyzenga: Okay.

Male: What's the heading for that one?

Andrew Lyzenga: 266. You mean the measure number or that particular question?

Male: Yes just so I can track it. Is it a 1, a 2? It takes a while to find it.

Andrew Lyzenga: Yes, 2A1.B.

Male: Thank you.

Andrew Lyzenga: Sure.

Male: Did anyone from the endocervical surgical centers want to talk about - maybe give a short description of the measure and then we can open up for discussion.

Female: Donna, are you going to take that or do you want me to...?

Donna Slosburg: Sorry I'm on mute, I'm sorry I'm talking to myself again. I apologize. This measure is an outcome measure. It's for ambulatory surgery center and it's AFC admissions experiencing the following within the AFC. I'm not sure what else you want to know about the measure.

(Pam), I don't know if you wanted to add anything? One comment, ambulatory surgery CMS just released the quality reporting program for ambulatory surgery centers starting October 1 this year. And the fall measure we have five NQF endorsed measures and this fall measure is one of the measure's that's included in the ambulatory surgery quality reporting program.

It's a very straightforward measure. It's all admission; it's everybody that comes into an ambulatory surgery center and...

Male: Great, any questions for Donna or any comments on this measure?

Saul Weingart: So this is Saul again. My - I have two concerns. One was, you know, I think that the measure clearly has, you know, very strong face validity, but the process for demonstrating the

validation of the measure was quite challenging and I worry that information about this calls might be potentially recorded differently in different sites.

The other concern I had was it looks like the rate of these events is quite low on the kind of parts per 10,000 and because they're so unusual and rare I thought it might be very difficult to demonstrate that a change was important or significant. And I wondered if the, you know, the folks have any thoughts about that?

Male: All right, any additional comments or did anyone want to address Saul's question?

Pat Quigley: Well this is Pat Quigley; I'll try and take a stab at it. I'm not - trying to look at these calls. I know the literature that was reviewed was predominately literature that falls in nursing homes and hospitals. You know, I don't know what interventions have even been implemented on the ambulatory setting, the ambulatory hospitals. But this idea is a good time to just say, you know, there's different types of falls and I don't know at one point in time or NQF might even consider looking at types of falls.

There's a little bit of discussion as descriptive about types of falls and there are preventable falls and there are falls that are not preventable. So when you add these all up even if they're, you know, a small number of falls you cannot prevent all falls. So that - I don't know how to take it any further than that fall other than to say that this is still aggregating all the falls even if it's a small number of falls that are occurring.

But there are some falls that you just cannot prevent, you know, patients who fall because they had a sudden heart attack or stroke or seizure. You know, those are what we call unanticipated physiological falls, so I don't know how to, you know, make it more specific other than to see if we could get into types of falls.

Male: Yes I mean I was more concerned about, you know, if this is an ambulatory population that are coming in for elective procedures, than I'd really be much more interested in injurious falls than somebody who trips on the doorway coming in.

Female: Or a preventable fall.

Male: Preventable falls, right. So since these are all, you know, things collected presumably by incident reports, then we could be more specific about what we're looking for and hopefully get information that is both more informative and more actionable.

Female: Right.

Female: Donna, can I make a comment? I appreciate your comments and I hear what you're saying and that is eventually our goal. I just want you to know that this measure is obviously from maintenance. It's been out since 2006 and the data that we have shared with you is voluntarily reported. There's about 5300 certified or licensed AFC's in the country and the data is from a very small number of that population.

I think if this measure continues to be endorsed and moves forward and continues in the CMS quality reporting program, once all of the surgery centers are reporting I think we will have a better and clearer understanding of what that actual rate is and then eventually our goal is to potentially put together a registry where we could actually dig in and figure out the falls within injury and the falls within injury and maybe some of the causes.

But right now the data we have and the data that we've given you is all based on voluntary reporting because on October 1 there has no mandate from CMS for quality reporting from ASC's. So we believe there isn't any literature out there and there really isn't a lot of data other than what our volunteers have been reporting.

Female: The other point that may be salient to bring up is that in the ambulatory surgical center environment virtually all the patients if they're not initially at risk become at risk because of the type of services that are offered in these centers. And therefore it is essential not just to look at falls with injuries, but all falls that can be indicators of flaws in the processes for patient care during a patient stay at the center and during their care for the procedure.

Janet Nagamine: This is Janet, I echo the concerns that Saul had about the numbers and I was curious for the measure steward about the sort of underlying impetus to create the measure. I'm not familiar with falls that occur in ASC, how often, how much.

So is your belief that we're not capturing the magnitude of the problem? And also was are your thoughts about the falls that occur after they go home? Because that's what worries me at the hospital is that some of these elderly patients coming in for same day surgery you just know they're going to go home and fall.

And that's another question I had, do we capture that?

Female: This measure doesn't attempt to capture falls that occur outside the center primarily because ASC's have such a limited time period of contact with the patient that it would be very difficult to collect reliable information and feel secure about how valid that information was.

And so that is the reason for confining it to the period of time when the patient is under active observation from the staff at the center.

Pat Quigley: And this is Pat Quigley and I'd like to thank Donna and your colleague for the discussion. I'd just like to say and recognize that it isn't a measure that has been endorsed for some time as to really help you think differently about having better precision or specificity in the type of fall

because I appreciate that all patients are at risk of falls after surgery just like I'm in the VA. All my patients who come in are high risk for falls, you know, the veteran population who isn't unless they're in a coma.

But, you know, for us we know if you're really going to link an indicator to quality of care you cannot prevent all falls, so to really help be more specific and relate it to the quality of care and providing it in these settings is to help you think about going - moving it forward to types of falls in the future.

Thank you.

Iona Thraen: This is Iona. So this is a qualification question from staff. So is it at this stage of maintenance where if we in the conversation we determine that a measure that has been in place needs more work or needs to be more specified or whatever the case might be.

Do we - remind me again what the process is about in endorsement versus not endorsement if we've got these recommendations.

Andrew Lyzenga: Well at the in-person meeting what we're going to do is we're going to go through and vote on each of the evaluation criteria on importance, on scientific acceptability which includes reliability and validity testing. And the way we're doing it these days is each of those votes will basically roll up into the Steering Committee's recommendation.

So if you vote in both importance and scientific acceptability or must pass criteria - well if you end up voting then it is not sufficiently tested or not sufficient on scientific acceptability, then that would mean the measure would not be recommended for endorsement.

Female: Well I guess my question's a little bit different than that Andrew. I'm sorry, in its current form...

Andrew Lyzenga: Yes.

Female: ...it could probably pass, but if the conversation and the direction that we would like to see the measure go includes a different definition, okay, which is it has to be done differently in the future, where does that fall in? Otherwise we end up kind of just rubber stamping, you know, anything that came before gets to go forward.

How do we build this into the process?

Andrew Lyzenga: Yes we can include the recommendations in the report, sort of in the narrative section of the report. Beyond that I'll check into it and see if - you know, and we can even discuss it with the developer, with Donna and the rest of the developers to see how amenable they are to that sort of change and what their plans are for, you know, improving the measure in the future.

And we can again take that into consideration in the report and maybe your evaluation as well.

Donna Slosburg: This is Donna, if I could interject. I just want to let you all know that the collaboration has other measures and in the past when the Steering Committee has made recommendations to either make some changes in the measures or to add an additional measure, we have taken those recommendations very seriously and are working towards whatever those recommendations are if we can do it if at all possible.

What I would ask though is that because this measure is now in the quality reporting as it stands, I would hope that this measure would get endorsed with the recommendation maybe to add as someone was speaking earlier about more specific, maybe falls with injuries or more specific detail. But as I said this is voluntary at this point and it will not be mandatory until October, you know, we can certainly look at adding on or making some changes and were definitely amenable.

But I'm hoping that the measure will pass in its current state as it is because of the quality reporting program.

Andrew Lyzenga: And again I...

Carol Kemper: This is...

Andrew Lyzenga: Oh sorry.

Carol Kemper: This is Carol Kemper. Iona's point though, the thing that I'm concerned about it sounds like with this measure you're certainly taking efforts to further that and, you know, add to some of the recommendations that you're receiving.

But I think about when it's going to come around the next time and is there any way to know - I mean, you may very well follow up on this, but for other measures too if those recommendations have been taken or the - where the development has actually been acted upon. I don't know if we've ever gotten any information or feedback maybe from previous reviews.

Male: Right, also opportunities for the measure developers to do annual updates and those don't go through the full committee to review process, but they can update their measure with any new evidence for changes during that time.

Again, I'll look back into it. I don't know that there is anything that we typically do related to sort of endorsing a measure with binding conditions like that, like they have to make these changes within a certain period of time.

I think typically we say, you know, you endorse the measure as it's written with the recommendations to make certain changes and then I think it would have to be sort of the next time it came around for maintenance or during the annual update or potentially at the ad hoc review, you know?

