

NATIONAL QUALITY FORUM

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PERSON- AND FAMILY-CENTERED CARE PHASE 2
STANDING COMMITTEE MEETING

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THURSDAY
JANUARY 22, 2015

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Lee Partridge, Co-Chair, and Chris Stille, Acting Co-Chair, presiding.

PRESENT:

LEE PARTRIDGE, Co-Chair, National Partnership
for Women & Families

CHRIS STILLE, Acting Co-Chair, MD, MPH, FAAP,
University of Colorado School of
Medicine/Pediatrics University of Colorado
School of Medicine & Children's Hospital
Colorado

KATHERINE BEVANS, PhD, University of
Pennsylvania School of Medicine and
Children's Hospital of Philadelphia

SAMUEL BIERNER, MD, UT Southwestern Medical
Center

REBECCA BRADLEY, LCSW, National Director of
Quality Standards and Case Management
HealthSouth Corporation

DAVID CELLA, PhD, Northwestern University

SHARON CROSS, LISW, The Ohio State University
Wexner Medical Center

DAWN DOWDING, PhD, RN, Visiting Nurse Service of
New York and Columbia University School of
Nursing

SHERRIE KAPLAN, PhD, MPH, UC Irvine School of
Medicine

SHERRI LOEB, RN, BSN, EMMI Solutions

ANN MONROE, Health Foundation for Western &
Central New York

LISA MORRISE, MA, Patient & Family Engagement
Affinity Group National Partnership for
Patients

ELIZABETH MORT, MD, MPH, Massachusetts General
Hospital/Massachusetts General Physician
Organization

ESTEE NEUWIRTH, PhD, Center for Evaluation and
Analytics and Care Management Institute
Kaiser Permanente

LENARD PARISI, RN, MA, CPHQ, FNAHQ, Metropolitan
Jewish Health System

DEBRA SALIBA, MD, MPH, UCLA/JH Borun Center, VA
GRECC and Rand Health

PETER THOMAS, JD, Powers, Pyles, Sutter &
Verville, PC

CARIN van ZYL, MD, FACEP, Palliative Care,
Supportive Medicine City of Hope National
Medical Center

NQF STAFF:

NADINE ALLEN

HELEN BURSTIN

MITRA GHAZINOUR

ANN HAMMERSMITH

MARCIA WILSON

ALSO PRESENT:

SOPHIA AUTREY *
JEROME CONNOLLY
KEZIAH COOK *
BETH DEMAKOS
ANNE DEUTSCH
DANIEL DEUTSCHER
DAVID GIFFORD
CHRISTINE GOERTZ *
JAYNE HART CHAMBERS
DAVID HITTLE *
BEN JOHNSTON
NICOLE KEANE *
MARJORIE KING *
TRACY KLINE *
STEVE LICHTMAN *
JASMINE LARSON *
JANE LUCAS *
STACY MANDL
TARA McMULLEN
PAULETTE NIEWCZYK *
POONAM PARDASANEY
COLLETTE PITZEN *
LINDA RESNIK *
GARY REZEK *
ANGELA RICHARD *
JEANNETTE SHRIFT *
LAURA SMITH
ANITA SOMPLASKY *
ELLEN STRUNK

MARK WERNEKE

TRACY ZHENG

* Present via telephone

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Adjourn

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

2 8:34 a.m.

3 CO-CHAIR PARTRIDGE: Good morning
4 everybody. I know we're still getting
5 caffeinated and all that early morning fog is
6 still clearing a bit, at least for me.

7 But, we want to be able to move along
8 pretty expeditiously this morning. We are losing
9 people. We've already lost, I think permanently,
10 Carin van Zyl, who's ill and she indicated she
11 would try to phone in from her hotel room. But,
12 frankly, I'm hoping that she's sleeping and
13 getting better before she has to fly back to
14 California.

15 David is heading off to NIH to make a
16 speech and I know that Deb and Esther, I believe,
17 are both slated to leave at noon, or maybe Esther
18 is not. You're okay.

19 Okay, I've had this in my head that we
20 had a couple of people with planes that were the
21 -- that they had to leave by noon and Chris has
22 to leave for his plane by 2:00.

1 So, we may lose our quorum at noon, in
2 which case, I think almost certainly we're losing
3 our quorum at noon, in which case we will
4 continue with our discussion of the measure, we
5 will just not vote in person on them. And if we
6 need to discuss then still further on our call,
7 we'll make this judgment at the end of today.

8 If we need to discuss them further on
9 our scheduled call next week, we will. If we
10 don't, we'll send a SurveyMonkey survey out
11 fairly promptly after this meeting and we'll vote
12 by email.

13 We will probably also not attempt to
14 do the discussion of related and competing
15 measures. However, I do want to call your
16 attention to the part of the package that was in
17 front of us is a cheat sheet that Sarah put
18 together to help us as we think about related and
19 competing.

20 I recommend not losing it because
21 she's laid out quite nicely the difference in a
22 chart form, the differences between the various

1 measures. And I personally find it very useful
2 as I'm trying to keep in my head what I'm
3 considering as related or competing.

4 CO-CHAIR STILLE: That'll be your
5 homework for the trip home is to review that.

6 CO-CHAIR PARTRIDGE: Right. So with
7 that, I'm going to turn the gavel over to Chris
8 who's going to take us through the first set of
9 measures and we'll do housekeeping.

10 MS. SAMPSEL: So, we do have just a
11 couple of things.

12 One, I know for some folks, there were
13 some issues at the hotel with how they were doing
14 charges. Some people they put on the master
15 bill, some people they charged your credit card.
16 They have somebody's suitcase in hostage. And
17 we'll try to -- you know, we have our meeting
18 department working on that to figure that out.

19 But everything was supposed to be
20 direct billed, so if your credit card was
21 charged, we ask that you watch it, notify us
22 because we'll try to get all -- the goal is to

1 get all of those charges reversed.

2 I somehow got a new scarf last night.
3 It showed up on my chair at the restaurant and I
4 don't think I have kleptomania issues. But if
5 this is anybody's scarf, it started living with
6 me yesterday and I apologize because I didn't
7 intend to take it. And it's nice, it's cashmere,
8 it's made in Germany.

9 And then, you know, I think, Liz, I
10 don't know if you're prepared, I think you had a
11 couple of questions.

12 But I think the other thing we just
13 wanted to do was kind of regroup a little bit and
14 I want to remind you all that you do have the
15 decision logics, algorithms in front of you on
16 how to work through each measure based on what is
17 presented regarding importance in evidence and
18 then through scientific acceptability.

19 You know, I think we want to make sure
20 that if anybody has questions on how they should
21 be voting based on information presented that you
22 ask that before we vote. But, you know, and we

1 don't want to spend a whole lot of time kind of
2 rehashing criteria, but if you do have that need,
3 we can certainly do that.

4 We also just wanted to revisit where
5 we were yesterday or what we ended up with
6 yesterday and out of the 28 measures, we did make
7 it through 13. So, I think, you know, there's
8 some success there. We got into the double-
9 digits.

10 And the first slide, just, you know,
11 as a recap with the FOTO measures, so 0422
12 through 0428, those were the measures that are
13 technically in NQF-speak are currently not
14 recommended because they failed at the importance
15 criterion and the developers will have the
16 opportunity to provide more information prior to
17 the end of public comments. So, we will re-
18 discuss these measures.

19 We did not -- we only got to, this is
20 I think the highlight of the day, 0688 is, you
21 know, went through as recommended. The other
22 measures we will be discussing today, actually

1 those will be later this morning.

2 And then for long-term care hospitals
3 and some of the outpatient rehab for long-term
4 care, 2631, which was the percent of long-term
5 care hospital patients with admission and
6 discharge functional assessment and a care plan,
7 that measure was not recommended. It did not
8 pass the importance criterion.

9 With outpatient medical, with the
10 outpatient measures, we made it through all of
11 those where we had one recommended, one not
12 recommended and two in the gray zone.

13 The gray zone measures do move forward
14 as recommended but we will re-discuss those as
15 well.

16 So, that's where we were with those
17 and if anybody has any questions regarding
18 process and kind of overall criterion
19 adjustments, if we could do those now before we
20 start heading into the measure discussions.

21 MEMBER MORT: I just had a question
22 about, I felt, and maybe if I read these

1 algorithms in a more detailed way I would
2 understand how we did what we did.

3 But, I thought at the end when we
4 recommended the pre- and post- six-minute walk
5 test for pulmonary patients that it passed as an
6 endorsed measure. But what they recommended,
7 what they were proposing wasn't the pre- and
8 post-, they're proposing a percent change across
9 patients.

10 So, I thought we sort of gave them a
11 by and we went ahead and approved it anyway. And
12 I felt that we had been a little bit more strict
13 in looking at exactly what the recommended
14 measure was and critiqued it based on exactly
15 what the developer was proposing earlier on.

16 Am I the only one who felt that way?
17 And I think in some -- if I am, then --

18 MS. SAMPSEL: I think that's what I'm
19 just trying to look around and see if there's
20 folks who are.

21 MEMBER KAPLAN: What bothered me a
22 little bit was the shift from the morning to the

1 afternoon and it was some part of sort of a
2 direction that -- and maybe this is not what
3 you're getting at, Liz, but I thought we kind of
4 were shifting into we're going to look at, you
5 know --

6 Usually, I understood that NQF only
7 reacts to what it sees, not what it thinks it
8 could see if other analyses were done or
9 different changes were made or, you know,
10 different assumptions were held or something.

11 And, Sarah, I kind of felt that same
12 shift from morning to afternoon that we were kind
13 of maybe doing things differently in the
14 afternoon than we have done in the morning.

15 MS. SAMPSEL: Well, I guess my
16 question then would be -- I mean there were
17 differences in the measures. So, in the morning
18 we really were, I would say the vast majority of
19 the measures were patient reported performance
20 measures, the PRO-PMs and in that case, the NQF
21 standard is higher than just the outcomes and the
22 process measures.

1 So, I don't know if that was part of
2 the shift that you were seeing that there really
3 is a difference in the criteria based on those
4 measures and I guess, you know, as staff, we can,
5 you know, keep that under consideration of, you
6 know, how do we make sure that we separate those
7 out well so that there's an understanding of the
8 shift.

9 CO-CHAIR STILLE: I think that was a
10 particular issue with, I think it might have been
11 the last one we talked about because they were
12 proposing to use it for accountability at the
13 organization level and they had only tested it at
14 the patient level and we had a lot of problems
15 with that.

16 MEMBER MORT: That's exactly the one
17 that got me a little muddled at the end. And I
18 think in part it's because these patient-reported
19 performance measures are new.

20 Having been on the group that worked
21 through the concepts a couple of years ago, it's
22 difficult to sort of get through it

1 methodologically and understand exactly what a PM
2 is or a PRO-PM is. So, I can understand the
3 developers are working through that as well.

4 So, I guess what I would ask is,
5 today, if the chairs and facilitators would just
6 be really clear as to remind us and help coach us
7 along as to exactly what measure is being
8 proposed so we have the right construct in our
9 head and then we can move through it in a more
10 reliable way I guess is what I would say rather
11 than shifting a little bit.

12 MS. SAMPSEL: Okay. And then I think
13 the other thing that, you know, regarding, I
14 think that as your 0701, what we can do with that
15 is, you know, and this with all of the measures,
16 is we have the -- we'll write the report, there's
17 the public comment period and then there's a
18 post-public comment call where you always have
19 the opportunity to say, this isn't what we were,
20 you know, we approved or this is a totally
21 different concept and we can reopen that vote.

22 MEMBER KAPLAN: Can I ask one other --

1 and not to slow us down, but can I ask one other
2 clarification question?

3 Some of what I've been looking at and
4 reading the reliability and validity sections in
5 these measures, they use the reliability at the
6 patient level and they're very careful to
7 document how reliable it is at the patient level.

8 But then the proposed use is at the
9 facility level and there is no evidence of
10 reliability at the facility level.

11 So, is NQF, what's the instruction to
12 us on that issue?

13 MS. SAMPSEL: And we tried to get at
14 that a little bit yesterday. And so, when you
15 follow through the algorithm what it does is that
16 you almost to the bottom.

17 And so, the first criteria is did they
18 perform reliability or validity at that measure
19 of population level that they're reporting at?
20 And if the answer is no, you go down another
21 level and did they do it at the patient level or
22 item level if it's off an instrument?

1 And then if you follow that across,
2 you get to the point of you can vote it as
3 moderate or low.

4 So, frankly, the criterion is it's an
5 and/or criteria. You either do it at the measure
6 level and the patient level or you do it at the
7 other level but you have a lower grade of, you
8 know, you would give them a lower rating when we
9 vote.

10 MEMBER KAPLAN: So and now, why
11 wouldn't you give it an insufficient? Because if
12 there's no evidence, I mean if there's one level
13 of evidence but the level of evidence that
14 they're proposing to use the measure at is not
15 there, why wouldn't you give it an insufficient
16 data? Because you don't know if it's going to be
17 low until they run the runs.

18 MS. SAMPSEL: And I'm not sure I'm
19 really the best person to answer that one. But I
20 think technically you could, as a committee
21 member, give it insufficient. So, your choices
22 there at the bottom, you could do that.

1 But I would also say that, you know,
2 I think even Helen admitted that, you know, the
3 kind of difference in criterion between if it's
4 process outcome or the patient-reported outcome
5 is something that I think NQF needs to revisit.

6 And especially for these measures.
7 And I think that's bringing -- these measures are
8 bringing that to light that that really is an
9 issue.

10 CO-CHAIR STILLE: And Sherrie, you
11 would say insufficient because the developers
12 might actually have those data that they can then
13 bring back and present, yes.

14 MEMBER KAPLAN: Yes, I mean you want
15 them to get -- if they have the data or they have
16 an opportunity to get you the data, you'd
17 certainly want to have it rather than give it a
18 low because it's already been done and it's low,
19 I would feel much more comfortable --

20 CO-CHAIR STILLE: That makes a lot of
21 sense, yes.

22 MEMBER KAPLAN: -- saying it's

1 missing, you know.

2 MEMBER MORT: And I just have one more
3 question about goals.

4 I was under the impression that when
5 we were approving measures for NQF endorsement,
6 the construct was these measures would be used
7 for accountability purposes and not for QI
8 purposes.

9 And if that's changed, and that's what
10 I thought I heard peppered throughout the
11 conversation yesterday, I just want to have
12 clarity around that because that would change my
13 whole way of thinking about the voting if we were
14 approving them for QI.

15 Oh, here's Helen.

16 And if the criteria for acceptance or
17 endorsement include both acceptability as an
18 accountability measure or suitability as an
19 accountability measure or a QI measure, that
20 makes me think about it slightly differently.

21 So, could we get clarity on what we're
22 endorsing, Dr. Burstin?

1 DR. BURSTIN: Yes, Dr. Mort, yes.
2 It's, again, a perennial issue for us. At this
3 point, we do have an expectation that a measure
4 that's endorsed by NQF is available for all
5 purposes. That could include, you know, QI.

6 I think what we don't have are
7 measures purely for QI. And I think there's
8 always an expectation they can fulfill the full
9 range of accountability applications as well.