Carol Kemper: And I'm - yes I wasn't suggesting binding kind of recommendations, but I think it's nice for the group to be informed by what those recommendations have been in the past.

Male: Right, right.

Female: I also think from sort of a developmental perspective, so this is an example where they've done some voluntary testing of the measure and they've gotten some results back and now she's talking about it's been rolled out at the CMS level in which you're going to have a much broader audience of participation as a mandate. And then the results accumulated from that experience.

So taking it from a developmental perspective I think that we need - I need to think - I need a conscience of where measure is. This is not just a maintenance phase, it's - if the measure...

Female: You've got evolution.

Female: Yes exactly right, thank you.

Pat Quigley: And this is Pat Quigley. Again, as you go through this document, it's Item1C.6, where it talks about types of falls and what's in parentheses after that is with or without injury and that's not a type of fall, that's the outcome of the consequence of the fall. So that, you know, the types of falls there is typology that's out there and I'm always happy to share that with the developers, but I just want to say that what's in here is not quite correct.

So but it does have types of falls in there which gives the opportunity for creating a, you know, a different document or raise in the floor if you will to have more precision or specificity on this.

Susan White: This is Susan White with the ASC QC and I just want to point out something that's probably obvious to everybody, but in tweaking the measure in collecting information like types of falls or, you know, whether there's a typology or not, really sort of compromises if you will. I was looking for the right word.

Or reliability and validity testing because we've done some, you know, on-site reviews of records to make sure that we have a good reliable measure and I think that would require some additional reliability testing and know that we would be getting the type correctly and that might require some education of the centers. I think it would.

Pat Quigley: Oh it does. This is Pat Quigley, but I just want to say that again I'm trying to link really some things to quality. You cannot prevent all falls. If you really want this to be a quality outcome measure about the effectiveness of your care then it has to move to a different level.

Susan White: Yes no, agreed. And I don't know if it was you or another person that described it as an evolutionary process, but I think all these measures are.

Male: This has been a really great discussion. Why don't we just in the interest of time, let's keep moving forward if we could. The next measure on the table is going to be the - we have two similar measures, both submitted by the ANA patient fall rate, 0141, which is going to Iona and then 0202 which Jason is going to be presenting that.

So since these are similar why don't we - Iona, why don't you go ahead and a quick description and any major issues and then Jason why don't you do a quick description and any major issues and then we can open it up for discussion?

Jason Adelman: Sure.

Iona Thraen: All right, so this is sponsored by the American Nursing Association. It's the patient fall rate, all documented falls with or without injuries. So it's a denominator of sorts if you're looking at the injury-related measure. And it uses patient days as the definition of the measures, total number of falls per patient days.

It's an outcome measure. The thing that I - just a couple of notes I wanted to make about that is it's at the unit, it's focused at the unit level, the inpatient setting. Obviously there is a great concern; it documented the data that they provided documented performance gaps by different types of units.

So adult critical care, step done, medical, surgical, combined, rehab and critical access. So we have some variability in terms of ((inaudible)). I thought that overall this was well-documented information in terms of defining specifically how they were going to collect it, what were the definitions of the metrics, et cetera.

The thing that I thought was curious and I don't know if it's relevant to this or not that much of the literature support that they brought to the table was not so much about size as it was about nursing staffing and staffing characteristics associated with falls. And I'm not sure how that sort of plays out in this conversation in terms of quality and, you know, even though I understand the argument in terms of nurse staffing and nurse characteristics, I just didn't see how that fit here with this definition of falls or this conversation about falls.

And I think with that I'll turn it over.

Male: Great, so maybe Jason. Go ahead.

Jason Adelman: Sure, so as you pointed out the measures are very similar. They're both in the NDNQI, nursing sensitive indicators for falls. Iona did the total fall rate and minor falls with injuries because I think it's a very good measure. Based on evidence I understand Iona's point. The data that they shared from the existing NDNQI database that showed that falls is still significantly a real problem and there's plenty of citations of all the national programs around falls.

And so with the data they established the performance gap. I think it's usable and feasible and as for collecting - having these two measures separate, one just on falls and one falls with injury, that makes a lot of sense to me. You can, you know, a successful fall program might still have some falls, but have very few falls with injury.

If you're escorting somebody to the bathroom they still may fall, but somebody would catch them and prevent them from having any harm. So I need for the distinction. I didn't have any major concerns with this measure; I think it's a very good measure.

Jean Deleon: This is Jane Deleon. I have a quick question about 141, the numerator. In the material we were given it says that it's whether the fall was assisted or not assisted and in one of our summary's the sheet said actually just unassisted falls.

Is it assisted and unassisted or just unassisted? The measure was like an Excel spreadsheet that kind of gave a quick overview of what it was and it says total number of falls per patient date times 1000, but it literally says unassisted falls in the Workgroup A. But in the actual measure and the blue writing it says in the numerator with and without injury and whether and not assisted by a staff member.

So that would include all the physical therapists that are walking the patients and doing assisted fall which is many times a day in a very heavy acute rehab.

Female: When you say assisted fall many times a day, are you saying are you - in terms of rehab are you talking about the training of someone on how to have a fall or you're talking about unplanned falls?

Jean Deleon: Unplanned, but if you're in an acute rehab facility, you know, 100 bed plus facility and you have brain injuries and complex rehab patients trying to work on their mobility, they're not going to be injured, but even when they are lowered back down to their wheelchair that's because it was unexpected. They were supposed to continue whatever their mobility was.

It still counted as an assisted fall.

Pat Quigley: This is Pat Quigley; I think I can help answer that. With this indicator there was a tabs for the indicators sent out to us, the reliability and validity testing that NDNQI had completed back in 2010 supporting a lot of this work and the definition of fall that is used for this is an unplanned descent to the floor or, you know, to another area with or without injury.

So yes the physical therapist is walking a patient on a unit and they have an unplanned descent, then even if they're there it's still an assisted fall just like it would be with a nurse. So you know, the numerator is clear on the 2A11 that it would still be all falls. That would be the numerator.

Female: I would also add to that that this definition it says nursing unit. So if you have any physical therapy and some nursing unit specific measure.

Pat Quigley: Yes it's not going to be in the physical therapy department. It's on the nursing unit because it's reported at the unit level. And I did want to say too that we've had the discussion - this is Pat Quigley - was for NDNQI about preventable and non-preventable falls and, you know, that's been some of that literature you've read as well. I know with the two indicators submitted by ANA.

So you know, that's the future direction too.

Female: Just to follow up, so are you saying that in a rehab hospital the only falls that will be counted are those in the nursing unit, not those that occur during therapy?

Pat Quigley: Correct, yes so this is at the unit level. That's correct. In your own internal reporting if you're at the rehab facility - you know, we have rehab facilities. I imagine hospitals as well. We have, you know, there are so many hospitals, over 1300 reporting into NDNQI.

But, you know, within your own facility you would still have your data analysis and quality improvement program evaluation, your department level, but for this reporting for NDNQI, for the nursing unit level and there's very clear specification of what the units are - the nursing unit.

Male: And it specifically excludes for example obstetric, psychiatric and others in this descriptor?

Pat Quigley: Correct.

Male: I believe we do have a representative from the ANA on.

Pat Quigley: Yes.

Male: Darryl, are you on? Is Darryl Roberts on the line?

Operator: He was, but he disconnected.

Darryl Roberts: No I'm here, but I am not representing the ANA. Pat Quigley is representing the ANA. I'm on the call as a guest.

Female: And Nancy Dunton should be on the line. Nancy or (Diane Boyle)? This is (Maureen Daly) speaking.

Male: Hi (Maureen).

(Diane Boyle): This is (Diane Boyle). I think I can address both of the questions that you asked. Going back to the question about the unassisted falls, what we have found in our sort of testing and work with these hospitals is that we added the unassisted fall rate in this particular iteration because we are coming to believe that the unassisted falls are where people should be putting their quality improvement efforts.

So we know that if the patient has an assisted fall there's much less likelihood of injury. And we're starting to do quite a bit of work around these particular unassisted and assisted falls. So I think with our next endorsement we'll have a lot of good information around that, but clearly if the patient has an assisted fall there's much less likelihood of an injury. So we think the hospitals need to have an unassisted fall rate so they can see where they're at with that and then direct their quality improvement. So that's why added it.

And the data are directed at the nursing care unit level so that the nurses in the hospitals and the nursing units can improve quality. And whether or not the other question was...

Female: It was about falls that occur within physical therapy for example.

(Diane Boyle): Right and I think somebody addressed this. If the therapist that's on the unit is walking the patient in the hallway then those count, but if they're down in the physical therapy department they know they would not be counted because it didn't happen on the nursing care unit.

Nancy Dunton: This is Nancy Dunton; there was a question earlier about the literature discussing staffing measures and other kinds of studying measures of the setting with fall rates. And we did that to demonstrate the relationship between structure and the process and the outcomes of falls.

Female: Okay that's useful, thank you.

Female: Right, if you look at the criteria 1C.1 at the beginning of the evidence section that's what they direct you to do is put together the relationship and the structure process and outcome. So that's why that section is.

Female: Okay thank you.

Female: We always have a large development agenda around falls as Pat mentioned, so I think there's many places where we can in doing measures like those discussed in an advanced quality of care around patient falls.

Iona Thraen: This is Iona again, also want to comment that I thought the work that they've done in terms of the fall scenarios and the education and the testing to make sure that there was agreement in terms of whether or not the fall or not a fall, et cetera I thought was quite extensive. And I wanted to just compliment you on that.

Female: Thank you.

Jim Smith: And this is Jim, this has become more clear as we've discussed it. I just want to commend you on the evolution towards unassisted falls. I'm often concerned that the data we get from the action of falling has unintended consequences of eliminating the risk for falls by immobilizing our patients.

And that will actually have an additional adverse effect, so the focus on the unassisted falls is very helpful and I commend it.

Male: Great, this has been a really great discussion. Any additional comments on 1041 or 10 - I'm sorry 0202?

Janet Nagamine: This is Janet; this is a clarification question on 202. Under 4D the data collection, the definition of no injury, I just want to clarify that it does not require a CT or X-ray to be negative like the physician just write a progress note and say no apparent injury or something like that?

Female: Right, that's correct. It does not require it.

Janet Nagamine: Okay thank you.

Male: Thanks for clarifying that. Let's go ahead and then move into 537. Saul, do you want to talk about the multi-factor fall risk assessment conducted in patients 65 and older?

Saul Weingart: Sure, so this is a CMS measure that looks at patients 65 and older in home health care. So at the start or resumption of care they're supposed to have a multi-factor fall risk assessment and the denominator is that the total number of these episodes where care is reinstated, those who have to sign these forms are very familiar with how this works.

So you know, the rate of falls in a community setting is something that has only been, you know, moderately well-studied and in the home health care setting that subset of patients, that's not at all well-known. But there is one study that identified a rate of about 30% in the context of all elders which is, you know, rates from 11-30%, but seems to be a risk there.

The proposers of the measure describe a number of research studies that show the benefit of a multi-factor risk assessment on fall rates, but in fact that literature is a bit of a tenuous literature and I'll just mention it now because I think it applies to a lot of these fall initiatives, particularly ones that are in the context of home. So many of the individual studies are either null studies or go one or the other ways, but there were a couple of meta analyses and reviews that suggest that risk assessment plus intervention result in fewer falls in community dwelling elders and in other settings.

The problem is we don't know about the specific group that are home health care patients, so presumably they'd be somewhere between independent elders and those in nursing homes. So if it applies in both of those settings it would apply to the home health care population.

And the other issue is you can't really separate those who had the assessment from those who had the intervention associated with the assessment. So you know, the research is not terrible, but it doesn't exactly answer the question that's been asked. So that's just by way of background. This is a reassessment of the measure - let me see, apparently last time this went through the NQF there was some concerns about lack of variability in the measure across healthcare agencies.

Even now the average compliance based on 2010 data is 95% and when I checked our local home health care agencies it was still cited as a national rate of about 95%. So I think it rated a question about to what extent there are opportunities for pushing that even higher. The data is drawn from the OASIS-C System which is required by Medicare for Medicare certified home health agencies. So the data capture is quite good.

Let's see, okay I'm just looking at other notes. So overall, you know, it seemed to me that the measure was well-specified and seem to be valid and reliable and seem to be linked to outcomes. There is a request in the submission that us - that this committee consider extending

the scope of the measure to include not just individuals over age 65, but include those under 65 as well.

And the rationale was provided along with some data that this younger group often has a lot of medical co-morbidities, gait disorders and frailty that would also put them at risk for falls. And by not endorsing a measure that included the under 65's it would potentially send a message that it wasn't important to do a fall assessment in this group.

So you know, on that point, you know, I found that rather compelling. There is no benchmark data that I'm aware of for looking at home health care agents under 65 and their risk of falls, but it seems to me that this is a perfectly good place to go and in fact it seemed to me that they might even be at higher risk than the over 65's given MS and other sorts of medical problems they could experience.

And it could increase the number of people covered by the measure by another half million. So I thought that that was quite interesting and reasonable. Overall I thought it was a good measure and didn't have any significant concerns.

Male: Great, thanks. That was an excellent description. Any comments? Questions?

Janet Nagamine: This is Janet, a question for Saul and others about sort of risk stratification in this group. They had somewhere on here the statistics of falls in different populations and the highest risk was if you're over 65 and on five plus meds.

Saul Weingart: Right.

Janet Nagamine: And my question was about further stratification to narrow the population or the target population, would that help or hurt it in terms of the yield and overall improvement of patient outcomes and falls?

Jesse Pines: You know, it's a very interesting question. I mean the way I think about that is the greatest benefit in doing an assessment is likely to come for those who are most vulnerable, right? But at the same time there's a large population of people who are at lower risk of falls. And if we identify vulnerability in that larger group that might end up in aggregate identifying the most falls or intercepting the most falls

And there are those are high risk but they're a smaller group. And then there's a larger group of people who have less risk but constitute a larger population of vulnerables.

I mean I, you know, given that they've gotten to 95% of eligible patients already I think that casting the net widely makes sense in this particular - for this particular measure.

Female: Thank you. No, just a question I had. It's...

Jesse Pines: Yeah. That's reasonable, very reasonable.

Pat Quigley: Yeah. This is Pat Quigley. And thank you for bringing up that comment. That's in (2B33) is where they, you know, talk about the different comorbidities. And part of what they've also done is to separate out the risk based on frailty.

You know, if I was to change it differently for - especially for the home health population is irrespective of fall risk is who's at risk for having an injury if they fall. So that would be the way that I would move it in a different framework.

Female: Yeah.

Male: Yeah.

Female: You just want to get the biggest bang that you can.

Pat Quigley: Right. Yeah. I mean in our setting so many of our patients in home care that this population's really your ((inaudible)) patient population, cancer population. But I thought it was very important.

Jesse Pines: Yeah. And I think the other direction is, you know, how do we make sure that the plans that are recommended get implemented and acted on. We don't have a lot of information about that.

Pat Quigley: I agree with that too. And that - again that's why we integrated injury risk into all of our work. It's not just fall risk. It's risk for a fall-related injury...

Male: Yeah.

Pat Quigley: Cause interventions are different.

Male: Yeah.

Jesse Pines: Well there have been a number of comments about kind of expanding the scope or even narrowing the scope of the measure. Does CMS or any representative of CMS want to make any comments?

Deborah Deitz: This is Deborah Deitz. I just want to mention that we actually do collect information and report to agencies two additional measures. One is whether or not there are care - the care plans

do involve interventions once a patient has been found to be at risk for falls. And the other one is whether or not for those patients those - that - those interventions were implemented.

And we are, as I said, already collecting and reporting that data. When we presented the three measures together to NQF in 2008 this was the one measure that received endorsement. So we've continued to collect and report the other two.

And, you know, maybe we should be considering those two for endorsement as well. But at this point we just came back with the measure that you had previously endorsed.

Pat Quigley: Well this is Pat Quigley. I'd just like to thank you for that feedback and hope that maybe you would include risk for injury as well in your future development.

Deborah Deitz: Can you elaborate a little bit where you...

Pat Quigley: Yes.

Deborah Deitz: If you...

Pat Quigley: A lot of our work has been reducing especially in the home population where, you know, the majority of falls occur -- 60% of our falls happen in-home -- is to identify those patients who are at risk for moderate to serious injury, fracture risk, anti-coagulated, blood dyscrasias, people at risk for bleeding, anyone who comes into our care, if they're admitted into hospital-based home care, anyone who's already had a fall-related injury which is part of what's built into the AGS guidelines cause you have that in - cited in your literature review because when you're on the more vulnerable side of the AGS guidelines you're identifying those people who've had more than one fall in the last year or an injurious fall.

So if you were to go beyond just fall risk and what is implemented in relationship to a care plan based on multifactorial risk factors is you would also integrate risk for injury for anyone who comes into our care. And then the interventions for protecting people from moderate to serious injuries are different than mitigating or eliminating fall risk factors.

Deborah Deitz: All right. Well that is something that we would like to think more about and certainly would be something we would be interested in.

Pat Quigley: Thank you.

Jesse Pines: Great. And so at this point we've gotten through I think all of the fall measures. And there are a total of - it looks like eight -- one, two, three, four, five, six, seven -- eight of them.

I would like to have some discussion about harmonization now. And, you know, the - these measures kind of hit, you know, different elements of falls. And, you know, does the group want to - is the group leaning to endorse all of these, some of these or potentially modify some of these or combine them?

And I also do want to direct your attention to a document that was sent around by Jessica earlier called Falls Related and Competing, which was really good. It kind of gives you a side by side in terms of some of the measures and the - how they're done and which groups that they apply to so.

Jessica Weber: Jesse, actually that document did not go around. But it is up on the webinar right now for other people to look at. And we will distribute it before the in-person meeting.