10 As I mentioned yesterday, that's in
11 play as we move to potentially moving towards
12 endorsement by ratings or grades or intended use.

13 MEMBER MORT: So, it has to be good
14 enough for accountability, but of course, it
15 could be used for anything?

16 DR. BURSTIN: Exactly.

17 MEMBER MORT: Is that the way we think
18 about it?

19 DR. BURSTIN: Yes.

20 MEMBER MORT: Got it.

21 DR. BURSTIN: Good.

22 MEMBER MORT: Thank you.

1 CO-CHAIR PARTRIDGE: And ideally,
2 accountability and public-reporting, but
3 obviously, in a number of instances the public-
4 reporting is planned as down the road, it hasn't
5 been used that way yet.

6 MEMBER MORT: Thanks for the
7 clarification.

8 CO-CHAIR STILLE: Okay, great. Let's
9 begin our long task this morning.

10 We're going to start, I don't know if
11 we mentioned, the order is going to be pretty
12 different to both facilitate speedy reporting and
13 speedy analysis and also help people that need to
14 go to different places.

15 We're going to start with the UDSMR
16 measures 2287, 2286 and 2321.

17 We're then going to do the American
18 Health Care Association measures 2613 and 2612.

19 After the AHCA, we'll do the CMS
20 measures 0167, 0174, 0175, 0176 and 0177.

21 And then the IRF ones from CMS 2635,
22 2633, 2634, 2636 and 2632.

1 And hopefully, we'll get through most,
2 if not all, of those. If we -- we may well lose
3 our quorum and if that happens, we'll have
4 discussions but not voting right now. So that's
5 going to be the plan.

6 MS. KEANE: Hello?

7 CO-CHAIR STILLE: Hello?

8 MS. KEANE: Hi, this is Nicole Keane
9 from Abt Associates. We're the contractor for
10 the five measures from Home Health that were at
11 the end Day 1.

12 Usually when the day goes over, we
13 start with the measures that were meant to be
14 done on Day 1.

15 And our developers are shifting their
16 schedules so that they can be available this
17 morning. We are going to lose people at 10:30.

18 CO-CHAIR STILLE: Okay, and which
19 measures are those?

20 MS. KEANE: 0167.

21 CO-CHAIR STILLE: Okay, yes. We
22 anticipate --

1 MS. KEANE: So, I would respectfully
2 request that we could --

3 CO-CHAIR STILLE: Right, right, we
4 still need to do UDSMR first. We will -- I
5 believe we'll be able to get those done this
6 morning, but so we may do some shifting depending
7 on how long the UDSMR measures take. Does that
8 make sense?

9 MS. KEANE: Thank you.

10 CO-CHAIR STILLE: Great. Great.

11 Okay, so we'll start with 2287,
12 Functional Change in Motor Score at IRFs and I
13 believe Sam and -- no 2287, Sam and Deb were the
14 discussants for that and they're both here and
15 that's good. So, okay, go ahead.

16 MS. DEMAKOS: I'd just like to confirm
17 that Dr. Paulette Niewczyk is on the phone with
18 me as well. Paulette, are you there?

19 MS. NIEWCZYK: Hello, I'm here.

20 MS. DEMAKOS: Okay, great.

21 So, first of all, I would just like to
22 thank everyone. Our schedules are shifted a

1 little bit, that may be a good or a bad thing,
2 depending on how early morning you're used to
3 being.

4 But, I'd like to thank the committee
5 for their work and for the opportunity to present
6 our measures to you.

7 Just as a little background, in 1987
8 a task force of physicians, therapists and
9 researchers was charged with establishing an
10 instrument to measure functional outcomes,
11 medical rehabilitation and patient burden of
12 care.

13 After three years of research, measure
14 development and instrument testing and
15 validation, the FIM instrument was developed.

16 The FIM has been endorsed by the
17 American Academy of Physical Medical
18 Rehabilitation and the American Congress of
19 Rehabilitation Medicine.

20 The work was a result of a federal
21 grant awarded to the researchers at the Center
22 for Functional Research, CFR, at the University

1 of Buffalo. Today, CFR remains a division of the
2 U.B. Foundation and is housed within UDSMR. It's
3 also a not-for-profit division of the U.B.
4 Foundation whereby the subsequent maintenance of
5 the FIM has been occurring for the past 25 years.

6 For those not familiar with the FIM,
7 it's an 18 item measure that measures patient
8 function and burden of care. It's currently used
9 across the post-acute care continuum which speaks
10 to the core measure set that was mentioned
11 yesterday, and we do have subsets that are
12 abbreviated versions for other venues.

13 Each item is rated on a scale from 1
14 to 18, I'm sorry, 1 to 8 7 which refers to -- one
15 refers to complete dependence, seven which refers
16 to complete independence and the overall range is
17 18-126.

18 It might help to bring up the measure
19 form that we submitted with this so that people
20 can see a visual.

21 We're thrilled that the functional
22 measures are now being considered by the Patient

1 Family Centered CARE Committee.

2 Function affects every person and
3 function is a high priority for patients in all
4 venues of care. A greater level of function
5 allows a greater level of independence for the
6 patient and a decreased burden of care on family
7 members in care settings.

8 The FIM has been used by thousands of
9 clinicians from interdisciplinary rehabilitation
10 teams for case management, monitoring and patient
11 goal setting. And patients can be directly
12 involved and we encourage that by participating
13 in goal setting with their care givers.

14 The FIM provides estimates of patient
15 burden of care. In other words, the number of
16 hours the patient requires one-on-on assistance
17 from another person for personal care on a daily
18 basis in the home setting and community.

19 As the FIM ratings increase, the
20 minutes of care per day decreases. The FIM
21 contains several subsets of measures within,
22 three of which we are putting forth today for

1 endorsement.

2 The proposed change in measures score,
3 Measure Number 2287 that has been put forth by
4 UDS is constructed by utilizing a subset of 12
5 items from the FIM, eating, grooming, dressing
6 upper body, dressing lower body, toileting, bowel
7 management, transfers to bed/wheelchair or chair,
8 transfer to toilet, locomotion/walk or
9 wheelchair, locomotion/stairs, expression and
10 memory.

11 These items are currently collected in
12 the IRF setting and imbedded in the IRF-PAI as
13 the instrument developed by CMS and used for the
14 IRFs to assess functional outcomes and for
15 payment by Medicare. So the burden of collection
16 is low as the IRFs have routinely collected these
17 measures.

18 The change in self-care that we're
19 putting forth as well which is Measure 2286 and
20 the change in mobility which is 2321 are also
21 subsets of the FIM and subsets of the form that
22 we're putting forth today for mobility.

1 And I think I'd like to turn it over
2 to Paulette to talk about the evidence.

3 CO-CHAIR STILLE: Just quickly, if any
4 of you are following along, it's one of the
5 Appendices in the SharePoint.

6 MS. NIEWCZYK: Hello? Can everybody
7 hear me?

8 CO-CHAIR PARTRIDGE: Yes.

9 MS. NIEWCZYK: Okay. Thank you so
10 much, Beth.

11 My name's Paulette Niewczyk and I'm
12 sorry I couldn't physically be there in person
13 today. So, I thank you very much for the
14 opportunity to speak on the line.

15 And when we had submitted the measures
16 to the NQF, we had a little bit of back and forth
17 with some of NQF folks because there was a little
18 bit of confusion and I can understand why that
19 may be the case.

20 If you have taken a look, and I know
21 there's a lot of material to review, you may have
22 noticed that the motor score, or I'm sorry, that

1 the motor measure is in essence the self-care
2 measure as well as the mobility measure.

3 So, it is important for us to give you
4 a little bit of that background and history about
5 the FIM. I assume several of you may be, you
6 know, very well versed in it, but some may not.

7 The FIM is the larger entity, so it's
8 18 items and it's been used very widely in
9 inpatient rehab as Beth had mentioned for several
10 decades now. But it's not only been used in the
11 inpatient rehab setting, skilled nursing
12 facilities have used the tool as well as long-
13 term care facilities.

14 So, it has been an instrument that has
15 been used in many different post-acute care
16 venues to look at patient outcomes and function
17 as well as patient burden of care as was already
18 mentioned.

19 These new measures that we're
20 submitting are new in the sense that they're
21 being looked at as a separate entity. But the
22 items are not new.

1 So, I want to make that clarification
2 because they are verbatim the same items that do
3 exist in that larger FIM instrument.

4 So, and one of them that I mentioned,
5 one of them does contain the self-care plus the
6 mobilities. So, when we talk about motor,
7 there's 12 items, but you'll see that the other
8 two measures are nested within.

9 Now, why did we submit three separate
10 measures?

11 Because depending on the patient for
12 goal setting or depending on the venue, it may be
13 more critical to look at self-care alone without
14 being nested in that composite score, so that
15 total summed score.

16 So, we felt it was important,
17 especially for patients that may not ambulate,
18 and it may not have to do with their course of
19 care for a specific condition. So, if they
20 haven't ambulated their entire life, we didn't
21 feel if we're looking at quality outcomes that it
22 would be important to necessarily fault the

1 facility or the clinicians on something that they
2 may not be working on because it has nothing to
3 do with their condition that they're presenting
4 to.

5 If you'll notice the evidence, we
6 reference the FIM extensively and that is
7 because, as I said, the measures are new. We
8 have not been testing them as their own entity,
9 they are exact items that are currently living in
10 this larger instrument.

11 So, the reliability and the validity
12 have been extensively studied and I did provide
13 bibliography with each of the measures, but I'd
14 be happy to provide a more expanded bibliography
15 on some of the reliability predictive validity,
16 construct validity and so forth.

17 I do want to clarify that even though
18 each of these measures, the items within are
19 being rated on a 1-7 scale, all of them have a
20 Rasch conversion. So, they can be used not only
21 in their ordinal properties but also in a linear
22 property.

1 So, we do have those item level raw to
2 Rasch conversions and that will actually be a bit
3 more sensitive to patient change. So, when
4 you're looking and you're trying to compare the
5 patient to themselves or between patients or
6 between facilities, it allows you to do some of
7 those facility level comparisons.

8 The data that we presented and
9 provided within the submissions have been from
10 actually a random sample from our large data
11 repository. So, this is -- we have data about
12 half a million patient level cases per year and
13 that's just in the IRF venue.

14 So, we took a random sample to provide
15 these cases. And, of course, you know, we could
16 certainly expand that in any capacity.

17 And we had presented only the
18 inpatient rehab facility results to you. So, we
19 do have data repositories on skilled nursing
20 facility as well as long-term care hospitals.
21 That is not provided in our submission but if you
22 would like additional analyses we certain could

1 provide that as well.

2 CO-CHAIR STILLE: Great, thank you.

3 MS. NIEWCZYK: I feel it important to
4 mention that in terms of feasibility -- oh,
5 sorry.

6 CO-CHAIR STILLE: I think we need to
7 start the discussion. Everyone's kind of looking
8 at me. Sorry.

9 MS. NIEWCZYK: Okay, sure.

10 CO-CHAIR STILLE: So, I just had a
11 clarification question before I turn it over to
12 the discussants.

13 So, all of the items on 2286, 2287 and
14 2321 are part of the FIM and the self-care items
15 plus the mobility items make up the -- so 2286
16 plus 2321 equals 2287, am I right?

17 MS. NIEWCZYK: Correct, exactly.

18 CO-CHAIR STILLE: Okay, okay. So,
19 that's important for people to understand. Good.

20 The other thing is I think just for
21 purposes of doing what we need to do to figure
22 out how to vote, we need to really start to talk

1 about importance first and then we can jump into
2 the methodology.

3 Okay, so, Sam, are you going to start?

4 MEMBER BIERNER: So, this is Sam
5 Bierner.

6 The use of the FIM primarily has been
7 in the inpatient setting. And for those of you
8 just so you understand, this is a clinician-
9 derived score and requires training of the
10 clinician who can be a therapist or a nurse or a
11 physician has to undergo a training session to be
12 certified to give these scores. So, it's a
13 fairly detailed process to learn to do the FIM
14 scoring.

15 So, as I read it, you're wanting this
16 to be a one year score. This score is going to
17 be scored one year after an event or after
18 discharge from rehab? That's my question.

19 MS. NIEWCZYK: No, so the time period
20 is one year. But the way that the patient would
21 actually be scored is by looking at their rating,
22 the change from their admission to their

1 discharge.

2 So, if a patient had stayed in an
3 inpatient rehab for, let's say, 21 days, they
4 would have an admission assessment taken within
5 24 hours of admission to the facility and then
6 they would have another one done within 24 hours
7 of discharge. And it would be that change from
8 the admission to discharge.

9 MEMBER BIERNER: So, really -- okay,
10 so, what is the purpose of saying it's a one year
11 score? That threw me off in your writeup.

12 MS. DEMAKOS: I think that's for
13 benchmarking purposes, Paulette.

14 MS. NIEWCZYK: Yes, that's exactly it.

15 So, in addition to looking at the
16 patient level which is critical for that patient
17 and that family, we also look at aggregate data
18 comparing, you know, all patient and we adjust
19 the adjustment methodology is included in the
20 submissions, but also at the facility level.

21 And then you can look at some best
22 practices or see what some of the variability is

1 over the course of a one year period.

2 MS. DEMAPOS: So, I would just like to
3 clarify one thing as far as the training and
4 credentialing as well.

5 UDS, I mean if you were to use this
6 instrument through us and request benchmarks and
7 outcomes, you would be required to do the
8 training and credentialing.

9 However, CMS is using this same
10 instrument within the IRF-PAI and they do not
11 require training or credentialing to use that
12 instrument.

13 So, there's --

14 MS. NIEWCZYK: Yes, thank you. That's
15 an excellent point, Beth.

16 So, there is extensive guides that are
17 available to in essence self-teach. So, you
18 could certainly -- we have those available and
19 you can certainly do the assessment without the
20 extensive credentialing and passing on the master
21 exam.

22 However, it's been demonstrated

1 through a number of studies that in order to
2 display the very high rater reliabilities, it's
3 critical to have some basic understanding of how
4 to do the rating, otherwise it's just -- there's
5 vast inconsistencies.

6 MEMBER BIERNER: Right, and from
7 personally using frequently, I can tell you that
8 the training is necessary. We've had to do a lot
9 to ramp up training of others in our facility to
10 get better inter-rater reliability.

11 But, what about the patient that goes
12 through inpatient rehab and then six months later
13 has had additional therapies as an outpatient?
14 Are you expecting that you'll do another score
15 then? Otherwise, you're just using it during the
16 inpatient rehab state. So, are you expecting
17 you'll use it at other times on the outpatient
18 basis?

19 MS. NIEWCZYK: That's a great
20 question. On the outpatient side, the FIM
21 certainly can be used as an assessment
22 instrument. However, it's key to look at the

1 construct that's being measured and what's being
2 measured is, is patient function, but it's also
3 burden of care.

4 And burden of care really refers to
5 how much time that patient would require from a
6 helper, another person, one-on-one if they were
7 living within a community setting.

8 So, if the patient was now in a
9 community setting receiving outpatient therapy,
10 it's not to say that the patient's level of
11 function doesn't require any additional services,
12 that's not what we're saying by any means.
13 However, they may not require an hour or more of
14 helper assistance.