Female: That would be good, Jessica, cause I never got into the webinar.

Jessica Weber: Okay. Thanks.

Female: In my review of the individual measures -- and I may have missed the linkages here -- but most of the measures as I recall indicated that there were not competing measures, that they were related measures. All of the different measures are related.

So you have a cluster of process measures. You have a cluster of outcome measures. And then of course you have potentially varying definitions, numerators, denominators, sources of the data and settings in which the measures are going to be used and the target population.

So I guess, you know, I'm looking for some sort of I guess dashboard approach or some way of organizationally saying okay here's how these process measures relate to these outcome measures or don't relate to these outcome measures so if you're doing this we know that it should have an impact on that. And being able to sort of look at those in that framework would help me better make a decision about how to go about endorsing these measures.

The - I think the challenge is you've got - I think you've got three or four different sponsoring agents. So you have NCQA. You have the (ANA). You have CMS. I think those are the three that I remember.

And whether or not they could do that for us or with us in their conversations with each other, how do their - these measures relate in terms of achieving what we're trying to achieve which is improved outcomes, knowing that, you know, if you've got process measures in place that they need to be linked to those outcomes and whether or not that's a conversation that those sponsoring agencies are willing to have, similar to what we did with CDC and was it CMS? I can't remember who the two agencies were in the surgical infection measures.

Jesse Pines: Yeah, the American College of Surgeons in...

Female: Oh yeah. Okay.

Jesse Pines: D.C. We actually...

Pat Quigley: This is Pat...

Jesse Pines: Do have...

Pat Quigley: Oh sorry.

Jesse Pines: Okay. Go ahead.

Pat Quigley: This is Pat Quigley. I was going to say that I thought that the (ANA) one should stand alone cause they're hospital-based. I thought the one for home health because of the database for that is (Oasis), is different.

So to me those are very clear. If I was to see any that were to be harmonized it would be 0101 and 0 - and 1730. Those were the ones about fall risk.

If 1730 was the entire patient or adult population over the 65 being at risk for falls then to me that would be - that could almost be a standalone. But 0101 would be subset of that because that's the patients who are at risk for falls but they've had more than one fall or an injurious fall in the last year.

So those would be the two that could be harmonized but be - and even more so after the discussion because part of what we learned is that - and they said that -- I believe it was Donna -- that 1730 was built upon 101 -- I didn't get that right -- 0101.

But those are the - to me the only two because they're both dealing with patients at risk for falls in a multifactorial risk assessment. And then you move onto the care plan. But those are the two that I thought could be harmonized.

And the care plan...

Male: I think...

Pat Quigley: One, 0035 and 1733 could be harmonized cause those are both management, care plans and management.

Jesse Pines: So if we...

Pat Quigley: I guess.

Jesse Pines: Do have...

Female: ((inaudible)).

Jesse Pines: Yeah. Go ahead.

Female: This is NCQA. I just wanted to follow up on that comment if that's okay.

Male: Yeah, absolutely. Go ahead.

Female: Okay. So 0101 is - and 0 -- I'm sorry -- 0101 which is the screening for future falls risk is used to determine the denominator for 1730. So we, you know, this I think comes down to if you are splitters versus lumpers.

We tried to - because for measurement purposes it is easier if you have discrete measures of first did you assess if someone was at risk for future falls, second did you then do a risk assessment for those people who were at risk. So the risk assessment is well let's go through all of your various risk factors.

The reason that 101 is separate from 1730 is that - because we, given the evidence, didn't feel that risk assessment, going through the multifactorial risk assessment, was appropriate for all individuals over the age of 65. And maybe NQF can help us to come up with a better way to link these three measures together such that they are seen as three distinct steps that all have to do with the process of screening for future falls risk, doing a multifactorial risk assessment and then developing a care plan.

I also wanted to speak to 0035 because we - I didn't get a chance earlier to respond to the comments which we really appreciate and whether or not that can be harmonized with the other measures. Zero zero three five is a very different measure because it is a patient-reported measure. And while we understand that there are some concerns around the, you know, validity of a patient-reported measure we felt that it was very important that there be different ways of getting at whether or not a falls risk assessment is being conducted and whether or not people are talking with their doctors about falls risk.

The three measures which rely - that would be 0101, 1730 and 1733 do rely on right now, given the current data systems we have, optional reporting. And so we're not really able to get at a full range of patients. We're only able to really measure patients whose doctors chose to optional report on this whereas 0035 we really can get at all patients and get an assessment of - an idea

of whether or not they discussed with their doctors falls risk and whether or not their doctor suggested interventions to help them reduce their falls risk.

So we don't really see a way that we can harmonize in terms of combining measures, a patient-reported measure with the clinical claim measures. But we would certainly be open to, you know, if there were suggestions from the committee in terms of standardizing languages - language or definitions we would be open to that.

Iona Thraen: This is Iona. You know, I - and I understand your rationale in terms of the harmonization question. And I'm wondering if harmonization or streamlining are - is not an adequate descriptor here.

What I'm seeing - what I'm actually seeing is the notion of bundling. So there are measures that relate to each other. And when bundled together these are the - this is what you're trying to get at. And whether it's a multiple surveillance approach using patient and claims and whatever as one sort of bundle or another bundle might be across the sect - the various continuing - continuity of care sectors so this notion of how these measures relate to each other, what their interdependences are and the value, the more robust information that you might be getting by having these measures put together in a bundle so something along that line. So maybe even if you don't - can't work across agencies maybe working across the individual measures in such a way that when they're brought forward we get the picture you're trying to capture.

Pat Quigley: And this is Pat Quigley. I'd like to speak to your response related to the risk assessment.

If you're true to the AGS/BGS guideline the multifactorial risk assessment is for any older person who has a positive screen - any positive screen. So whether it's just a fall in the last year or more than one fall - injurious fall we still do the multifactorial risk assessment.

So I just wanted to say that it's not just for those patients who've had more than one fall or an injurious fall in the last year. The spirit of those guidelines, the application of its evidence, is to anyone who's had a fall in that age population in the last year.

Female: Thank you.

Jesse Pines: But one of the questions I have is: so is there a proposal to bundle the measures together where we would vote on them as a bundle or as - when we present this to the in-person - at the in-person meeting that it be framed that way?

Pat Quigley: Well this is P.Q., Pat Quigley. I still would like to harmonize the risk assessment and then harmonize the management ones. And then that could still be a bundle in relationship to fall prevention.

Female: This is NCQA. I'm sorry. Can you just be more specific, the management meaning the patient-reported management question and the risk...

Pat Quigley: It would be...

Female: Assessment?

Pat Quigley: It would be the 0035 is management and the care plan is management, 1733. The risk assessment ones are 0101 and 1730.

Female: So let me just clarify that 0035 actually has two rates in it. One is discussed in it - discussing whether or not you had a fall. And the second rate is discussing...

Female: Yeah. But it's still...

Female: Managing fall risk. So...

Female: Yes.

Female: There's two rates within that measure, one of which is managing a fall risk, the other which is discussing your fall risk.

I'm not sure I think - I'm not sure I understand the difference between harmonizing which means to just the - are you trying to combine these into a single measure or bundling, just saying these are better when they're reported together?

Pat Quigley: This is Pat Quigley. I don't know that I know enough to answer that. Maybe staff could answer that, Jesse.

Jesse Pines: Yeah. I'm not sure. I mean I guess this is a question for the NCQA. So it sounds like the bundling suggests the interdependence of the measures. So it sounds like if one is dependent on the - if they're all dependent upon one another in order to be - to create - to basically do what they're supposed to do, if one does not get endorsed but the other two do get endorsed what - is it - what happens then? I mean is there - do you think that the value of two is, you know, it makes the, you know, if all three aren't endorsed that you can't really endorse each of them separately?

Female: Well this is NCQA. I've not, you know, in my previous work with - working with NQF on harmonization the word bundling hasn't really come up. So I'm not really sure how NQF would like to handle that.

I can say that the combining into a single measure with the same - with a single numerator and denominator, a patient-reported measure which is done through a survey and a claims measure

which is done, you know, through administrative claims I just don't - I don't really see how that's feasible.

So - and then for this I'm referring to the combination of 0035 and 1733 which I believe was Pat Quigley's comment to try to combine those two. I don't...

Iona Thraen: This is just - I'm sorry. I just...

Female: I don't really see - I don't quite know how that would happen.

Iona Thraen: This is Iona. So what I see is that you're trying to capture some conceptual idea about fall and that - in the example that you just gave the patient reporting piece is one source of data. The claim...

Female: Yeah. Yeah.

Iona Thraen: Approach is one source of - a second source of data to capture this idea of fall risk or fall assessment or fall planning, whatever it is that the measure that you're trying to capture is - the idea that you're trying to capture. So right now the way it's constructed and maybe that's the framework that you're dealing in is that we have to treat each of these individually when in fact we're just talking about two different ways to get at the same idea.

Janet Nagamine: Right. And elaborate on the concept piece. This is Janet. I think it's a step-wise fashion. And I think the more we talk about this it makes sense to split some of this. Did you assess is the first question. And the second question is if the assessment was positive did you do something about it. And I do see that 35 and 101, 1730 and 1733 have many similarities.

And as Iona said in terms of assessing the fall risk you could ask the patient or you could look at the chart to see if it's documented - it was discussed. In terms of managing an intervention you could ask the patient or you could look at the chart so different ways of getting at the same two questions.

And I do think - and this is a question about 35; it seems that - well I guess in a survey it may not be difficult to operationalize. But I'm just wondering if there's value in splitting it out.

Female: This is NCQA. I will - I mean, I defer to if NQF can provide us guidance with how to - how to submit a measure where the measure concept is the same but the way in which you get at the measure concept is different. If they have any examples of forms that combine a claims and patient reported measure we'd certainly be open to that.

Male: Yeah, I haven't seen anything like that. We'll look into that a little bit and we can touch base offline to...

Female: Okay.

Male: ...see what kind of precedent there is for that or...

Iona Thraen: And this is Iona. I'm thinking that, you know, part of the struggle here is that we're all sort of evolving in our thinking. And that the way in which you've responded is - the way - the issue that we're talking about is about the way the structure is currently in place and you've responded to that structure.

So I'm not, you know, I'm not trying to make anybody feel bad about what they've done it's just as we move forward and we try to figure out what's the best way to decrease burden, to really get at

what it is we're trying to measure, etcetera, etcetera, that we're - maybe there's a little bit of a paradigm shift in terms of how we're approaching this.

Female: Yeah, and I think it'd be cool if you gave somebody an option, you know, that a group can assess their performance by doing either or - or if you're really ambitious do both. You look at the audit and you ask the patient and you see what's the correlation there.

Iona Thraen: Well as a matter of fact I would take it one step further and say that one might be a validation approach to the other. You know, so you have patient reports or what we've found here at (IHC) - and I don't want to confuse everybody or make anybody depressed - is that when we're trying to measure something and you use three different surveillance systems the overlap between those three different surveillance systems in terms of trying to count numbers of events is pretty small.

(Crosstalk)

Iona Thraen: ...you know, the type of surveillance system that you develop is going to yield you what you're looking at but it may not be the whole picture.

Female: Yeah.

Pat Quigley: Yeah, this is Pat. I really agree with that discussion. Even with some patients they really can't tell you, you know, we've got a lot of dementia patients and you talk with the family as well. So I think this has been great discussion.

Female: And I would just like to clarify that - because there's no space on the NQF forum because I guess NQF doesn't get a lot of survey measures. But this survey measure does allow for proxy response. So for patients with dementia this would be a proxy response.

Male: Hey, this has been a really great discussion. Any additional discussion about the competing measures, harmonization bundling, all the different ways we could potentially combine the measures and that we here at NQF will definitely look into if there's any precedence or mechanism whereby the - we could potentially bundle a few of these together. Any additional discussion before we move on to pressure ulcers?

Okay great so let's go ahead then and move into 0337 which is the pressure ulcer rate. And Carol Kemper is going to be presenting it. Go ahead, Carol.

Carol Kemper: Yes, thank you. This is an AHRQ measure. And it's one of the pediatric quality measures - pressure ulcer rate. It's derived from administrative or billing data and it's looking at the percentage of discharges that meet the inclusion and exclusion criteria that have a coded pressure ulcer that's either a Stage 3 or a Stage 4 in that secondary diagnosis field so again trying to get at ones that have occurred during the hospitalization.

The specific algorithm or sort of software that's used to run these data has some exclusion criteria including oh various kind of comorbidities that are primarily neuro-sensory sort of comorbidities. There are other sort of risks that might make it more of a non-preventable or a less likely to be prevented sort of a pressure ulcer.

This measure has gone through iterations over a number of years and so in addition to those kind of exclusions that are hoped to ferret out those cases that occurred before admission. There's also now that present on admission code that's used to exclude those cases.

The measure is also included as part of a composite measure for pediatric safety. It is used quite a bit I think for public reporting in quality improvement. And of course has a lot, as I think pressure ulcers do in general, has a lot of emphasis and there's a lot of focus on this partly because of

CMS and just a recognition that it is a harm event that we think we can prevent and maybe get to zero.

The measure itself - I haven't seen recent studies but the developers identify the original studies that were done and I think said the positive predictive value was somewhere around 50-some - 54%, 51%. And again that should be higher now with that present on admission code. But I haven't seen anything that's been updated, you know, since that present on admission code has been used.

I think, you know, looking at the responses that we got certainly it's very feasible to use this because it's administrative data so it's not hard data to get. It's obviously fraught with the potential for coding errors or coding issues that can occur. But overall it looked like the recommendation was to continue endorsing the measure.

Any other thoughts or questions?

Male: Do we have the representative from (ARQ) on the line?

John Bott: Yeah, John Bott is - from (ARQ) is here.

Male: Hey, John. Do you want to respond to that - the question about the - any additional studies since the positive predictive value of the 51% was reported?

John Bott: If it's not cited in the - if it's not cited in the maintenance form there very well may not be any studies at this time. Now - but I believe we submitted this maintenance form about six months ago so there would be the outside chance that something has been published since that time.

If we published it in regard to our validation studies it was probably in relation to the PSI - the adult version and I think people are aware this is the pediatric version which the thought and I believe there's some evidence that there's a lot lower prevalence of present on admission of pressure ulcers in pediatrics.

But I'll make a note and we'll make sure to cite in the - I don't know what you call it - the full steering committee meeting if there's been studies subsequently released since the - when we put the maintenance form together.

Male: Great, thank you. Any additional comments or questions on this measure?

Jean Deleon: This is Jean Deleon. Are DTIs included in your unable to stage deep tissue injuries?

John Bott: I wouldn't know the answer to that but (Patrick Romano) would be able to answer that in the full steering committee call. Sorry.

Jean Deleon: Okay.

Female: That is a good question. I wondered that as well because at least in just looking at the description in the numerator it only is listing stage - well I'm going to take that back; it stays Stage 3, 4 or un-stageable.

Jean Deleon: Just making sure - it depends if you're talking about something like the care tool or some other tools that are out there they will ask you to lump DTIs in unable to stage; sometimes they give it a separate code. I just...

Female: Okay.

Jean Deleon: ...wanted to be clear that it did include DTIs is the un-stageable.

John Bott: You're - so I can take this question back you said DTIs?

Jean Deleon: DTIs - deep tissue injuries.

John Bott: Okay thanks.

Female: Yeah, it looks like it's included (DQ).

Jean Deleon: Is it stated somewhere?

Female: I have it on our table. It says diagnose pressure ulcers Stage 3, 4 or un-stageable. And any secondary diagnosis field.

Jean Deleon: No I'm looking for deep tissue injury. Did you see that somewhere?

Female: I didn't see anything specific about your question of deep tissue injury. I was just - I just noticed the un-stageable.

Female: Yeah, un-stageable.

Jean Deleon: Why in the exclusion criteria for the denominator transfers from a hospital, from a skilled nursing facility or another healthcare facility? I didn't understand that.

Carol Kemper: Well I think that - and I really should let AHRQ speak to that but I believe that's also in the adult measure. And I think the thought was - and this was before the present on admission code

that was in there. And it was sort of a way to be able to call out that population that was more likely to have a pressure ulcer that was present on admission.

Jean Deleon: But now that we have...

Carol Kemper: Present on admission...

Jean Deleon: ...on admission would we drop that from the denominator exclusion?

John Bott: This is John with AHRQ. We're in the midst of studying that very question right now along with a number of other exclusions we've classically employed prior to the existence of POA. So we're revisiting that at at this very moment. I actually had a call about it this morning. And when that's completed we'll likely drop a number of exclusions given the presence of POA.

Mary Sieggreen: This is Mary Sieggreen. Are you also considering dropping neo-nates from that?

John Bott: Are neo-nates currently excluded?

Carol Kemper: They're excluded now.

Mary Sieggreen: Yes.

John Bott: I'm not sure if that's one of the cases - if that's one of the exclusions we're studying. We're studying exclusions that we feel are proxies for POA so I...

Mary Sieggreen: This is not - they would not be considered under present on admission because they're neo-nates...

(Crosstalk)

Mary Sieggreen: ...oftentimes get pressure ulcers that are unrecognized so anything that they get that's a pressure ulcer they would get it in the facility.

Pat Quigley: This is Pat Quigley. I wanted to go back to the deep tissue injury; it's on 1c-1 under the discussion it has that as excluded if they're present on admission - the very first paragraph there. Our colleague who was asking about that...

Jean Deleon: I'm sorry, Pat, this was Jean. What paragraph?

Pat Quigley: It's 1c-1 under Structure Process Outcome Relationship.

Jean Deleon: Okay.