15 So, in essence, you're going to see a
16 ceiling effect or you're going to see patients
17 top out and it's just because the instrument
18 isn't sensitive enough to pick up on some of the
19 very, very small but still important elements of
20 function that a patient may need once they are
21 able to, you know, community-dwell, go back to
22 work and so forth.

1 So, at that point, it might just mean
2 other additional measures would be used to check
3 that patient.

4 MEMBER BIERNER: Okay. So, the --

5 MS. NIEWCZYK: I do want to say it's
6 not just used for inpatient rehab. So, we do
7 have, and have for the past 20 years, have
8 patients assessed in the skilled nursing facility
9 as well as in long-term care hospitals.

10 So, all of the items that we have
11 submitted to NQF would be applicable and
12 appropriate for those other levels of inpatient
13 care.

14 CO-CHAIR STILLE: I'm sorry to cut you
15 off again, we just need to be as brief as we can
16 --

17 MS. NIEWCZYK: Oh, sure.

18 CO-CHAIR STILLE: -- in assessing
19 these things.

20 MEMBER BIERNER: So, the instrument
21 itself has been used a long time and has a large
22 database, so I don't have a problem with the

1 instrument. I'm not quite clear on the
2 distinction of the three different scores and how
3 you're calling one a motor score when it
4 encompasses -- it's a composite score of many
5 different functions.

6 But other than that, the instrument
7 itself, you know, I think has certainly been
8 validated and has reasonably generated
9 reliability when it's used with trained
10 clinicians.

11 CO-CHAIR STILLE: Other thoughts about
12 importance, gap in care or gap demonstrated up to
13 for improvement disparities?

14 MEMBER SALIBA: I did not see the data
15 on disparities. I may have just missed it in
16 here. Was there information about disparities?

17 CO-CHAIR STILLE: Not as far as I
18 know.

19 MS. NIEWCZYK: No, thank you for
20 asking that.

21 So, we weren't exactly clear as to how
22 in depth the analyses should be and we absolutely

1 can and we'd be very thrilled to provide that
2 information to you.

3 We do have patient level as well as
4 facility level data on different patient
5 characteristics, so we certainly can stratify and
6 look at these outcomes by race or by payer source
7 or by age category.

8 And I think it's critical, especially
9 on the heels of last night's discussion, I was on
10 the call I think until nearly the end, and in
11 looking at all payers I think is an important
12 thing.

13 So, this is not restricted only to a
14 Medicare/Medicaid population or to an age 65 or
15 older. We do have data on 18 and above and would
16 recommend its use among all adults ages 18 and
17 over, all payers, all races and socio-economic
18 strata, status, strata and so forth.

19 So, we do have that available and we
20 can provide it to NQF.

21 MEMBER SALIBA: An additional follow-
22 up question.

1 I know that you indicated that it is
2 done in multiple settings and that's true, the
3 physical therapist in SNFs will often use the FIM
4 because they've been trained in it, but it is not
5 required in SNFs or nursing homes.

6 Are you targeting this measure towards
7 particular types of facilities? Because I noted
8 in the feasibility section you're talking about
9 it being, you know, collected as part of the IRF-
10 PAI. Are you proposing this as an inpatient
11 rehab facility measure or are you proposing --
12 so, what type of setting or institution are you
13 proposing this measure for?

14 MS. NIEWCZYK: We propose this to be
15 used in inpatient rehab, skilled nursing
16 facilities, long-term care facilities and as well
17 as home health facilities.

18 So, all of this inpatient or quasi-
19 inpatient as I like to refer to them, facilities
20 could benefit from using these three measures
21 that we have submitted. All items would be
22 applicable to patients in those venues.

1 So a ceiling effect as I spoke to a
2 couple of minutes ago with an outpatient venue
3 wouldn't be applicable with those four that I had
4 just mentioned.

5 MEMBER SALIBA: So, when you looked at
6 the --

7 MS. NIEWCZYK: The data submitted were
8 only on inpatient rehab --

9 MEMBER SALIBA: Yes, when you looked
10 at the --

11 MS. NIEWCZYK: -- because that is
12 where it is used in terms of the IRF-PAI,
13 however, as I mentioned before, we do have data
14 in those other venues and we could share that
15 with the committee.

16 MEMBER SALIBA: Okay. So, I guess I'm
17 trying to understand the proposal that you've put
18 in front of us now would be for this to be a
19 measure in all settings or just to be a measure
20 in IRF?

21 MS. NIEWCZYK: In all settings. So,
22 all settings except in outpatient. So, home

1 health, long-term care, skilled nursing and
2 inpatient rehab.

3 Again, I guess I'm going reference
4 yesterday's conversation late afternoon again,
5 somebody mentioned, I believe it might have been
6 Ann Monroe, but somebody had mentioned the
7 importance to have a tool or a measure that could
8 be appropriate in, I think she referred to it as
9 a common core, in all post-acute care venues.

10 I think that's critical and that's
11 really what we're posing here. We have items
12 that have been well tested and validated and used
13 in payment for the IRF facilities but --

14 MEMBER SALIBA: Yes, I think --

15 MS. NIEWCZYK: -- voluntarily by some
16 other facilities.

17 MEMBER SALIBA: Yes, can I ask --

18 CO-CHAIR STILLE: I'm sorry, we're
19 going to have to cut you off again.

20 MEMBER SALIBA: Yes, so the only other
21 point would be that the data that's broken out
22 here right now is not broken out by settings,

1 correct?

2 MS. NIEWCZYK: Correct.

3 MEMBER SALIBA: Okay, all right.

4 MS. NIEWCZYK: This is Just IRF.

5 MEMBER SALIBA: Right, this is just
6 IRF data which is where we would expect the
7 performance to be probably the best.

8 MS. SAMPSEL: Yes.

9 MEMBER SALIBA: Okay.

10 MS. SAMPSEL: Yes, so a couple of
11 things. One, you know, the committee will be
12 asked to review this measure and vote on this
13 measure as it's presented with the data presented
14 which is the inpatient rehab facility.

15 The other thing is I just want to, you
16 know, we're really, again, getting out of control
17 on time, so we'll be asking as we go forward, you
18 know, if the chair's asked the developers to
19 respond then at that point you can respond.
20 Otherwise, developers should not be responding at
21 this time.

22 And I think otherwise, are we ready?

1 CO-CHAIR STILLE: Yes, Peter?

2 MEMBER THOMAS: A quick question. So,
3 I am glad to see that -- well, clarify for me if
4 you would, I read expression and memory are part
5 of what is recorded in the self-care measure, is
6 that correct?

7 MS. DEMAKOS: Correct.

8 MEMBER THOMAS: So, that's -- I just
9 want to make a point that that's critical because
10 you, you know, the whole cognitive development of
11 some of the patients that are in this setting is
12 really critical and you're sure you can move to
13 some degree, but you don't know where you're
14 going if you don't have the cognition. That's
15 obviously a big factor.

16 I also wanted to say that if you're
17 looking at just inpatient rehab, I can see these
18 measures being appropriate. I'm a little
19 concerned that outside of the inpatient rehab
20 setting that do these measures go far enough?

21 Are they fairly elementary in terms of
22 the ability of the person to really be fully

1 mobile as opposed to -- I see locomotion and
2 stair climbing, but is that it for locomotion?
3 I'm Just trying to get a sense for --

4 I can see in the inpatient rehab
5 setting that's a big -- those are two big
6 important measures. But, if you have any further
7 information about additional measures on mobility
8 in particular that would round out the experience
9 or the assessment of someone's real ability to be
10 mobile and ambulatory?

11 MS. NIEWCZYK: Yes, so for the
12 mobility measure there is --

13 CO-CHAIR PARTRIDGE: Paula, sorry.

14 Peter, again, I just have to go back.
15 We're judging on what's in front of us and that's
16 kind of a -- if you were going to use this
17 another setting question is where you're heading
18 and I think --

19 MEMBER THOMAS: Okay.

20 CO-CHAIR PARTRIDGE: -- maybe we
21 should not take time to push it.

22 CO-CHAIR STILLE: Any other questions

1 on importance before we vote on importance for
2 this measure?

3 Becky?

4 MEMBER BRADLEY: I just had a comment
5 that I think it is important that the measure be
6 applicable to more than just Medicare patients
7 because we have more than Medicare patients in
8 the inpatient rehab facilities. And so, it is a
9 measure that can be used across all payers.

10 CO-CHAIR STILLE: Okay. David?

11 MEMBER CELLA: Just a proposal that
12 this vote be carried over to the other two so
13 we'll do three at once because they're very
14 overlapping.

15 CO-CHAIR STILLE: Right, I think we
16 might want to do -- should we maybe go all the
17 through this one and then consider the other two
18 kind of quickly and see if the votes for the
19 first will carry to the second? Okay, then the
20 third. Great, thanks.

21 Okay. You're proposing that we vote,
22 yes, okay, great. She's got the clicker in hand.

1 Okay, so voting on importance for
2 Measure 2287. Nadine, tell us when.

3 MS. ALLEN: Voting on evidence, one
4 second, the vote. Please do not begin voting
5 until I say start the votes. That's why I had to
6 go back.

7 Now we're voting on evidence, one yes,
8 two no. Voting starts now.

9 MS. SAMPSEL: I think you're missing
10 one.

11 MS. ALLEN: Oh, we have 17 now.
12 Sorry, guys, it's saying we've got 17 votes but
13 I'm not seeing the votes.

14 CO-CHAIR STILLE: All right, should we
15 just do a hand vote?

16 So, yes?

17 (A SHOW OF HANDS)

18 CO-CHAIR STILLE: Is that everybody?
19 Okay, 17 yes, zero no.

20 MS. ALLEN: Let's try this again.
21 Voting on performance gap, one high, two
22 moderate, three low, four insufficient. Voting

1 starts now.

2 All votes are in, 24 percent high, 47
3 percent moderate, zero percent low, 29 percent
4 insufficient.

5 Voting on high priority, one high, two
6 moderate, three low, four insufficient. Voting
7 starts now.

8 All votes are in, 53 percent high, 47
9 percent moderate, zero percent low, zero percent
10 insufficient.

11 CO-CHAIR STILLE: Okay, let's have a
12 brief discussion on reliability and validity.

13 MEMBER BIERNER: Just as I mentioned
14 before, the reliability is very dependent on a
15 trained clinician. It will certainly suffer
16 reliability by someone who isn't trained in the
17 use of it. It's not as easy to use as some
18 measures that we've looked, but when trained, it
19 can have high inter-rated reliability.

20 And it's validity has been well
21 established I think over the last 20 years or so.

22 CO-CHAIR STILLE: Sherrie?

1 MEMBER KAPLAN: Yes, can I ask the
2 developer a question?

3 Okay, so especially if this is going
4 to come up again and again, there is a lot of
5 evidence obviously for reliability at the patient
6 level and the Rasch modeling that you did looks
7 like there's only -- there may be one clunk item
8 in this.

9 But that kind of modeling suggests
10 that, you know, the reliability at the patient
11 level certainly is good. But, I'm concerned that
12 the reliability at the agency level, you've got a
13 beta binomial model here and the interclass
14 correlation coefficients, to me, look like a
15 measure level mean variance were used to estimate
16 rates as opposed to the composite score which is
17 what I think you're going to use within
18 dimensions to evaluate the performance of these
19 institutions.

20 So, it doesn't look to me like you
21 actually rated the interclass correlation
22 coefficients at the facility level to compare in

1 the unit that -- the groups of measures you're
2 actually going to compare.

3 You did it at the measures level it
4 says on page 33 of your analysis as opposed to
5 the composite across scores by agencies.

6 Is that accurate?

7 MS. NIEWCZYK: Yes, that's correct.
8 We just had only so much space at the end to that
9 application would allow us to include. But we
10 have that other data and we can make it
11 available. But you are correct in your
12 interpretation.

13 MEMBER KAPLAN: So, you could make
14 those data available to us?

15 MS. NIEWCZYK: Between facilities?
16 Absolutely.

17 CO-CHAIR STILLE: And, David?

18 MEMBER CELLA: So, we're talking about
19 the total FIM measure now, but the next two will
20 be subsets of that. So, this question kind of
21 relates to all three.

22 And I mean my first question comes out

1 of a concern that I've actually in my own work
2 been grappling with for ten years now which is,
3 you know, it's just by way of quick background,
4 when you convert raw sum scores in to Rasch or
5 IRT scores, you convert them from ordinal
6 measures to integral measures so that the
7 distance between each number is equal no matter
8 where you are on the scale. And that's nice, it
9 sounds nice.

10 But what it actually does
11 functionally, and I think this to me is very
12 important to understand here, is that inevitably
13 when you're in the middle of a distribution, it
14 takes more raw score change units to get the same
15 interval change as opposed to the tails.

16 So, therefore, if you're using the
17 black-box Rasch-transformed score and you have
18 somebody that the extreme end, a very small
19 change will look very big on the Rasch interval
20 measure.

21 And I still don't know after thinking
22 about this for years which one's correct.

1 So, my question is, I mean I tend to
2 suspect the raw score is more correct because I'm
3 not convinced that the same amount of change at
4 the extreme means more than in the middle, but
5 it's really a belief, I don't know.

6 So, my question is, since they have so
7 much data, this is to the developers, are all of
8 these determinations and scores based on the
9 Rasch-transformed score? And if so, have you
10 ever compared that to the raw score changes to
11 see if that would change the individual or
12 facility level change?

13 MS. DEMAPOS: Paulette, can I give it
14 the quick --

15 MS. NIEWCZYK: Great question.

16 MS. DEMAPOS: Paulette?

17 MS. NIEWCZYK: But this is a project
18 we're working on aside from this. But, yes, the
19 answer is yes.

20 We have looked at raw to Rasch
21 conversion and we've kept it in its raw or its
22 ordinal level state and we're working on a

1 publication to submit. We didn't provide but the
2 data you're seeing are Rasch-converted.

3 So, it's patient level where their 1-7
4 have been converted to what their Rasch-
5 transformed value would be.

6 Yes, you do see bigger jumps so from
7 the 1 to a 2, whether it's in its raw or Rasch-
8 converted state is a big jump as well as the 6 to
9 7.

10 By converting to a Rasch measure, it
11 helps to correct for some of those drastic
12 differences. It lets you know that they're not
13 all to be assumed equal. A 2 to a 3 is maybe not
14 the same as a 1 to 2 would be. But that also
15 adds to its clinical significance as clinicians
16 would probably know that it's probably easier to
17 get a patient from a 2 to a 3 than it is from a 1
18 to 2 in practice.

19 So, it would -- the Rasch-converted
20 value would give you greater sensitivity at that
21 patient level and likely mimic what you'd see in
22 practice with treating a patient in practice.

1 MS. DEMAKOS: Can I just add quickly
2 here, too, that we've also taken the raw scores
3 and taken those and converted those to minutes of
4 care so you know what level, how much time it
5 takes for the burden of care with those raw
6 numbers as well.

7 CO-CHAIR STILLE: Okay. Lee has a
8 question then Sherrie.

9 CO-CHAIR PARTRIDGE: I just want to
10 understand the risk-adjustment methodology a
11 little bit because I think it's different from
12 what we've seen in some other measures.