Pat Quigley: It's the top of Page 6.

Jean Deleon: Okay.

Pat Quigley: That very first paragraph.

Jean Deleon: It does reference deep tissue injury in that paragraph, you're right.

Male: On admission.

Pat Quigley: ...yes...

Jean Deleon: On admission.

Pat Quigley: ...excluded, right.

Jean Deleon: Excluding progression from Stage 2 to 3 if Stage 2 was recognized on admission and pressure ulcers that developed in areas where deep tissue injury is documented as present on admission. It's just - I would be nice to see it literally written in the - somewhere else, not just in the...

Pat Quigley: As an exclusion?

Female: Yeah.

Jean Deleon: Yes.

Male: Great, any additional comments on this measure?

Jean Deleon: Did we get an answer to the neo-nate question? Will it be removed as a exclusion?

John Bott: I don't know at this particular moment if that's one of the exclusions being studied...

Jean Deleon: Okay.

John Bott: ...in our POA analysis. There's a number that are and aren't being included in the study. I can respond to that in the full steering committee call.

Male: Great, and John, you've mentioned a lot of these ongoing studies are going on - are those going to be, you said finished by the in-person meeting?

John Bott: No, they won't be finished by the in-person meeting; they'll be finished this fall.

Male: Oh, okay.

John Bott: So they'd be considerations for version 4.5 of our measures for spring of 2014.

Jean Deleon: I would also ask about the length of stay less than five days why that's excluded?

John Bott: Okay. I think that is part of our study but I'll...

Jean Deleon: Okay.

John Bott: ...note the question.

Male: Okay. Great, any additional comments on 337? Okay let's go ahead then and move on to 538; pressure ulcer prevention ((inaudible)) care and Jean Deleon is going to be presenting.

Jean Deleon: Yeah, just in brief this is a home health measure. It is a process measure; it is not an outcome measure. And it looks at the percentage of home health episodes in which there is a physician-ordered plan of care that includes pressure ulcer prevention measures.

I actually sat on the steering committee for home health so this is probably my second time around with this home health measure. I was interested in what the testing showed on this. And from what I could tell the testing of using - having a care plan that has prevention orders in it did not impact the incidents of pressure ulcer formation or the hospitalizations associated with pressure ulcers from what I could tell. And that was my biggest question.

And going back to even the falls discussion I think this is something that's prevalent to all of these measures when you isolate each piece it's very difficult to endorse it as an evidence-based measure because there's no evidence that says if there's an order in the care plan that it impacts outcome but we would all agree that it helps drive best practice.

And it's a step and it's an important step so I'm very - I'm always torn when we get to these and we're all split up that you need to make an assessment. You need to put it in a care plan. But the meat of it is implementing it in order to effect and then measuring the outcome.

So separately, I didn't agree with the measure. Is it important as a best practice? Absolutely. But that's where I'm stuck, because there really isn't evidence that says putting a care plan together changes the outcome. You would hope it would, but it doesn't.

Pat Quigley: Well, Jean, this is Pat Quigley. Just on the side, I hope Jesse will allow me this point and personal privilege. Is it the same thing with falls? I mean there's preventable pressure ulcers and those ones that are not. So you know, that's the issue.

Jean Deleon: I agree, but, you know, a care plan in a home health form, if you signed several hundred or thousands of them, as I have, I didn't write it. I signed it, and I have made additions to it or changed it if I thought there was something in there that was not what I ordered. But is it supposed to be a reflection of the home health agency or a reflection of the physician, the quality of care? That was also another question, but I just don't - it - I think a lot of people just put it in a computer and they print it out, but they don't ever do it.

Pat Quigley: Right.

Jean Deleon: They at - you know, I just - it's like risk assessment too or pressure ulcers, we write down scores, but we don't really do anything about them. And it doesn't affect quality, because we're

never held to the task of doing the intervention. So - I - my support is in taking things like this and I guess from our previous discussion, bundling them not harmonizing them, but bundling them and saying, "You've got to do all three in order to get endorsement, because you've got to assess it. You've got to then have a plan or an intervention, and then you've got to do it."

Pat Quigley: Right.

Female: Jean, this is ((inaudible)). I think that's critically important. Again, we think that pressure ulcers are important. We think we should do something about it, but if at the end of the day, measuring it and going through all that trouble is not going to make a difference, then I think we have to ask, "How can we tweak this measure or bundle it so that we affect change and improved outcomes?" I think that's critically important here.

Carol Kemper: This is Carol Kemper. I think - and I think I put that in my comments. I would like to see a bundle that included that 0538539 and 540. And, you know, I could envision that it would be helpful for agencies to see how their performances on each one of those, but you need to see it in aggregate as well as a - you know, in that bundle format. You know, the individual is helpful if there is an area that you need to focus on to try to improve that entire process, but they really can't be viewed just in isolation.

Iona Thraen: I think - Iona - I think what you guys are discussing is, again, this notion of evolution in terms of their surveillance process. So are we wanting to support surveillance for the sake of surveillance? And obviously not. How does surveillance then inform action and improvement? So I think that you're - what you're addressing is symptomatic of where the quality improvement and measure process is in terms of its own development.

Female: Yes, it seems like - didn't we have a similar discussion at our last meeting, and it was around those pain assessment and intervention measures.

Male: ((inaudible)).

Female: And I think - yes, we had a similar issue.

Male: Yes, it's similar to our discussion on DVT prophylactics that it was the opportunity to do something, but it wasn't necessarily a best practice and the weakness of that approach.

Female: But I can understand early on that it was very important in order to drive action and participation that you simply said, "It's important that everybody look at it," and just make it very low-hanging fruit so that, you know, you could kind of ease people into the process. But if now the auditing and the record keeping is becoming such an onerous task, should we not limit it to things that are going to actually make an outcome difference?

Male: And not practicing in this arena, my understanding is OASIS is a onerous task.

Jean Deleon: According to the home health nurses, yes.

Male: Yes.

Jean Deleon: But, you know, just...

Female: And...

Jean Deleon: ...in general if you were to take this measure and, you know, expand it to even other health care settings, everybody should be doing an assessment, and then everybody should have a plan of care. And where it comes down to making a difference for the patient and their quality is truly in

the interventions and the implementation of the interventions. Are they the correct ones and are you doing them?

Male: And that would be our - idea would be to get to the point of outcome measures rather than process measures.

Female: And to your point that 0539 is the - and I know we haven't talked about that one yet, but that one is the most closely linked I think with the outcome. You know, the other thing - the other thing that I worry about with these measures - and I don't know - but if they're reported as, you know, just individual patients like - in reality I want to know that patients got all three of those. And so again, you know, with the bundle, it wouldn't just be as an agency what my percentage is but it's really - it's at that patient level.

Male: Well, with that, do we want to maybe we can open the discussion further to 539? Mary, do you want to talk a little bit about that and maybe we can ((inaudible)) it, and it sounds like a lot of this is related. So maybe we could have you present that measure and then Tracy could present the final measure, and then we could discuss pressure ulcers in general.

Mary Sieggreen: Okay.

Tracy Wang: Sure.

Mary Sieggreen: I think, first of all, I'm looking at the dates, and they all were endorsed on the same date, August 5, 2009. And all the dates are similar for all three of these measures. And I'm - was looking at the measure that I was addressing, 539 Pressure Ulcer Prevention Implemented During Short-Term Episodes of Care, and wondering why, when we look at the description, why there even was an 0538, because in the description, "Short-term home health episodes in which

interventions to prevent pressure ulcers were included and the physician ordered plan of care implemented."

So that takes care of the plan of care and the implementation together. Also I'm wondering why it has to be a physician ordered plan of care for a prevention of pressure ulcers? It seems like that belongs to the whole care team and that anybody should be able to initiate that. So that was one concern that I had, and I thought, "If we're going to do measuring, we should measure at the highest level, and that would be either implementation or as was previously discussed, the outcomes."

I think it's important to have the measure in some form in here and being looked at, because I think that we need to look at the patient population as they go from an acute care site to home care or to a long-term care facility, there should be some kind of a transition for all of the things that they're at risk for. And it should be - I know it'll never be seamless - but there should be some continuity in that. So we're looking at the same kinds of risk measures and there should be some flow in there.

So that was one concern that I had. Also, I'm looking at the wording in "Denominator Exclusions" on the first page, number of home health episodes in which the patient was not assessed to be at risk. Do they mean to say the patient was assessed to not be at risk or to be not at risk rather than not assessed? I don't know. I'm not sure exactly if that was the intent of that.

But I think that I'm looking at the support, and the support is - the research and the guidelines for supporting all three of these are the same or similar. And seems like they could be combined. And other than that, I think it is important, and I - and also they all come from CMS, so that should be fairly simple to combine them all from the same group.

It's a process and not an outcome, and I'm wondering if we are going to have anybody submit a measure for outcome for this. So I don't have anything else to add to that, other than the comments that were made for 0538.

Male: Great. Well, then - well, there were a number of questions posed there. Did - does someone from - representing CMS wants to comment?

Deborah Deitz: It's Deborah Deitz again. I think that many of your comments that were relevant to the falls risk and assessment and implementation of interventions apply here. We, you know, all three of these things are things that independently if agencies want to examine their processes and make sure that they're doing the steps necessary to make sure the patients get high quality care, they would want to see where, you know, they might be falling down.

But the idea that, "Did the patient receive all three of those steps," as a - as sort of a bundle to measure, I think definitely has some value and something that we, you know, would be interested in talking further with you about.

I can also address the issue about the physician ordered plan of care, and that has to do with the way that agencies develop a care plan. It's not like there are - it's not as if there's a separate care plan and then there's the physician ordered one. The physician ordered one is sort of their care plan that the physician signs.

And we are - what we - as we developed this measure, we realized that - and from working with agencies - that if it's not actually in the physician ordered plan of care and it's just something that one of the nurses who's providing care or the PT thinks is a good thing to do, but it's not actually in that physician ordered plan of care, it won't be known to the entire care team. And that's why it was specified to be in the physician ordered plan of care, which is really the agency's and the team's plan of care, but it...

Female: So it's like an order set then?

Deborah Deitz: Pardon me?

Female: It's like an order set from the physician?

Deborah Deitz: Yes, yes. So what agencies are doing since this, you know, became, you know, part of the OASIS reporting and data collection, is that they're making sure that once they assess someone as being at risk, that they develop those lists of the - of what the interventions are going to be and they submit that as part of the plan of care to the physician who then signs off on it. But then that's available to all the team members who are caring for that patient.

I don't know if there were any other questions that...

Eugene Nuccio: Deborah, this is Gene Nuccio from University of Colorado. Let me - the question about the denominator exclusion, those are patients who were assessed, but the result of the assessment indicates that they were not at risk for a pressure ulcer. So it's perhaps a grammatical issue.

Mary Sieggreen: Okay.

Male: So Mary, did that answer all your questions?

Mary Sieggreen: Yes, thank you.

Male: Okay. Excellent ((inaudible)). So let's go ahead then and move to 540. Tracy, this is a pressure ulcer risk assessment conducted. Why don't we go ahead and present this or any questions, and then we can, again, widen the discussion to all the pressure ulcer measures. Go ahead, Tracy.

Tracy Wang: Sure. Thank you. So again, this is a CMS measure. It's a process measure, and it's collected using clinical data and reported to the OASIS system. It's looking at the percentage of the home health episodes of care where the patient was assessed for risk of having or developing pressure ulcers using - evaluating clinical factors or a standardized tool. And this is done at the beginning or resumption of care.

I think this is a very important measure, and it's, again, it's currently reported already. But there's definitely still room for improvement. I do feel that the body of evidence presented is quite strong that, again, studies on home health care settings are just some ((inaudible)) up to date, and I think the major weakness and many have pointed out earlier is that there is a lack of predicted value to linking those to quality or an outcome. But it does pass the face validity assessment from the typical panel.

And I'm also in favor of looking at this particular measure as a bundled measure with the previous two. And I think that's about it.

There were some, I think, if I was looking at the preliminary evaluations, so it's somewhat divided, but most of all, we think that this is a pretty good metric.

Male: Great. Thank you, Tracy. Any specific comments about this measure or about pressure - the pressure ulcer set of measures?

Pat Quigley: Well, this is Pat Quigley. And my question related to this one, and it was kind of like my question when we were at our face-to-face meeting about the pain risk assessment. Isn't this just so - isn't this done? I mean is this something that still needs to be monitored?

I - you know, whenever I look at the observed rate under (1.1B4), I mean this is like it's so highly done. If this is something that really still needs to be here. This is like a fifth vital sign or something. Because all this is is measuring whether or not someone had a pressure risk assessment done. It's not, you know, how at-risk they were. Am I right? Ought oh.

Mary Sieggreen: This is Mary Sieggreen. And I think the problem is we still have pressure ulcers, so we're going back to try and figure out what's going on here. And maybe we don't need the pressure ulcer assessment to be documented, but we need to know that the appropriate things are being put in place for implementation.

And then what happens when we do that? And if we think they're appropriate and we put it in place, and they still get pressure ulcers, how do we - how do we reconcile that? Are these those same kinds of problems that were unavoidable pressure ulcers or did we pick out the wrong interventions?

Pat Quigley: Right, because I know in my practice in the VA - I mean 100% of our patients get assessed for pressure ulcer risks.

Mary Sieggreen: Well and when we look at - when we look at people who are doing the assessments, sometimes they don't understand the tools they're using.

Pat Quigley: Yes, and, you know, that's why we had that discussion about pain risk. You know, that's a whole other issue. That's a practice issue. It's not, you know - that's something that should be dealt with in the home health agency just like we would deal with it in the hospital. If there's a

clinical practice issue, we're going to go back and deal with it. But I don't know that that brings it to the National Quality Forum related to patient safety and trying to move outcomes in a different way. That's a clinical practice issue.

So that's why my question related to this - even - it's important. I mean I think everybody's doing it, but if it's so well done, do you need to still monitor it? I mean it looks like there's other issues that need to be in place like, you know, is it indeed a multifactor in plan of care? Is it interdisciplinary? What's preventable versus non-preventable pressure ulcers? How involved is the family in their role in prevention? I mean home health staff are only in there for a short period of time.

So those - that was my question really is that this is so over-monitored and is an expectation of practice that this is done.

Mary Sieggreen: I think...

Female: And yet if we still think there's a problem, if there's still are pressure ulcers, then maybe these measures are not helping us to target interventions to decrease that.

Pat Quigley: Right, because it's a screening tool. You know, ((inaudible)) by using the Braden score - scale or something like that. That doesn't work, but usually the Braden Scale - I mean they assess the risk.

Female: Right, right.

Mary Sieggreen: And what we're finding in the hospital too is, you know, as we learn more and more about how pressure ulcers develop and the whole business of the relationship with DTI, people don't even recognize what they're looking at. So again, that's another issue. But - so maybe just

checking whether they had an assessment or not , we're looking at the wrong component of the assessment

If they're looking at a scale but they're not looking at the patient or they're not knowing what they're looking at and that's really getting around looking at this measure. But we still have a problem so how do we address the problem?

Male: Just to focus your attention there - as part of this admission form there is a section for a performance gap. And, you know, the pressure ulcer measures are not at 100%.

Female: I'm sorry, where's the performance gap? Is it under 1?

Male: Yeah...

Female: ...gap is 1b-2...

(Crosstalk)

Female: ...top of Page 3. Yes and so looking at the (Oasis) data so the average - so it's 91%, it's still for the 25th percentile nationwide so I guess, you know, there is still room for improvement.

Janet Nagamine: You know - this is Janet. I'm just struck by the repeating themes here and the notion of yes we assessed something but did we do something and did it change anything. And the concept of bundling, you know, ventilator associated pneumonias with that bundle they made incredible changes in outcomes.

And I know we're not in the business of bundling but I have to wonder if our ultimate goal is to improve outcomes, you know, how can we modify this metric-making process to help people be more successful and to capture and measure what's actually happening?

As you mentioned earlier are we just documenting and not doing or are we doing the wrong thing? How can this inform us to get to the next stage? Because I agree continuing to measure - even if we're at 91% or 98% if it's not making any difference we've got to do something different. And what is that difference?

And just something to ponder about the notion of bundling and step-wise or layered metrics that help people to tackle a problem in a step-wise fashion that might inform them about what accounts for the success or lack of success.

Pat Quigley: So this is Pat Quigley. You know, maybe this comes back to, you know, like the indicator for falls is how do you deal with risk management? You know, what do you do when you do the risk assessment? And the agency average that I see here is 91%, I mean, that's pretty good.

But, you know, just to document whether or not a risk assessment is conducted is not necessarily - I'll just come back to that - it's not, I mean, that sets an expectation of process and it has been for 20 years at least in nursing I know - however long - go back and look at the year that the Braden Scale came out and the Norton Scale.

Janet Nagamine: Yeah, I think we could raise the bar a little bit.

Iona Thraen: And this is Iona. And of course, you know, I support that.

(Crosstalk)

Iona Thraen: You didn't think I fell asleep.

Female: No we didn't.

Male: So I have a question which is do we think the problem has to do with the implementation of the, you know, the action plan based on the findings or is it that, you know, we have weak scientific connection between doing the assessment and outcomes? You know what I mean? I mean so I'm thinking back to what we talked about before with the falls.

We know that screening plus intervention makes a difference; there's good science on that. But we don't know - but we don't know how to separate the two pieces. We assume that if somebody does a screening that that leads to an intervention because we know that the combination makes a difference. Is that the issue - the scientific connection?

Janet Nagamine: I think it's the check the box syndrome. I think...

(Crosstalk)

Janet Nagamine: ...a lot of times we say we did stuff but what did you actually do? Did you do what the intervention really was? Did you do part of it? Did you do all of it? Did you do an ineffective one? I think that's the huge gap. What exactly did you do that you said you were doing?