13 As I understand going through the
14 steps, you'd start by classifying your patient in
15 to one of the impairment groups and you calculate
16 the patient score. And then you take a look at
17 what I call a facility case mix.

18 In other words, sometimes you're
19 looking at the patient and doing the adjustment
20 at the patient level and then saying now we're
21 going to measure the change beginning where that
22 patient was.

1 As I understand it in this process,
2 you're doing that but you're also looking at the
3 facility and stepping back and saying, what does
4 the facility's case mix look like?

5 And I'm calculating what is, in
6 essence, an adjustment at the facility level so
7 that if 80 percent of the patients were this type
8 and 20 were that type, I then adjust the results
9 not based on the patient's -- you see why I'm
10 getting all tangled up?

11 MS. DEMAOKOS: Yes, I do. Yes, I do
12 see what you're saying. So you're saying --

13 MS. NIEWCZYK: Yes, you can -- we do
14 adjust at both the patient level as well as the
15 facility level. That allows for comparisons
16 between facilities.

17 So when we're looking at, you know,
18 actually quality or outcomes by facility, if you
19 were to speak with a facility, they're always
20 going to say, oh, my patients are different. My
21 patients are more severe. My patients are worse.

22 Not only would you be able to look at

1 that severity, but you can also then compare
2 facilities that are truly like the -- meaning if
3 it is a designated, you know, stroke center, you
4 can compare that facility to other facilities
5 that are also designated stroke centers or --

6 MS. DEMAKOS: But I think what you're
7 -- Paulette, I think what the question was really
8 is that you're looking to compare patient to
9 patient within a facility, is that what you're
10 saying?

11 CO-CHAIR PARTRIDGE: As I understand
12 this --

13 MS. NIEWCZYK: You can do that as
14 well.

15 CO-CHAIR PARTRIDGE: Wait a second.

16 MS. NIEWCZYK: So, you can get at the
17 patient level but you can also do it at that
18 facility level so that way, you're really seeing
19 apples to apples comparison, correct.

20 MEMBER KAPLAN: I just wanted to
21 follow-up on the earlier question about some of
22 these items in the Rasch scores.

1 Could you give us, if you're going to
2 give us the ICCs at the facility level, could you
3 also give us the mean square fit statistics that
4 you use, you know, in-fit and out-fit?

5 MS. NIEWCZYK: Yes, absolutely.

6 MEMBER KAPLAN: Because that would
7 help answer that question I think.

8 MS. NIEWCZYK: Absolutely.

9 CO-CHAIR STILLE: Okay, anything else
10 about reliability and validity?

11 Dave?

12 MEMBER CELLA: It's just -- I want to
13 make sure I'm clear that we're voting on the use
14 of now the overall motor FIM in inpatient rehab
15 facilities using the Rasch score with an
16 understanding that they do have raw score data to
17 compare and they're working on academic work to -
18 - is that --

19 So we're voting on the Rasch score.

20 MS. NIEWCZYK: You're voting on the
21 Rasch score, yes.

22 All of the data has -- it's collected

1 using the 1-7. So, when the clinician does an
2 assessment, they don't do anything with Rasch,
3 they don't use the Rasch-converted value. They
4 only use a 1-7.

5 On the back end, in order to validate
6 these measures, we performed Rasch analysis and
7 we converted each of those values. So, a 1 then
8 became converted to a Rasch-transformed.

9 So, I'll give you an example. One
10 might be a --

11 MEMBER CELLA: I'm sorry -- I
12 understand all that. I was just clarifying what
13 we're voting on. I know it's all been --

14 MS. NIEWCZYK: Yes, it is.

15 MEMBER CELLA: Okay, thank you.

16 MS. NIEWCZYK: Transformed, yes.

17 CO-CHAIR STILLE: So, this is just
18 sort of a question -- a procedural question, so,
19 it sounds like there's a lot of data people are
20 interested in. We're voting on the data that we
21 have. After the vote, depending on the vote,
22 does that determine whether or not we need to get

1 more data or can we request that or sort of what
2 happens with that?

3 MS. SAMPSEL: We can still request it
4 before public comment.

5 CO-CHAIR STILLE: Okay, before public
6 -- okay, great.

7 MS. ALLEN: Voting on reliability, one
8 high, two moderate, three low, four insufficient.
9 Voting starts now.

10 One more vote. Thank you.

11 Thirty-five percent high, 35 percent
12 moderate, six percent low, 24 percent
13 insufficient.

14 CO-CHAIR STILLE: Okay.

15 MS. ALLEN: Voting on validity, one
16 high, two moderate, three low, four insufficient.
17 Voting starts now.

18 Twenty-four percent high, 53 percent
19 moderate, zero percent low, 24 percent
20 insufficient.

21 CO-CHAIR STILLE: Okay, any discussion
22 on feasibility?

1 I have just a quick question on
2 feasibility. It appears as though the public
3 availability and use of this is dependent on kind
4 of how you're going to use it.

5 For the purposes of accountability and
6 reporting between institutions and benchmarking,
7 is that all within the public domain? I was a
8 little bit confused as to the description.

9 MS. DEMAKOS: The benchmarking piece
10 of that is not available to the public. I mean
11 as far as that's concerned, you would go to a
12 vendor if you wanted benchmarking. So, but this
13 would be made available to the public, obviously,
14 but the purposes of use for a patient level.

15 MS. NIEWCZYK: Measures used, yes.

16 CO-CHAIR STILLE: Okay.

17 CO-CHAIR PARTRIDGE: But, going back
18 to Sam's earlier question, as I understand it, it
19 would be -- there could be some problems if your
20 staff isn't trained in using FIM.

21 MS. DEMAKOS: We totally promote
22 training and credentialing with this instrument,

1 not everybody does it, but we would highly
2 suggest it and agree with Sam's comment.

3 MS. NIEWCZYK: And there's other
4 models that could be used, like a train the
5 trainer. So, it doesn't mean you have train all
6 clinicians within an entire facility. You may
7 select one or two and those then could go back to
8 the facility and train the others.

9 CO-CHAIR STILLE: Dave?

10 MEMBER CELLA: I'm just going to
11 repeat myself here, but I think it's important
12 that, and particularly with feasibility, that
13 this vote is an inpatient rehab facility vote,
14 it's not other sites. Because there was some
15 comment earlier where there was a recommendation
16 for other inpatient-like sites. But this is an
17 inpatient facility vote on feasibility.

18 MEMBER BIERNER: It's not exactly what
19 she said, though. She said she's going to use it
20 in others -- I mean because skilled nursing --
21 other settings can maybe used in as well. So,
22 it's not as well - those are not, in our view,

1 those are not inpatient settings even though
2 they're classified here.

3 MEMBER SALIBA: But I think the
4 measure is just that we're voting on that's in
5 front of us, it's just for IRFs. That's what I
6 was trying to clarify earlier.

7 MS. NIEWCZYK: In the submissions we
8 indicated on each of them the settings and we
9 listed all of the four venues that I spoke, IRF,
10 SNF and LTCH and home health.

11 MEMBER SALIBA: So, I'm incorrect in
12 my interpretation that this is a measure just IRF
13 that you've put in front of us?

14 CO-CHAIR STILLE: Yes, you're
15 incorrect about that.

16 MEMBER SALIBA: Okay.

17 DR. BURSTIN: But we only endorse
18 measures for the levels for which we have
19 testing. So, if we've only been provided data on
20 the IRFs, then that is the only setting
21 applicable today.

22 MEMBER SALIBA: So, I'm a little

1 confused about what we're voting on. I'm sorry.

2 So, are we voting on this as a measure
3 for any setting or are we voting on this as an
4 IRF measure?

5 CO-CHAIR STILLE: An IRF.

6 MEMBER SALIBA: IRF, okay, great.
7 Thank you.

8 MS. DEMAKOS: May I ask a question?

9 So, if we've submitted the data just
10 for the IRFs, would it be possible then, again,
11 to submit it for the skilled nursing and the LTCH
12 to be considered for that as well?

13 UNKNOWN PARTICIPANT: Not today.

14 MS. DEMAKOS: Oh, no, not today.

15 MS. SAMPSEL: I mean I think we'll
16 have to think about that internally. But I mean
17 the way that this was submitted and, you know,
18 clearly, even in the measure title were you have
19 IRF, we were considering this as an IRF measure
20 and, therefore, as one measure submission.

21 If, you know, if you want to submit
22 additional data, I almost think that's a new call

1 for measures.

2 CO-CHAIR STILLE: Okay. Oh, Liz?

3 MEMBER MORT: I have just a quick
4 question.

5 Since these data are used for IRF-PAI
6 with regard to payment, does Medicare do any
7 auditing for quality on sites?

8 That might just mitigate the concerns
9 around variability and implementation somewhat.

10 MEMBER BIERNER: I can't -- the
11 facilities can be audited, yes. There's RACs
12 which audit the IRF facilities.

13 CO-CHAIR STILLE: Anything else on the
14 feasibility issue or should we vote? Let's vote.

15 MS. ALLEN: Voting on feasibility, one
16 high, two moderate, three low, four insufficient.
17 Voting starts now.

18 All votes are in, 18 percent high, 65
19 percent moderate, 18 percent low, zero percent
20 insufficient.

21 CO-CHAIR STILLE: And usability? Any
22 usability comments? Okay, let's vote.

1 MS. ALLEN: Voting on usability in
2 use, one high, two moderate, three low, four
3 insufficient information. Voting starts now.

4 Thirty-five percent high, 53 percent
5 moderate, zero percent low, 12 percent
6 insufficient.

7 CO-CHAIR STILLE: And then finally,
8 suitability for endorsement. Any other last
9 comments before we vote? Okay, let's vote.

10 MS. ALLEN: Overall suitability for
11 endorsement of Measure 2287 functional change.

12 Change in mode of score, one yes, two
13 no. Voting starts now.

14 All votes are in, 83 percent yes, 12
15 percent no. Sorry, 88 percent yes, 12 percent
16 no.

17 CO-CHAIR STILLE: Okay, so there's
18 been a lot of discussion that crosses the UDSMR
19 measures which is great.

20 What we've decided to do is allow the
21 discussants here on the panel any opportunity for
22 making more comments on 2286 and then 2321 and

1 then we'll figure out how to vote.

2 Dave?

3 MEMBER CELLA: I just have one thing
4 that's, you know, specific to really these two
5 subset, or I guess you could say short forms.
6 But their sub-domain related short forms, and it
7 relates to the reliability data that were
8 provided.

9 The coefficients are kind of moderate
10 and normally, I would just assume that they are
11 adjusted for item overlap but I didn't see that
12 in the report.

13 So, when you correlate a four item
14 mobility score with a 12 or 18 item overall total
15 score that includes those four items, you're
16 going to inflate that relationship because four
17 units of information are identical.

18 So, were those correlations that you
19 reported on reliability adjusted for item overlap
20 or do they include the common items in both sides
21 of the equation?

22 MS. NIEWCZYK: The inter-item

1 correlations were specific to that measure. So,
2 for the mobility, they were how well each of
3 those four items correlate with each other in the
4 measure. So, it was not independently correlated
5 to the 18 items.

6 MEMBER CELLA: There's a section
7 though where you talk about the correlation of
8 the four item measure, for example, with the
9 total. That's the one I'm referring to, not the
10 inter-item.

11 MS. NIEWCZYK: Okay. So, what we did
12 is taking those four items, how well do those
13 four items and only those four items predict what
14 the patient's full 18 item FIM score would be.
15 So, that we ran regression analyses to see how
16 well those individual four items of that measure
17 could predict the full 18 item value for that
18 patient.

19 MEMBER CELLA: All right. Well, it
20 would be useful, yes, I mean just as a comment
21 then, given the magnitude of the coefficients
22 which are around .6, that suggests to me that

1 that's a relationship between the four items that
2 are subbed out and the other items, it's fairly
3 low which ironically may be a case for these two
4 sub-measures as better measures than the overall.

5 But that's just what -- I think it
6 would be worth knowing the adjusted correlations
7 and you might want to consider over time
8 migrating to these two sub-scores as better than
9 the overall since the overall seems a little
10 cloudier.

11 CO-CHAIR STILLE: Interesting.

12 Sherrie?

13 MEMBER KAPLAN: When you reduce item
14 batteries like that, that drastically you take a
15 hit in Cronbach's alpha because of the -- well,
16 what I'm staring at is.

17 And so, you would expect that in
18 Spearman-Brown that that's almost exactly what
19 you'd expect.

20 So, my concern, however, was as with
21 the other measure, you don't have -- you don't do
22 it at the facility -- the inter-class correlation

1 coefficients are missing for facility level
2 reliability, is that accurate?

3 MS. NIEWCZYK: Correct. So, this all
4 just done on the whole sample of patients, not at
5 the facility. Now, we do have other data that
6 was not submitted and that's not in front of you.
7 So, this is at that patient level.

8 MEMBER CELLA: Okay.

9 MS. NIEWCZYK: And thank you for also
10 stating that. Yes, so the fewer items you have
11 you will take a hit in terms of the reliability,
12 the more items, typically, the more reliable the
13 measure.

14 MEMBER CELLA: I need to just clarify,
15 it's in your validity section, actually, because
16 you're citing it as validity and I'm not talking
17 about the internal consistency or the inter-time
18 correlations within. I'm talking about the
19 relationship of the mobility score with the total
20 FIM and the relationship of the self-care score
21 with the total FIM.

22 Those coefficients are moderate,

1 they're not high. And given --

2 MS. NIEWCZYK: That's actually not
3 just correlations, though. We're looking at the
4 proportion of variance accounted for. So, a
5 point --

6 MEMBER CELLA: That's true, you've got
7 --

8 MS. NIEWCZYK: -- that's pretty
9 respected if we know roughly 60 percent of
10 variance could be accounted by those four times
11 alone. That's very respectable.

12 MEMBER CELLA: Yes, that's -- but not
13 when you have common items. You're explaining
14 variance of one side with the same thing on the
15 other side. So, I think you should separate them
16 out.

17 But my point really is not against the
18 measure, it looks okay and I just wanted to make
19 that clear. It's that I think you actually --
20 the data suggest over time, you might be better
21 off with the two sub-scores as more valid than
22 the overall. And in some cases, more -- and in

1 some sense, more reliable. But, that's all.

2 Thank you.

3 MEMBER KAPLAN: Can I make on point of
4 clarification?

5 If you square the correlation -- the
6 inter-items, the reliability coefficient, that's
7 the maximum reliable variance that you can share
8 with another variable.

9 So, if you square the lower
10 reliability coefficient, you get a lower number
11 that's reliable variance to be shared with other
12 variables.

13 So, just for clarification, if you
14 shrink the score, you're going to take a hit in
15 reliability and that in turn is going to
16 compromise your ability to see reliable variation
17 in a different variable.

18 MEMBER CELLA: Okay.

19 CO-CHAIR STILLE: so, the other
20 discussant, let's see, Brian was the other
21 discussant for 2286 but he is not here.

22 Sam, did you have any other specific

1 things to 2286 or are you pretty much done?