Pat Quigley: Well and this is Pat. I would say probably it's just - it's very similar to falls too. I mean, there's absolutely no evidence, even in hospitals, that a nurse-led, nurse-managed fall prevention program works. It has to be multi-(factorial) and interdisciplinary. So it's the same thing with pressure ulcers.

And maybe that's why, you know, having a physician ordered prevention program is there because it has to be multi-(factorial) and interdisciplinary.

Jean Deleon: This is Jean Deleon. I think a lot of it when you look at inpatient and home health is it's also the consistency. You don't assess somebody once and think that the intervention that you may have come up with from that one assessment will continue for the next six weeks. You have to go back and reassess the patient and reassess what interventions need to be done and maybe they need to be changed.

When you bring them in the hospital - and I admit a lot of patients for pressure ulcers that failed in the home health setting and mostly what I do is exactly what they were supposed to be doing at home but I can enforce it in the hospital on a daily basis so I know that that the prevention interventions are done every day consistently.

Pat Quigley: Right...

Jean Deleon: ...they just didn't get enforced and nobody reassessed to see if they changed, got better, got worse...

Pat Quigley: Right and it doesn't mean you have to use a Braden Scale every shift either every day.

Jean Deleon: No absolutely not. But that's not necessarily going to just that one Braden in the very beginning, I mean, you do have to go back when your patient has some other issue in the home health setting; maybe something is changed, they stopped eating, they got a urinary tract infection...

Pat Quigley: Exactly.

Jean Deleon: ...they were getting up but now they're not, something.

Pat Quigley: Right, right.

Jean Deleon: But the measure doesn't account for that. But a lot of...

Pat Quigley: Exactly.

Jean Deleon: ...a lot of the care can be the right intervention and that was the original question, is it the intervention? Is it the scientific data? I think you won't - you won't know that unless you study that intervention when it's done on an inconsistent manner and a consistent manner whether it's the right intervention or whether it was implemented appropriately. But that's a different measure whether it was implemented.

Female: Whether it was implemented at all because I think whoever had mentioned the check the box thing one of the studies that (Barbara Braden) talks about is a study of turning the patients and all the boxes were checked if you look at the documentation but they had little sensors on the side of the patient's thighs to know which side they were turned on and when.

And it turned out that reported every two hour turning was really turning every three to five hours. So you know, that's something else - that's another issue. But you would only uncover that if you were doing a research study or if somebody was following these - the caregivers.

(Crosstalk)

Female: And that kind of work is typical quality improvement work too in addition to research. And I think if you've got measures that help point you in a direction so that you do further assessment, so looking at sort of the outcome in this case, I think if you're looking at, you know, was there an

intervention and then what's the outcome? And if you're still having poor outcomes then it makes you look back and say well what exactly about the process do I need to change?

Female: Right. Right.

Iona Thraen: This is Iona. I want to jump in a little bit with this conversation. In terms of the way the measures are currently being constructed, aside from our previous conversation, is more of a cross sectional look. And what you all are speaking to is the idea of a sort of a stream of data elements that would indicate so if you did a screening, the screening led to an assessment, the assessment led to a plan, the plan led to an action...

Female: Right.

Iona Thraen: ...and those action components are coming out of maybe an electronic medical record in terms of a physician order or a lab result or a nurse documentation or a physical therapy charge of some sort. So you're actually now sort of extending this notion of a cross sectional rate approach to more, again - and bundle is maybe not the right word but a stream of measures that get at the question you're trying to answer.

Female: And I think you're right to call it a bundle but again it's a bundle at the patient level; it's not at the agency level.

Iona Thraen: Well and then that can be - if you're doing it - if you're approaching it from a patient level and you're using electronic sources, etcetera, and you have this stream of measures those things then can be rolled up at a facility level so you can look to say that well 98% of our patients got screened and 50% of them were positive then only 25% of the positive ones actually got the assessment and of those 25%...

Female: Absolutely.

Iona Thraen: ...that got the assessment only 5% actually got a physician's order that said turn every two hours or whatever, you know, whatever that action-oriented piece is dot, dot, dot, dot. So it's almost a cascading approach that starts with the cross sectional but then drills down, you know, at the individual patient level that rolls up into more of a systems approach.

Female: I agree and I think that really helps drive the improvement efforts because you have a better understanding of what's working and what's not.

Janet Nagamine: Right and did A, B and C happen or did A happen but not B or it breaks it down into sequence or a series of steps and interventions. And I just wanted to quickly echo the check the box syndrome as an unintended consequence of these measures.

You know, I think over the last decade I joke around that we've gone from measuring nothing to measuring everything. And I think that nurses are pretty overwhelmed; quality departments are pretty overwhelmed. And I see a lot of the checking boxes things that don't correlate with what's actually happening and with what people said that they did.

So I just think we need to keep that in mind as we look at meaningful measures and these assessment ones.

Female: ...unintended consequence of EMR.

Saul Weingart: Yeah, yeah. So this is Saul. I guess one of the questions is how to implement some of these very creative and thoughtful ideas you've all been raising and whether - I guess one approach would be, you know, we're making this up as we proceed, we're raising the bar with each iteration. And, you know, we're making case law.

And the other approach would be, you know, we've articulated an approach and a concern that we think should guide further measure development. We're putting measure developers on notice that next iteration they're going to have to demonstrate not only that the documentation is done by that there's clinical practice that's behind it and that is connected to an improvement.

I mean, my preference I think would be to give the developers a head's up that we're raising the bar so that they can decide whether they think it's worth submitting a measure that may not pass muster next time around.

Iona Thraen: I would add to that. I agree with what you just said. I would add not only to - a head's up to the developers but sort of a head's up to NQF...

Saul Weingart: Yeah.

Iona Thraen: ...as an organization that says as a measure enters a certain stage of maintenance whether it's the first three years or the next three years, whatever the case might be here are the increasing expectations that are going to occur associated with that stage.

So that when the vendors and the developers actually look to complete the application for the next round of maintenance...

Saul Weingart: Yeah.

Iona Thraen: ...you know, it's consistent with what we expect and then they can respond accordingly.

Saul Weingart: Okay.

Janet Nagamine: Yeah, I don't see a lot of that so I do think that's worth calling out.

Male: Great and that's definitely something that we can, you know, discuss and look into at NQF. Great, well this has been I think a really fantastic discussion. Are there any additional comments about the pressure ulcer measures? Or any outstanding questions that we missed?

Iona Thraen: If we did we should be shot.

Male: Well we've got another shot at the in-person meeting to...

Iona Thraen: You still have a half hour, you know.

Male: Well we - if we want to end early I've got no problem with that. But so any additional questions, comments, anything from - anything that the developers wanted to mention or any plans to respond to any of the discussion before the in-person meeting?

Deborah Dietz: It's Deborah Dietz. I just wanted to say that we are extremely - we've been kind of emailing each other back and forth - the clinical - the development team - and we're just extremely grateful for the thoughtful review that you've given our measures. It's just - it's very gratifying to us because we certainly have worked long and hard on these and you've raised some really interesting points. And it seems like you really get it and you - and it's very exciting for us to have that so thank you.

And in terms of, you know, whether or not we want to be thinking about even not before - either at the next iteration of these measures or before your next meeting whether we want to think about sort of bundling and that the measure would be did the patient get an assessment, an appropriate intervention and that intervention was carried through? You know, do we want to try to do that now or later? I think we need to discuss with CMS.

Male: Okay I think that's a really great point. Any additional comments?

Saul Weingart: This is Saul. What are we supposed to do before next time? Are we going to do another grid or...

Male: Well we'll have another round of preliminary evaluations and we'll send those out to the full committee so we'll ask you to do more evaluation before the steering committee meeting and we'll do those again to base our discussion around at the meeting. So we'll send you the full set of measures and request that you take a look at all of those.

Saul Weingart: Okay thank you.

Male: Great.

Male: Well why don't we go ahead then - Andrew, why don't you go ahead and take it from here? We're going to...

Andrew Lyzenga: Yeah, we should open up the lines for public comment if the operator could just either open up the line for the public or have - prompt for public comment.

Operator: And all lines are open.

Andrew Lyzenga: Okay. Is there anybody who'd like to make a public comment at this time? Sounds like not.

Iona Thraen: This is Iona. I'm going to say one thing. See what happens when you have an ER doc directing the show? We are going to finish a half an hour early.

Male: Did a good job.

Male: Thank you.

Andrew Lyzenga: All right well then the only thing I would note is that you should have received some information related to travel and registering for the meeting. Let us know if you still have any questions about that or if you need any help setting up your travel plans or anything like that and we'd be happy to get you to the right person to help you out with it.

And beyond I think that's it.

Female: Thanks, Andrew and Jessica.

Female: Thank you.

Male: Okay thank you everyone.

Female: All right, bye. Bye everyone.

END