2 MEMBER BIERNER: I'm done.

3 CO-CHAIR STILLE: Okay. And then,
4 2321 was Becky and Dave. Dave, you've made a few
5 comments and Becky, did you have anything else
6 you wanted to say about this particular measure?

7 MEMBER BRADLEY: I just wanted to
8 comment on the question about accountability and
9 auditing and just kind of reiterate, there is a
10 lot of auditing and oversight by CMS related to
11 the payment side of these measures. So, that is
12 occurring.

13 CO-CHAIR STILLE: Okay. Ann?

14 MEMBER MONROE: I'd like to ask Sam a
15 question.

16 You mentioned several times the need
17 to be well trained in delivering this instrument.
18 Because you've raised it so often, do you have
19 concerns that the lack of trained people will
20 impact the strength of the results in terms of
21 how well this tool is being used?

22 MEMBER BIERNER: Yes, because we know

1 from our own internal data looking at different
2 groups that we have to train -- residents and we
3 have to train new therapists and people that
4 without adequate training the inter-rater
5 reliability is very poor. No, I won't say very
6 poor but it's not very good.

7 And so, it definitely requires
8 training. That's why I was concerned about them
9 talking about using it in LTCHs, SNFs and other
10 settings where they aren't as well trained or may
11 not be as well trained as in an acute or rehab
12 hospital.

13 So, it definitely requires a lot of
14 training. It's not as easy to administer as some
15 instruments are.

16 CO-CHAIR STILLE: Okay. So, should we
17 take separate full votes on each of those
18 quickly?

19 (SIMULTANEOUS SPEAKING)

20 CO-CHAIR STILLE: Yes, all right.
21 Okay, so should we take a vote on assuming the
22 votes from the prior one applying to these? Any

1 objections at all?

2 (NO AUDIBLE RESPONSE)

3 CO-CHAIR STILLE: Okay. Okay, so
4 noted. Great, thanks.

5 CO-CHAIR PARTRIDGE: So, in response
6 to the concerns about whether we have our
7 developer resources available, we're going to
8 rearrange again and move to the Home Health
9 Measures which begin with 0167 and that's?

10 MS. SAMPSEL: So, that's the Abt folks
11 on the phone. And do we have CMS folks here as
12 well?

13 MS. KEANE: So, this is Nicole Keane
14 --

15 MS. SAMPSEL: And before you start, I
16 just want to be really clear, you really only
17 have three to four minutes for any type of
18 introductory statements.

19 If the Committee Members then have
20 questions for clarification, we'll do that. But
21 I really need you to restrict your opening
22 comments.

1 MS. KEANE: So, this is Nicole Keane
2 from Abt Associates. We have Tara McMullen from
3 CMS in the room and then we also have fellow
4 contractors from Acumen, Keziah Cook and then
5 also from Colorado, David Hittle and Angela
6 Richard who'll be presenting information.

7 Keziah?

8 MS. COOK: Yes, can everyone hear me?

9 CO-CHAIR PARTRIDGE: Yes.

10 MS. COOK: Great. So, I think one
11 thing to keep in mind is these five Home Health
12 Measures are all based on the OASIS instrument
13 and they're all calculated and risk adjusted to
14 getting some more methods and then, additionally,
15 the data we present on reliability and validity
16 are, you know, conceptually very similar.

17 So, there may be some efficiencies of
18 considering some of these features across
19 measures as your discussing results.

20 So, I'll start just with the
21 introduction for 0167 which is Improvement in
22 Ambulation or Locomotion.

1 Many patients who receive home health
2 care are recovering from an illness or injury and
3 have difficulty walking or moving around safely.

4 In particular, they may need help from
5 either a person or from special equipment to
6 ambulate or locomote.

7 Home health care staff can encourage
8 the patient to be as independent as possible and
9 can evaluate the patient's needs for equipment or
10 other devices to help them move around.

11 And very importantly, improving a
12 patient's safe ambulation and mobility are
13 absolutely critical to allowing that patient to
14 remain in their home rather than moving to a
15 facility-based setting.

16 Even improving functional status,
17 especially ambulation and locomotion contributes
18 to the patient's quality of life and allows them
19 to continue to live safely for as long as
20 possible in their own environment.

21 So, overall, recovering independence
22 and walking or otherwise moving around with

1 assistive devices is often a goal of
2 rehabilitation provided in the home health
3 setting. So, it makes it a reasonable evaluation
4 indicator of effective and high-value home health
5 care.

6 Overall, about 74 percent of home
7 health patients are eligible for this measure.
8 And the measure is calculated using the Home
9 Health Outcome and Assessment Information test
10 that's called OASIS.

11 There's a specific item on the OASIS
12 that documents several levels of ambulation.

13 So, basically it starts at a level
14 zero which indicates the patient has no
15 impairment to their ambulation, moves through,
16 you know, a couple of values that correlate to
17 using a single-handed device or a double-handed
18 device to walk around.

19 There another level that indicates
20 requiring assistance from a person for
21 ambulation.

22 And then finally, there are several

1 categories indicating wheelchair bound but able
2 to wheel independently, wheelchair bound and not
3 able to wheel independently and then finally
4 patients who are bed-fast.

5 So, the improvement in ambulation
6 measure uses this item captured at two different
7 time points. So, it uses the items that's
8 measures when the patient first enters home
9 health care at the start of care and that's based
10 on the OASIS assessment conducted within 48 hours
11 of the beginning of home care.

12 And then there's a second OASIS
13 assessment that's conducted when the patient is
14 discharged to the community setting. So, when
15 home health care has specifically achieved their
16 goals and is going to be no longer caring for the
17 patient.

18 So, in both cases, the patient is
19 assessed on this six point scale and if their
20 numerical score on that scale decreases, which
21 means they move from a sort of higher need
22 category to a lower need category, then they're

1 considered to improved in ambulation.

2 The home health agencies as a whole
3 are scored based on all home health quality
4 episodes that end during a 12-month period. And
5 the measure is their fraction of patients who
6 improve in ambulation and then for public
7 reporting purposes, that fraction is risk-
8 adjusted based on patient structure.

9 So, I'll stop there.

10 CO-CHAIR PARTRIDGE: Thank you.

11 We have -- Carol Levine was scheduled
12 to be one of the presenters on this one together
13 with Peter. Carol is, unfortunately, not with us
14 today because she is ill. So, Peter, you're up.

15 MEMBER THOMAS: I just have two main
16 comments.

17 First is that I found the rationale to
18 be very supportive of the need for rehabilitation
19 in terms of home health care but less in terms of
20 the value of measuring ambulation or mobility on
21 the individual.

22 I recognize the value of being mobile

1 and in terms of living independently and
2 performing manual tasks and all those things.
3 But, I didn't see any data or any background
4 about, you know, the say spinal cord injury
5 patients who are non-ambulatory and lose bone
6 density or muscle atrophy or the perils of lying
7 in bed all day and, you know, contractures and
8 bed sores and things of that nature.

9 So, I was wondering why that wasn't --
10 that seemed to me to be the obvious correlation
11 between measuring mobility and ambulation and
12 improving health care. Why was that omitted from
13 the packet?

14 CO-CHAIR PARTRIDGE: Would our
15 developers like to respond? I'm not getting a
16 response.

17 MS. COOK: I can speak up.

18 So, you know, I think our focus here
19 has been sort of across the range of ambulatory
20 abilities.

21 Our fraction of patients in home
22 health who are actually bed-bound, I don't have

1 the numbers in front of me, but it's quite low
2 and, you know, I think it's under five percent.

3 And I guess the important thing to
4 note is that if a patient is bed-bound at the
5 beginning of the home health episode and then
6 transitions to being able to even sit in a
7 wheelchair, even if they can't move about
8 independently in the wheelchair, that is captured
9 as improvement.

10 I think another thing to keep in mind
11 is that one of the core services provided by home
12 health agencies are physical therapy. So, it is
13 a care setting in which significant sort of
14 physical rehabilitation is a goal.

15 We do have other measures that aren't
16 in front of this committee that specifically get
17 at things like pressure ulcers that are
18 potentially more applicable directly to the small
19 sub-population of the home health patients who
20 are bed-fast.

21 CO-CHAIR PARTRIDGE: Thank you.

22 MEMBER THOMAS: Fine, well, let me go

1 to my main concern with the measure and that
2 involves the Jimmo v. Sebelius case and
3 settlement. And this is something that Brian
4 raised yesterday. I just need to make sure
5 people are well aware of this if you're not.

6 The CMS and the Department of Justice
7 and the Center for Medical Advocacy and selected
8 beneficiaries settled the case a few years ago
9 called Jimmo v. Sebelius that determined that in
10 the home health setting, the SNF setting and in
11 the outpatient therapy setting, Medicare cannot
12 impose an improvement standard that's different
13 than IRF. IRF you have to have an expected
14 improvement in the patient.

15 And so when we're measuring, I kept
16 looking for how you accommodate for that decision
17 because if this measure goes to eventually a pay-
18 for-performance model, which I can assume all of
19 these measures will eventually be looked at in
20 that light, you're going to have significant
21 incentives to not accept patients that require
22 only maintenance or prevention of deterioration

1 kinds of therapy and don't have any expectation
2 of improvement.

3 And if you're just measuring
4 improvement in ambulation in this setting without
5 accommodating for that, that's a major problem.
6 That's a disincentive to treat those patients for
7 home health agencies to accept those patients and
8 provide services because they're going to get
9 dinged for those patients.

10 So, my question is then, all right,
11 well, how do you accommodate for that? Can you
12 put that into the denominator as an exclusion or
13 can you risk-adjust that?

14 If you do it on a -- I suppose you
15 could do it on a condition-specific basis, but
16 you always leave someone out. If you did it on a
17 functional basis, then you're undercutting the
18 whole purpose of the measure because you wouldn't
19 want to keep out people that weren't improving,
20 you're trying to measure improvement.

21 So, can you help me this? Because
22 this runs not only throughout the home health

1 measure but the SNF measures and any outpatient
2 measures and I don't see it really accommodated
3 for in any of the materials that I've seen.

4 CO-CHAIR STILLE: So, it sounds like
5 this would be a usability issue potentially.

6 MEMBER THOMAS: Well, it may be, but,
7 boy, this is a critical for me and for a lot of
8 the folks that I kind of deal with. This is
9 critical because you don't want to have a measure
10 that ultimately creates a disincentive to treat
11 the very patients that you're trying to make sure
12 are getting access to good quality care.

13 So, I would hope to elevate it above
14 usability. I think this goes to the evidence
15 issue.

16 MS. COOK: Is David still on the line
17 from Colorado?

18 MR. HITTLE: Yes. Hello, this is
19 David Hittle from the University of Colorado.

20 And the fact is that the preponderance
21 of folks who are getting home care are relatively
22 short stay in home care, around 35 to 40 days

1 generally and are generally those who do have a
2 reasonable probability of achieving an
3 improvement in their functional status.

4 Jimmo may have changed that somewhat
5 in recent years. I don't have concrete data on
6 exactly how much that would have changed, but we
7 certainly are looking into that.

8 But we also have other measures
9 actually related to functional status that look
10 at whether or not you manage to keep somebody at
11 the same level of impairment in functional
12 status.

13 Generally, those measures tend to be
14 very heavily topped out and, therefore, you know,
15 usually during the first parts of a home care
16 episode, is it, you know, there's not much
17 differentiation in terms of whether or not you're
18 able to keep somebody reasonably stabilized in
19 their functional status.

20 And actually, we had, at one point,
21 there were stabilization measures that were --
22 there were one or two stabilization measures that

1 were endorsed by NQF and NQF withdrew that
2 endorsement several years ago because of the
3 topped out nature of those measures.

4 We are currently exploring whether or
5 not we can look at an overall functional status
6 stabilization measure and whether that would, you
7 know, if you look across several different
8 ambulation, bed-transferring, bathing, dressing,
9 the different kinds of ADL activities whether or
10 not you would end up getting a greater level of
11 variation, and therefore, a greater ability to
12 distinguish among providers on those measures by
13 like inspecting and, you know, constructing
14 composite measures.

15 CO-CHAIR PARTRIDGE: Thank you, Dr.
16 Hittle. I'm going to cut you off because I think
17 we really need to explore other pieces here.

18 And Peter, I'm very sensitive to your
19 concern about unintended consequences, so I don't
20 want to terminate the discussion, I just have a
21 feeling that it's probably going a little deeper
22 than we can accommodate right now.

1 MEMBER THOMAS: Yes, and I don't know
2 whether this is more in the validity, but I'll
3 raise it under the validity part so we can move
4 on.

5 CO-CHAIR PARTRIDGE: Okay. I would
6 invite the people who looked at bathing, bed-
7 transferring, management of oral meds and pain to
8 also chime in here since the measures are
9 somewhat similar. So, go ahead.

10 MEMBER PARISI: So, this is Len, and
11 I reviewed the second one on grooming and
12 bathing.

13 I am very familiar with the data
14 collection process and the use of the OASIS.
15 It's been in use for a long time and the rigors
16 involved in educating staff to be able to perform
17 a valid and reliable assessment and a lot of
18 effort goes into that.

19 The only thing that I have a question
20 about is the gap between the measured outcome and
21 the evidence to support those interventions that
22 would support improvement.

1 Much of the data that we collect
2 related to these outcomes are used for
3 performance improvement initiatives and
4 benchmarking purposes. But the way the -- and
5 the way it's reported on home health compare, the
6 language is different for the public as it is on
7 these measures as well which sometimes causes
8 confusion among staff members.

9 But, I don't see any evidence that
10 supports clinical initiatives or practice
11 parameters around improving these outcomes. That
12 would be my only comment.

13 CO-CHAIR PARTRIDGE: Do the developers
14 want to respond? They've submitted it and we
15 didn't find it or they would submit or?

16 MS. COOK: Is Angela on?

17 MS. RICHARD: Yes, I am. Hi, this is
18 Angela.

19 You know, I think in the literature,
20 we actually, particularly for bathing I guess,
21 there are several studies that really indicate
22 that home health care can really result in

1 improvements and functional ability, some were
2 ever specific to bathing. The Luft study of 2009
3 particularly calls that one out.

4 And, you know, so I'm a little bit
5 unclear about where the literature -- I mean I
6 think the literature really does support this
7 home visiting nurse intervention versus care as
8 usual.

9 Friedman, Lovell and Powers 2014 found
10 that and those are in the lit review. So, maybe
11 I didn't make those clear enough.

12 MEMBER PARISI: Well, I guess maybe I
13 wasn't clear.

14 So, the improvement in bathing, so if
15 an organization scores poorly, there's no, to my
16 understanding, connection between how you get to
17 improve bathing.

18 So, is it education? There are no
19 practice guidelines around educating people on
20 bathing. It really gets back to their functional
21 ability.

22 Clearly, it's an important indicator

1 because you want home health patients to be
2 independent and to be able to have the ability to
3 bathe themselves.

4 So, that was -- it's a little
5 different in an ambulation where you would have a
6 physical therapist and/or some of the other
7 measures, so that was the only thing that I was
8 trying to put together.

9 MS. RICHARD: Okay. And we did --

10 MS. MCMULLEN: This is Tara McMullen
11 from CMS.

12 A lot of these measures, this kind of
13 goes back to our discussion yesterday about the
14 use of the nursing home measure and how they're
15 used and commonly reported and benchmarked for
16 those multiple purposes.

17 Many times we create these outcome
18 based measures so that we can benchmark or set
19 thresholds or publically report beyond that of
20 the guidelines. We know guidelines exist and we
21 take those very seriously.

22 You know, crafting process or crafting

1 how care is given, we know that these measures
2 are a part of that but many times, like with this
3 measure specifically or the other ADL measures,
4 they're used as just basically, it's a mark, it's
5 a benchmark and that's how they're reported on
6 Home Health Compare.

7 So, they could be used to craft
8 practice, but the means for those outcome
9 measures at this time is just a benchmark and
10 publically report what is going on within that
11 setting.

12 CO-CHAIR PARTRIDGE: And I saw
13 multiple other hands over here.

14 Lisa?

15 MEMBER MORRISE: Thank you.

16 I looked at bathing and transfers.
17 The thoughts that I had around these, a couple of
18 thoughts.

19 One is that I understand what Len is
20 saying that there's -- when you determine that an
21 organization does not meet a ceratin level of
22 being able to provide these services, there's no

1 follow-up currently.

2 But that's a usability issue and one
3 that we may want to look at if it's going to be
4 used for payment so that there's some kind of
5 motivation to improve. Because there currently
6 is a gap between the small agencies and the large
7 agencies in ability to provide those services.

8 I really appreciate what Peter had to
9 say. I think, though, that that gets to a policy
10 issue in also with usability versus a measure.
11 The measure is still the measure and that we need
12 to look at policy if there are unintended
13 consequences to the measure when we get back to
14 usability so that we have some kind of follow
15 through. So, that's all kind of interconnected.

16 And I know that in our experience with
17 home health interventions like these, we do reach
18 a threshold where we've met goals and then home
19 health goes away and then we fall backwards.

20 So, there needs to be communication
21 with the patient so that there's kind of ongoing
22 assessment.

1 But anyway, those are just my
2 thoughts. I'd love to vote.

3 CO-CHAIR PARTRIDGE: Managing drugs
4 and I'm --

5 CO-CHAIR STILLE: Yes, the last two
6 are a little bit different from the others.
7 Maybe --

8 CO-CHAIR PARTRIDGE: Yes, I think --

9 CO-CHAIR STILLE: -- Med Management
10 and Pain.

11 CO-CHAIR PARTRIDGE: Pain's one of my
12 favorites.

13 CO-CHAIR STILLE: SD had Med
14 Management and Sherrie and Deb had pain.

15 CO-CHAIR PARTRIDGE: Esther?

16 MEMBER NEUWIRTH: Yes, so this one is
17 widely in use but -- is it working now?

18 This one's widely in use. I don't
19 think we had many questions in relation to it.
20 But, I would say, you know, because it's widely
21 used and tracked and has a long track record, I
22 guess some of the questions that we had related

1 to the fact that lots of patients are excluded
2 from this measure, so that seems like it -- some
3 questions around applicability and use.

4 And then personally, I was wondering
5 why this isn't a real PRO and I think that came
6 up in some of our reviewer comments as well.
7 Seems like there could -- this could very well
8 be, you know, directly asked of patients rather
9 than simply assessment because there might be
10 some bias there.

11 Then it wasn't also clear how this
12 really drove improvement efforts.

13 CO-CHAIR PARTRIDGE: Sherrie Loeb?

14 MEMBER LOEB: The pain one, I believe
15 is also widely used. Pain is just a really
16 tricky one to assess. You know, what's the worst
17 pain for one person is minimal for someone else.

18 So, you know, we've got to track it.
19 We've got to continue and home health is
20 important to know what they're doing, what
21 they're helping with, what the physician's
22 prescribing at home is going to work.

1 But, whether we ever can truly find a
2 tool to adequately assess it, you know, good
3 luck. I hate the 1-10 scale. I hate the smiley
4 faces, you know. Someday we're going to come up
5 with --

6 MR. HITTLE: This David Hittle from
7 the University of Colorado.

8 I should stress that we're not using
9 the 1-10 scale. We're not using smiley faces.
10 We're using how often does pain interfere with
11 activities.

12 MEMBER LOEB: Right.

13 MR. HITTLE: And that's the scale that
14 we're measuring folks on.

15 MEMBER LOEB: And that's so much
16 better. I mean, you know, when patients come
17 into hospitals and they're saying, you know, rate
18 your pain on a 1-10 scale and it's happened to
19 me, you know, at times. You know, if I'm going
20 into an emergency room, my pain's usually 15.

21 So, I like the fact that, you know, if
22 it's interfering, especially if you have home

1 health coming to your home, they're helping you
2 with your function, with your ADLs and to get
3 back to your --

4 You know, at least your baseline or
5 hopefully better, so to help that it's not
6 interfering and you're able to move on. So, I
7 like that.

8 CO-CHAIR PARTRIDGE: Katherine?

9 MEMBER BEVANS: I just don't know how
10 we're handling the multiple measures --

11 CO-CHAIR STILLE: We're discussing
12 that.

13 MEMBER BEVANS: -- in a minute.
14 Okay, I just want to suggest that I would like to
15 talk a little bit about the appropriateness of
16 other reporters for assessment of pain, in
17 particular, so that we can consider that
18 independently.

19 CO-CHAIR STILLE: Yes, we'll consider
20 pain separately, I think.

21 MEMBER BEVANS: Okay, thank you.

22 CO-CHAIR STILLE: As long as everyone

1 feels good about that.

2 CO-CHAIR PARTRIDGE: It's my judgment
3 as we've talked about these five that there are
4 issues and, perhaps, at different levels in
5 whether it's importance or feasibility or
6 usability.

7 And probably we should consider voting
8 one by one or if we could do it as a group but I
9 wonder --

10 Okay, but I would be open to
11 recommendations.

12 CO-CHAIR STILLE: Sure.

13 CO-CHAIR PARTRIDGE: Lisa and Chris?

14 CO-CHAIR STILLE: Lisa first.

15 MEMBER MORRISE: Let's just get on
16 with it.

17 CO-CHAIR STILLE: Okay. I'd like to
18 recommend that we talk about the first three as a
19 group and then the last two med and pain
20 separately.

21 I see some heads nodding.

22 CO-CHAIR PARTRIDGE: Okay. So,

1 Nadine, you want to work your magic?

2 MS. ALLEN: Voting on evidence, one
3 yes, two no. Voting starts now.

4 For this measure, for the three
5 grouped measures, can we do a hand vote? I'm
6 experiencing some difficulties with the evidence
7 slide.

8 So, yeses?

9 (A SHOW OF HANDS)

10 MS. ALLEN: Voting on performance gap,
11 one high, two moderate, three low, four
12 insufficient. Voting starts now.

13 Still waiting on a couple of votes.

14 All votes are in, 18 percent high, 76
15 percent moderate, six percent low, zero percent
16 insufficient.

17 For evidence, the results were 17
18 yeses and zero no.

19 Voting on high priority, one high, two
20 moderate, three low, four insufficient. Voting
21 starts now.

22 So, all votes are in, 59 percent high,

1 41 percent moderate, zero percent low, zero
2 percent insufficient.

3 Voting on reliability, one high, two
4 moderate, three low, four insufficient. Voting
5 starts now.

6 All votes are in, 35 percent high, 47
7 percent moderate, six percent low, 12 percent
8 insufficient.

9 Voting on validity, one high, two
10 moderate, three low, four insufficient. Voting
11 starts now.

12 All votes are in, 29 percent high, 41
13 percent moderate, 12 percent, 18 percent
14 insufficient.

15 Feasibility, one high, two moderate,
16 three low, four insufficient. Voting starts now.

17 Still waiting on one vote.

18 All votes are in, 53 percent high, 41
19 percent moderate, six percent low, zero percent
20 insufficient.

21 Voting on usability, one high, two
22 moderate, three low, four insufficient

1 information. Voting starts now.

2 So, all votes are in, 24 percent high,
3 65 percent moderate, 12 percent low, zero percent
4 insufficient information.

5 Voting on overall suitability for
6 endorsement of measure 0167, 0174 and 0175.

7 Voting starts now, one yes, two no.

8 All votes are in, 100 percent yes,
9 zero percent no.

10 CO-CHAIR PARTRIDGE: But I do not want
11 us to lose Peter's point. And the question is
12 how we incorporate that in our comments somehow
13 and perhaps CMS would like to come back to us to
14 talk a little bit about the possibility of
15 amending the exclusions of the denominator.
16 That's one obvious way to look at it. There
17 might be others.

18 But when this gets to CSAC, this issue
19 will come up and both of us who are -- Ann and I
20 are going to have to be able to respond.

21 So, I'm getting a nod from CMS, thank
22 you.

1 MEMBER MORT: If I could just
2 reinforce the importance of that comment.

3 And I looked through the OASIS, a 25-
4 page assessment, and as physician, when I order
5 home care services, I don't order everything.
6 It's in some menu and I'm picking certain things
7 that I want this particular patient to benefit
8 from.

9 That might be some way in which you
10 could identify what the goals of a home care
11 episode are and monitor exactly who gets in the
12 denominator.

13 So, to judge a home care facility on
14 a criterion that I wasn't looking to improve just
15 screws, you know, distorts it. And that would be
16 a way, I think, Peter, to get at what you're
17 concerned about.

18 If I'm ordering home care for nursing
19 care to monitor congestive heart failure and
20 ambulation is not an issue for this patient, the
21 patient is where the patient is going to be.
22 Then I think the home care services should be

1 judged on their performance on the medical
2 issues, not on the PT issues. PT may not even
3 come.

4 So, that's a way that I think you
5 could address some of these really important
6 issues.

7 CO-CHAIR STILLE: And when I agree, I
8 mean from a child health standpoint, and these,
9 you know, all should basically be extended down
10 once we get them going, right, it's a relatively
11 small number of kinds and adolescents that have
12 ambulation as a piece of their home health care.
13 It's usually a lot of different things, many
14 things on this list, but, yes.

15 MEMBER THOMAS: Just quickly, no one
16 is saying that it's not important, the measure
17 improvement in home health services. That's not
18 what I was getting at for sure.

19 It's very important for most people,
20 but my only concern is that you put -- you don't
21 want to create a system where you've got
22 disincentives to treat the people who may not

1 improve but still might need that therapy in
2 order to maintain or prevent deterioration of
3 function.

4 Degenerative, you know, progressive
5 kind of disorders or neurological diseases and
6 things of that nature where they have every right
7 to and Medicare is supposed to cover that care.
8 And if there's a system in place that measures
9 improvement alone without any recognition of
10 that, there is a real risk that those people
11 would be under served and that's -- it's not
12 something we should do.

13 MS. MCMULLEN: Yes, I mean -- and I
14 wanted to say something on behalf of CMS earlier
15 and I'm with my Deputy Director for the Division
16 of Chronic and Post-Acute Care.

17 We hear you and we agree with you and
18 we are moving in the way where we are able to
19 balance out the incentives so that we're not
20 developing measures that are seen as being able
21 to disincentivize care or take away from the
22 actual goals of the resident or the patient or

1 the individual whoever that may be.

2 So, yes, we hear you and I have taken
3 notes and we will be able to respond to that if
4 need be at the CSAC or what not.

5 MEMBER THOMAS: So, we don't need to
6 talk about this further every time this comes up.
7 This applies to home health, SNF and outpatient.
8 And whenever you've got that scenario, if you're
9 measuring improvement, you've got to have some
10 way to accommodate this settlement that CMS has
11 signed on to.

12 Thanks.

13 MEMBER KAPLAN: I have one quick
14 question. If we've endorsed these measures, is
15 there -- we would still like to get some of the
16 evidence that we've asked for on, for example,
17 inter-class correlation coefficients, the means
18 for the fit data for Rasch variables, et cetera,
19 et cetera.

20 Is there -- how does that work?

21 MS. THEBERGE: The developers can
22 provide it.

1 CO-CHAIR PARTRIDGE: I think it's
2 always in the developer's interest where we've
3 asked for it to provide it. It makes our case
4 for recommendation stronger or weaker, but we
5 hope strong, and particularly when we've got gray
6 zones -- we don't have gray zones here, but where
7 we do, it becomes very important.

8 Sherrie?

9 MEMBER LOEB: Just two quick comments.

10 I know that Liz who said as far as,
11 you know, you recommend just a certain thing with
12 home health, I think from the patient standpoint
13 and from the nursing standpoint, when the home
14 health nurses go out there, they may see things
15 that the physician doesn't see in their quick
16 visit.

17 And so, I mean I have had some -- a
18 phenomenal home health nurse who came out and
19 noticed things that maybe the internist didn't
20 because they were only there for a short time.
21 So they may pick up things they do need.

22 And, yes, you may have a CHF patient

1 who you want, you know, that taken care of, but
2 who can't walk because of the CHF and so needs
3 that kind of rehab, too.

4 And the other point is, if we know
5 there's not going to be any improvement because
6 of their chronic illness, that, unfortunately,
7 hurts the patient in a lot of aspects. They a
8 lot of times won't qualify for any more physical
9 therapy. There's no improvement so we're not
10 going to give them physical therapy. But what's
11 going to happen without that physical therapy?
12 Because they're going to go backwards.

13 So, the same thing can come into play
14 with the home health, you know, visits. You
15 know, there has to be some type of, you know,
16 exclusion much like, you know, not everyone can
17 get a beta blocker with cardiac disease, so
18 there's a way to, you know, exclude it so you're
19 not quote, dinged by accreditation.

20 So, in the future, somehow there has
21 to be a little box so you're not hurt by not
22 improving.

1 CO-CHAIR PARTRIDGE: All right. We've
2 talked about the first three and we've talked
3 briefly about 0176 and 0177.

4 Is there -- and Katherine wanted to
5 talk a little bit about those further.

6 MS. RICHARD: So, do you want sort of
7 the brief introduction of those other two
8 measures?

9 MEMBER BEVANS: No, not necessary.

10 CO-CHAIR PARTRIDGE: No, we're
11 comfortable with --

12 MS. RICHARD: Okay.

13 CO-CHAIR PARTRIDGE: Thanks anyway.

14 MEMBER BEVANS: Yes.

15 MS. RICHARD: No problem.

16 MEMBER BEVANS: It's really just, you
17 know, as I mentioned, the point that the validity
18 of other reports, other individuals reports of
19 someone's pain has certainly been questioned.

20 And so, to the developers, have there
21 been any validity tests done, evaluations of
22 accuracy of the other reporters in comparison to

1 the individuals report of pain at the individual
2 level?

3 CO-CHAIR STILLE: So, this is for
4 0177?

5 MEMBER BEVANS: Yes.

6 MS. RICHARD: This is Angela.

7 We've not done those particular
8 studies and in the latest reviews, I haven't
9 really seen a comparison of that.

10 MS. COOK: This is Keziah.

11 I think it may also be important to
12 note that when the home health agency fills out
13 the assessment item, the assumption is that they
14 are drawing on multiple sources of information.
15 They're drawing on their own observations of the
16 patient, they're drawing on things that the
17 patient has said and also potentially drawing on
18 information from other family members or care
19 givers.

20 So, they may directly ask the patient
21 to what extent is pain interfering with their
22 ability to do certain tasks, they're also

1 observing the patient.

2 So, if they notice the patient is
3 really slower, hesitant to stand up and they're
4 grimacing, that may, you know, be sort of
5 evidence that pain is interfering with that
6 patient's ability to do that particular task.

7 CO-CHAIR PARTRIDGE: Okay, further --

8 MS. RICHARD: Yes, that's very true.
9 I'm sorry, that's right, multiple sources of
10 information are used for the assessment of their
11 function.

12 CO-CHAIR PARTRIDGE: Further comments
13 or questions about either of these?

14 Lisa?

15 MEMBER MORRISE: In my experience, the
16 ability of a patient to manage their own
17 medications has a number of variables attached to
18 it and I'm not seeing those necessarily here.

19 For example, when you start getting
20 over a certain number of medications or a
21 complicated schedule, it doesn't matter if you
22 sit down and you do a chart and you do everything

1 possible. It's just you're not going to get
2 adherence because of the complexity of the
3 situation.

4 So, I'm looking at this measure and
5 thinking, gosh, you know, if they have two
6 medications then this probably works really well.
7 But in the realistic scheme of things where I had
8 one mom recently who posted a picture of
9 something like 30 medications that her child had
10 to take when he came home, no amount of health
11 care intervention was going to ensure that this
12 very adherent, compliant, trying to do the best
13 for her child mom was going to actually achieve
14 getting all of those medications in her child.

15 And I realize that the measure isn't
16 looking at pediatrics, but it's analogous to the
17 adult situation.

18 So, I'm questioning that maybe there
19 needs to be some other variables that are looked
20 at.

21 MS. RICHARD: it might be a caveat
22 that we do have a medication cross list measure

1 that looks at education and it's also possible
2 for the home health agency to request that a
3 doctor does sort of have medication
4 reconciliations.

5 MEMBER MORRISE: Can I just follow-up
6 and say, medical reconciliation current consists
7 mostly of going over a list. It does not help a
8 patient in terms of how they actually take those
9 medications.

10 I know when my adult child came home
11 from the hospital a little over a year ago with
12 ten medications to deliver by NJ tube, I
13 practically cried because it was more than I
14 could figure out. And all anybody ever did in
15 terms of MedRec was to say you're taking this med
16 and this med and this med and this med and that
17 is not helpful.

18 CO-CHAIR STILLE: So, Lisa, that's a
19 good point. I went into the validity section and
20 kind of re-read it and it sounds as though that
21 there's been a lot of validation by the fact that
22 they use it a lot and that people find it useful

1 but not a whole lot of objective things, which
2 would arguably be hard to do, although possible,
3 you know, chart reviews, bottle, you know, bottle
4 validation, stuff like that.

5 So, yes, that's a good point.

6 CO-CHAIR PARTRIDGE: Are we ready to
7 vote?

8 Nadine, 0176 and then 0177.

9 MS. ALLEN: Evidence, one yes, two no.
10 Voting starts now.

11 CO-CHAIR PARTRIDGE: This is a one at
12 a time vote just for any confusion.

13 MS. ALLEN: This is for measures 0176.

14 All votes are in, 94 percent yes, six
15 percent no for evidence.

16 Performance gap, one high, two
17 moderate, three low, four insufficient. Voting
18 starts now.

19 All votes are in, 31 percent high, 63
20 percent moderate, six percent low, zero percent
21 insufficient.

22 Voting on high priority, one high, two

1 moderate, three low, four insufficient. Voting
2 starts now.

3 All votes are in, 75 percent high, 25
4 percent moderate, zero percent low, zero percent
5 insufficient.

6 Voting on reliability, one high, two
7 moderate, three low, four insufficient. Voting
8 starts now.

9 MEMBER KAPLAN: I just had the same
10 comment I had for reliability that I had before
11 which is, we don't have the facility level
12 reliability inter-class correlation coefficients,
13 et cetera, et cetera. So, as that issue becomes
14 a uniform issue if these get approved and then we
15 don't get those data because there's no incentive
16 for the developer to give us those data.

17 MS. COOK: I'm sorry, this Keziah.

18 We did include our reliability
19 statistics at facility. The beta binomial tests
20 compared with in the between variation at the
21 facility level. And we also reported test,
22 retest, IPC.

1 MEMBER KAPLAN: No, it says at the
2 measure level and the earlier --

3 MS. COOK: I mean, so what those are
4 doing is they are calculating the measure at the
5 facility level and then comparing those rates.

6 MEMBER KAPLAN: No, no, no, I
7 understand that. But it's the measures that are
8 being -- it's not the way you're going to use the
9 score which is as a composite across the
10 measures. That's what we're looking for.

11 MS. COOK: We're not using these as a
12 composite. These are reported individually.

13 I'm sorry, I feel like we're being
14 conflated with the previous group of measures
15 maybe. Each of these measures are reported
16 separately as rates both for public reporting and
17 for quality improvement.

18 MS. ALLEN: Voting on reliability.
19 Voting starts now.

20 Still waiting on one vote.

21 Please vote again.

22 All votes are in, 13 percent high, 56

1 percent moderate, zero percent low, 31 percent
2 insufficient.

3 Voting on validity, one high, two
4 moderate, three low, four insufficient. Voting
5 starts now.

6 Still waiting on a vote.

7 All votes are in, six percent high, 56
8 percent moderate, six percent low, 31 percent
9 insufficient.

10 Voting on feasibility, one high, two
11 moderate, three low, four insufficient. Voting
12 starts now.

13 All votes are in, 38 percent high, 56
14 percent moderate, six percent low, zero percent
15 insufficient.

16 Voting on usability and use, one high,
17 two moderate, three low, four insufficient
18 information. Voting starts now.

19 All votes are in, 19 percent high, 56
20 percent moderate, 19 percent low, six percent
21 insufficient information.

22 Voting on overall suitability for

1 endorsement of Measure 0176, Improvement in
2 Management of All Medications, one yes, two no.
3 Voting starts now.

4 Still waiting on a vote.

5 All votes are in, 100 percent yes,
6 zero percent no.

7 CO-CHAIR STILLE: Okay, so let's have
8 a brief discussion of anything else related to
9 the pain measure. I know we've talked about
10 that, there may not be anything left to discuss.

11 CO-CHAIR PARTRIDGE: Silence.

12 CO-CHAIR STILLE: I think we need a
13 break, but I think we need to vote before a
14 break.

15 CO-CHAIR PARTRIDGE: Nadine?

16 MS. ALLEN: Voting on Measure 0177,
17 voting on evidence, one yes, two no. Voting
18 starts now.

19 All votes are in, 100 percent yes,
20 zero percent no.

21 Voting on performance gap, one high,
22 two moderate, three low, four insufficient.

1 Voting starts now.

2 Still missing a vote.

3 All votes are in, 31 percent high, 63
4 percent moderate, zero percent low, six percent
5 insufficient.

6 Voting on high priority, one high, two
7 moderate, three low, four insufficient. Voting
8 starts now.

9 All votes are in, 69 percent high, 31
10 perfect moderate, zero percent low, zero percent
11 insufficient.

12 Voting on reliability, one high, two
13 moderate, three low, four insufficient. Voting
14 starts now.

15 All votes are in, 19 percent high, 56
16 percent moderate, 25 percent insufficient, zero
17 percent low.

18 Voting on validity, one high, two
19 moderate, three low, four insufficient. Voting
20 starts now.

21 All votes are in, 13 percent high, 50
22 percent moderate, 13 percent low, 25 percent

1 insufficient.

2 Voting on feasibility, one high, two
3 moderate, three low, four insufficient. Voting
4 starts now.

5 Still waiting on a vote.

6 All votes are in, 50 percent high, 50
7 percent moderate, zero percent low, zero percent
8 insufficient.

9 Voting on usability, one high, two
10 moderate, three low, four insufficient
11 information. Voting starts now.

12 Still waiting on a vote.

13 All votes are in, 31 percent high, 69
14 percent moderate, zero percent low, zero percent
15 insufficient information.

16 Voting on overall suitability for
17 endorsement of Measure 0177, Improvement in Pain
18 Interfering with Activity, one yes, two no.
19 Voting starts now.

20 All votes are in, 94 percent yes, six
21 percent no.

22 CO-CHAIR PARTRIDGE: We are going to

1 take a break, a stretch. And congratulations for
2 moving through a lot of measures in a difficult,
3 fast way.

4 CO-CHAIR STILLE: Yes, great work.
5 And then we'll start with -- do you want to start
6 with the IRF ones or the AHCAs?

7 CO-CHAIR PARTRIDGE: I think -- I'm
8 trying to remember what was yesterday's.

9 CO-CHAIR STILLE: AHCA measures, yes,
10 okay. So, let's start with 2613 and 2612.

11 (Whereupon, the above-entitled matter
12 went off the record at 10:44 a.m. and resumed at
13 10:59 a.m.)

14 CO-CHAIR PARTRIDGE: If I can -- I
15 hate to do this everybody, but if I can pull us
16 all back together. I'm going to turn - I'm going
17 to just start talking and if nobody's listening
18 then that's the way it is.

19 CO-CHAIR STILLE: Everyone, please sit
20 down.

21 CO-CHAIR PARTRIDGE: All right, we are
22 going to turn next --

1 We are now going to turn to our long-
2 suffering colleagues who have been patiently
3 waiting their turn while we rejiggered the agenda
4 multiple times and proceed to discussion of 2613
5 and to -- I can't read from the distance -- 2612?

6 CO-CHAIR STILLE: 2612, yes.

7 CO-CHAIR PARTRIDGE: Okay. And our
8 developers are here and please proceed.

9 MR. GIFFORD: So, my name is David
10 Gifford, I'm a geriatrician. We're from the
11 American Health Care Association and we have
12 before you two different measures, 2613 and 2612.

13 This is Improvement in Self-Care and
14 Improvement in Mobility. They are both based off
15 of the CARE tool, self-care and the mobility
16 components of the CARE tool that was developed
17 and validated by CMS.

18 It calculates risk-adjusted change
19 from admission to discharge for anyone admitted
20 from a hospital to a SNF regardless of payer.

21 And I'm not sure how much you want me
22 to go any more detail given the time and the pace

1 you guys are going. Better to answer questions
2 from you all.

3 CO-CHAIR PARTRIDGE: Anything further
4 you want to add right now or, if not, we will
5 proceed to the -- we'll turn to our discussants.

6 CO-CHAIR STILLE: Sharon and Peter.

7 CO-CHAIR PARTRIDGE: Okay.

8 CO-CHAIR STILLE: Yes.

9 CO-CHAIR PARTRIDGE: All right, Peter?

10 MEMBER THOMAS: Well, I won't go --
11 belabor it at all, but the same issue about the
12 Jimmo case, I think.

13 Although I do recognize there is risk-
14 adjustment in this, am I not correct? I'm
15 looking.

16 I found this to be fairly highly
17 rated, well, the evidence in terms of this
18 measure, I found it to be moderate.

19 I through the rationale speaks of
20 independent living but the measures are pretty
21 basic and I'm wondering whether -- I don't know
22 enough about the CARE tool.

1 Did you select a subset of measures or
2 is this all of the measures that would go to
3 mobility under the CARE tool?

4 MR. GIFFORD: I think they're all the
5 measures. We dropped one or two based on
6 feedback from CMS that were measures that did not
7 perform well in the PAC demonstration item. They
8 are very similar to off the Barthell or any of
9 the other items out there.

10 The mobility has 14 items, the self-
11 care has eight items. They are aggregated
12 together into an aggregate score that goes
13 forward with that perform well.

14 MEMBER THOMAS: So, because there's a
15 sizable portion of the SNF population that
16 hopefully will go home and live independently, I
17 have found that it'd be great if there were some
18 measures that assessed the ability to cook and
19 ascend stairs and things that I Just didn't see
20 in these, more ADL and IDL kinds of activities
21 that would enable someone to actually be mobile
22 upon discharge from the SNF.

1 Other than that, I did find that there
2 was a significant variation and room for
3 improvement in terms of performance gap. There
4 was no disparities data. I read that there's too
5 low a sample size. Can you --

6 MR. GIFFORD: Overall, about 15
7 percent of the entire nursing home population in
8 the country admitted to a SNF or of any sort of
9 ethnicity group, they all tend to be concentrated
10 in individuals.

11 There's a -- most of the studies that
12 have looked at disparity work have shown that
13 there is differences in disparity is to access to
14 whether they go to a SNF or an IRF or an LTCH.

15 There's very little on the differences
16 in quality in the SNF. Those that have looked at
17 it, not in the ADL or mobility section have shown
18 that there are disparities but they relate to the
19 types of providers that are in -- that they tend
20 to go to inner city, poor quality centers where
21 both Caucasian and all ethnicities have equally
22 bad outcomes.

1 So, if you looked at it at a
2 population level, you'd definitely see
3 differences where you don't.

4 We were following the strict guidance
5 from NQF that if you are going to look at any
6 ethnicity, you need to stratify that, you don't
7 risk-adjust for it. And the sample size is so
8 small in most nursing homes with only about ten
9 or 15 percent being of any ethnicity that you
10 would exclude over three-quarters of the SNFs in
11 the country from the measure.

12 Certainly with renewed information out
13 there, there may be a question about now risk-
14 adjusting it with the changes in policy at NQF.
15 But the guidance we got when we submitted this
16 was to not to do that.

17 MEMBER THOMAS: Did you want to stop
18 at reliability and validity and do that a little
19 later or do you want to continue to go?

20 CO-CHAIR STILLE: Ideally, that would
21 be great, yes.

22 MEMBER THOMAS: Okay. I mean the only

1 thing I'd say is that there is a, you know, what,
2 2.3 million Medicare admissions to SNFs in 2012
3 data, \$229 billion spent on it. So, obviously,
4 this is a very significant priority to try to
5 assess measurement of mobility in SNFs.

6 CO-CHAIR PARTRIDGE: Any other
7 comments on importance with respect to 2613? For
8 example, gap.

9 MEMBER MONROE: Just one of the things
10 that appealed to me about this measure, that it's
11 regardless of care. And I think some of the
12 other similar measures that we've seen have been
13 payer-specific which I think creates another set
14 of problems and encourages duplication of
15 measure.

16 So, I appreciate that this is
17 regardless of payer which makes it a more widely
18 available use tool.

19 MEMBER THOMAS: And I'll also Just say
20 that the American Occupational Therapy
21 Association submitted some comments and I found
22 them to be very helpful.

1 Where the description of this measure,
2 you know, refers to that these patients are
3 admitted for therapy in a SNF, that they made the
4 point, well, they're really admitted for overall
5 need and they received a significant amount
6 therapy typically.

7 But that's not necessarily why they're
8 admitted and they made that point. I just wanted
9 to call that out.

10 Do you, you know, do you disagree with
11 that?

12 MR. GIFFORD: Right now, 90 percent --
13 well, about 85 percent of all admissions to a SNF
14 come from a hospital. Of those, 90 percent of
15 them, whether they are in Medicare or not, end up
16 in a rehab rug, which means they'll be getting
17 PT, OT or speech therapy out there.

18 They often are there for additional
19 information but one of the primary purposes for
20 the skilled services is to improve their ADL
21 function and/or mobility so that they can
22 hopefully return home.

1 I think what you're touching on is you
2 probably need a portfolio of measures to look at
3 post-acute care, not just these measures
4 including discharge to the community which we
5 have a risk-adjusted measure we'll be bringing
6 forward to NQF, it just doesn't go to this panel,
7 it goes to a different group.

8 We're looking at satisfaction. We're
9 looking at rehospitalization measure which just
10 got approved by a different panel from NQF
11 recently. But you almost need to look at those
12 all in conjunction in any of the post-acute
13 providers, not just SNF but IRF or LTCH or anyone
14 else.

15 And I think your point is well taken
16 that if you're looking at a portfolio for overall
17 global care, you do, but we were limited to just
18 looking at function at this point.

19 I think in your comments about the
20 items in there, we wanted to use an assessment
21 instrument that was in the public domain that was
22 going to comply with the IMPACT Act that was

1 passed by Congress this last year and that CMS
2 was going to use.

3 And since they had developed and
4 modified it and we approached CMS, they indicated
5 that they were leaning towards using the CARE
6 tool. So, we elected to develop the measure
7 around the CARE tool for that purpose on reason.

8 I think the additional ALDs or IADLs
9 that you're talking about would make sense, but
10 probably would be a separate measure because of
11 the differences in the domain and the functional
12 level of the individuals that were there. And so
13 we were restricted to that domain. That would be
14 a whole new sort of measurement development
15 aspect.

16 The measure does look at some aspects
17 to getting home which would be going up and down
18 stairs. But some of the more IADLs like cooking
19 and cleaning are not there but clearly you have
20 to be able to do your ADLs to be able to get to
21 your IADLs if you want to get there.

22 CO-CHAIR PARTRIDGE: I have a question

1 that really goes to the CARE tool.

2 Some of the other measures we've been
3 discussing over the past two days include
4 questions about the patient's memory and
5 communication skills.

6 Are there questions related to those
7 issues in the CARE tool?

8 MR. GIFFORD: So, we took the -- the
9 CARE tool is a compilation of different
10 standardized assessments. One of them is
11 cognitive function.

12 We took the mobility and the self-care
13 assessment tools and used those for this measure.
14 We had long and lengthy discussion, we risk-
15 adjust for cognitive status but we use currently
16 the FIM score which is a validated score out of
17 the MDS to do the risk-adjustment.

18 We elected to risk-adjust all for MDS
19 items because they are standardized and reliable
20 and have been tested. Deb Saliba who developed
21 it can probably tell you a lot more about this,
22 but we use that and so we risk-adjust for

1 dementia.

2 We had a panel of therapists that
3 indicated that was a strong thing there and we
4 include that in the risk-adjustment model.

5 CO-CHAIR PARTRIDGE: Good, thank you
6 very much.

7 MR. GIFFORD: We're just not based off
8 the CARE tool one.

9 CO-CHAIR PARTRIDGE: Right.

10 MR. GIFFORD: If CMS inserts that into
11 the MDS, OASIS and IRF-PAI, we would switch over
12 and use that at that time but come back to you
13 with the modification of that, but, yes.

14 MEMBER THOMAS: Did that risk-
15 adjustment model also include say not just
16 Alzheimer's but something into brain injury or
17 something along those lines?

18 MR. GIFFORD: It includes a FIM score
19 which is overall sort of cognitive status, so we
20 capture a lot of those. So, rather than do it by
21 diagnosis by diagnosis we sort of did it more at
22 that functional level with the FIM score.

1 CO-CHAIR PARTRIDGE: Thank you.

2 Becky?

3 MEMBER BRADLEY: And I apologize, this
4 may not be the right section to discuss this, but
5 I couldn't find it in your submission and maybe I
6 missed it, but since this measure is based off
7 the post-acute care pilot that was done by CMS,
8 how many skilled nursing facilities participated
9 in that PAC that this research is based on?

10 MR. GIFFORD: This was not based off
11 the PAC demo. We actually collected our own
12 data. We trained about 500 therapists and had
13 three corporations and did it across a number of
14 SNFs and then validated it in about 600 SNFs
15 across the country.

16 Since that time, we've got, what is
17 it, Ellen, how many organizations? Forty-six
18 therapy organizations representing over a
19 thousand SNFs collecting this data across the
20 country.

21 MEMBER BRADLEY: Okay, thank you.

22 MR. GIFFORD: But Ann can probably --

1 how many were in the PAC demo -- SNFs in the PAC
2 demo? About 40 SNFs in the PAC demo, but that
3 was for the validation of the instrument and
4 tool. We used it to validate the measure here,
5 used 600.

6 CO-CHAIR PARTRIDGE: Sharon, do you
7 have any comments to add to those that Peter
8 made?

9 MEMBER CROSS: No, he pretty much
10 covered everything that I was going to comment
11 about.

12 The only question that I had actually
13 was related to feasibility, but I was trying to
14 keep in line so, yes.

15 CO-CHAIR PARTRIDGE: Are people -- I'm
16 sorry, Katherine?

17 MEMBER BEVANS: Yes, I have a question
18 first of all about the mobility measure. Is that
19 fair game at this point? Okay.

20 About the applicability of the tool in
21 looking at, and this sort of I think, echos one
22 of Peter's comments about the level of the items,

1 how sort of difficult they are in reviewing the
2 Rasch coefficient.

3 It appears that the items are largely
4 pretty good at measuring people on the upper end
5 of the mobility continuum as compared to the kind
6 of extreme low end and I'm curious to know your
7 thoughts on whether you feel this mobility --
8 this combination of items is going to do a good
9 job of sensitively discriminating people who have
10 very low levels of mobility.

11 Is it going to be able to assess
12 change among people who have low levels of
13 mobility both in and at the end of their care?

14 MR. GIFFORD: I think the tool
15 performs relatively well at those extremes. I'll
16 defer to Ann Deutsch from CMS who developed the
17 actual CARE tool to answer that in more detail.

18 But you see the items that's on page
19 seven of the application, you can see the items
20 there that rate on a 1-6 level. They held
21 together and when we did a separate validation
22 through Rasch, it looked and performed equally

1 well as in the PAC demo.

2 We did not use Rasch analysis to
3 transform the scores on this. We used the raw
4 scores based somewhat on the comments earlier and
5 the fact that when we calculate this measure with
6 the transformed score on Rasch and we calculated
7 it without a transformed score, the correlation
8 was .98.

9 And so, to keep the measure simple for
10 providers and members to understand and use it
11 and be able to more calculate it, we elected not
12 to use Rasch in the transforming of the data that
13 was out there.

14 But, because again, as I think
15 Sherrie's been pointing out over and over again,
16 this is a measure of a provider level not
17 individuals. And when you aggregate all this
18 together, a lot of these questions that have been
19 coming up actually become immaterial because it's
20 aggregating at the provider level. This is a
21 provider level measure as are the other measures.

22 MEMBER KAPLAN: Can I just follow that

1 up?

2 So, all of the reliability we still
3 don't have the reliability at the facility level
4 nor do we have the validity at the provider --
5 the variables here at the patient level for
6 everything, correct?

7 MR. GIFFORD: So, we relied on the --
8 for the reliability, we did do what we could do
9 with the availability of the data and use out
10 there. We did a bootstrap analysis looking at it
11 over and over again.

12 Yes, I agree, not perfect but it's --
13 we did something. No one else has done anything,
14 we did something. You've got to give us some
15 credit on something. Okay?

16 MEMBER KAPLAN: I'm all over it.

17 MR. GIFFORD: You passed everything
18 else with nothing, so we did something.

19 MEMBER KAPLAN: I appreciate the
20 effort and I'm not trying to smoke anybody. I
21 just -- or set the bar too high.

22 But, you could do with the data you

1 have inter-class correlation coefficients, right?

2 MR. GIFFORD: Yes, we could probably
3 try to go back and look at it.

4 We did look at the reliability across
5 with other instruments because we did this in a
6 number of the SNFs that were doing other
7 instruments and it was very -- it worked with the
8 Barthell and then the other two were sort of home
9 grown instruments that they had done, worked
10 relatively well.

11 As far as the validity, we validated
12 the measure with the individual items. We didn't
13 go back and validate them, we relied on the PAC
14 demo where they had done the validation of that.

15 MEMBER KAPLAN: What we were looking
16 for again and again is a thumb print that
17 suggests that there is a reproducible score
18 within facility that can then be used to compare
19 between facility differences.

20 If there is kind of buckshot within
21 the facility, that really weakens the ability to
22 use these to compare facilities.

1 CO-CHAIR STILLE: Should we start
2 voting? Becky, did you have -- okay.

3 CO-CHAIR PARTRIDGE: Are we doing it
4 together? I'm sorry, I'm sorry.

5 CO-CHAIR STILLE: Together or
6 separately?

7 CO-CHAIR PARTRIDGE: Together or
8 separately?

9 MEMBER THOMAS: (OFF MIC)

10 CO-CHAIR PARTRIDGE: Yes.

11 CO-CHAIR STILLE: Yes. Right.

12 CO-CHAIR PARTRIDGE: Right, we're just
13 talking about importance, two measures, is that
14 what we're saying?

15 CO-CHAIR STILLE: I think there's a
16 consensus for together.

17 CO-CHAIR PARTRIDGE: Okay.

18 CO-CHAIR STILLE: I don't see any
19 different.

20 MS. ALLEN: Voting on Measure 2613 and
21 Measure 2612, evidence, one yes, two no. Voting
22 starts now.

1 All votes are in, 94 percent yes, six
2 percent no.

3 Voting on performance gap, one high,
4 two moderate, three low, four insufficient.
5 Voting starts now.

6 Still waiting on a vote.

7 Please vote again.

8 All votes are in, 31 percent high, 56
9 percent moderate, six percent low, six percent
10 insufficient.

11 Voting on high priority, one high, two
12 moderate, three low, four insufficient. Voting
13 starts now.

14 Still missing two votes.

15 All votes are in, 63 percent high, 31
16 percent moderate, six percent low, zero percent
17 insufficient.

18 CO-CHAIR STILLE: Okay, now
19 reliability and validity.

20 CO-CHAIR PARTRIDGE: Discussion on
21 reliability and/or validity?

22 MEMBER THOMAS: There we go. So, the

1 measure is risk-adjusted and I found it to be
2 qualified as kind of easy to administer and
3 clear. Two data sets were used.

4 In terms of validity, the developers
5 compared the mobility measure to a whole host of
6 other ratings including the five-star rating, the
7 Nursing Home Compare and then some specific
8 measures like pressure ulcers, rehospitalization
9 and the like and received or obtained kind of
10 mixed results I would say, some good, some
11 moderate in terms of correlation between those
12 measures.

13 The one that I wanted to ask you about
14 is was the rehospitalization measure because you
15 expected a certain outcome and apparently it
16 didn't develop that way. So, apparently there's
17 -- was it a negative correlation between improved
18 mobility and increased rehospitalization? Which
19 really makes no sense.

20 MR. GIFFORD: Yes, probably that is
21 reflecting that patient population and the level
22 of improvement. We correlated with the NQF

1 endorsed rehospitalization measure and it was a
2 different direction.

3 The correlation was small but it was
4 different than we thought. We thought that if
5 better improvement we'd see a lower
6 rehospitalization, that's what the therapists and
7 clinicians and the group thought. But we saw the
8 opposite through our direction, I'm not exactly
9 sure.

10 All the rest of the measures that were
11 correlated the way they were with five-star
12 either moderate -- mild or moderate.

13 The strongest correlation was with, as
14 one would expect, was with discharge back to the
15 community and it was very strongly and
16 statistically correlated with being discharged
17 back to, you know, which would make sense with
18 both ADL and mobility that's out there.

19 I will add, we also looked at this
20 measure whether it be a changed score and sort of
21 to what you talked about before, Peter, or we
22 used just a discharge score risk-adjusting for

1 admission and the measure correlated at .98 and
2 essentially, that's the exact same measure.

3 MEMBER THOMAS: Okay.

4 MR. GIFFORD: And so, that's why we
5 came with just this one measure for that. And
6 what really drove it is that functional level,
7 the admission level which is really highly
8 correlated with, as we all know as clinicians,
9 through your clinical coming in point.

10 And that rehospitalization piece is
11 probably what was why we saw the differences,
12 it's about the sort of the acuity that's out
13 there, that if you're really sick, you're not
14 going to see as much improvement and get as much
15 therapy to do that.

16 It ended up being sort of a business,
17 but kind of with anything, you can start making
18 any explanations, so I'm not exactly sure why it
19 was with the rehospitalization.

20 I will say that rehospitalization, you
21 know, all the post-acute measures that we are
22 working on and developing, how you address it in

1 the measures is really critical because it really
2 throws everything out of whack.

3 MEMBER THOMAS: The exclusions,
4 ventilator patients, persistent coma,
5 quadriplegic, hospice, children accounted for
6 about, you said in the data, 1.1 percent of the
7 patients were excluded, is that right?

8 MR. GIFFORD: Yes, and we actually
9 have national MDS data for all. But all four
10 million admissions to the nursing home from CMS,
11 about two and a half Medicare fee-for-service,
12 the rest are non. And we looked at that and
13 nationally, this would be about one to two
14 percent for the exclusions would be excluded.

15 MEMBER THOMAS: So, just a thought --

16 MR. GIFFORD: And when we looked at
17 it, whether it was concentrated, because a lot of
18 those are sometimes concentrated in SNFs. There
19 was only, I think, about five or six percent that
20 had more than five percent of their admissions
21 related to those exclusions.

22 MEMBER THOMAS: So, just a thought in

1 terms of the improvement standard not applying to
2 SNFs. If you're already listing SNF-specific
3 conditions like ventilator and coma, et cetera,
4 quads, you might consider some conditions that
5 are typically degenerative or aggressive in
6 nature, some neuromuscular conditions where
7 patients might need that maintenance therapy and
8 not -- get dings for not improving, if you see
9 what I'm saying.

10 MR. GIFFORD: Yes. No, and there was
11 some discussion. We had a panel of therapists
12 and clinicians reviewing and this was their list
13 that they thought came up.

14 We had a lot of discussion about
15 making sure -- the default was we wanted to
16 include as many people in this measure even
17 though many of the clinicians had the same
18 concerns you did because we wanted to avoid the
19 game-ability and the unintended consequence of
20 starting to try to avoid it and moving people
21 around.

22 There was a lot of discussion about

1 whether there should be some improvement in those
2 individuals with degenerative diseases or not.

3 But we can certainly go back and look
4 at that. It's a small population, it wouldn't
5 change it that much.

6 MEMBER THOMAS: Other than that, I
7 think the feasibility, over a thousand SNFs
8 currently, you know, collecting this data using
9 this measure, but, what are there, are there --
10 how many SNFs are there out there?

11 MR. GIFFORD: There is 15,326 SNFs, I
12 believe, last count, though it fluctuates quarter
13 to quarter.

14 And I think, as I said, the IMPACT Act
15 requires the standardization of assessment tool
16 and CMS has leaned towards, and included with the
17 development of the CARE tool and our membership
18 has fully endorsed the adoption of the CARE tool
19 to be inserted into the MDS.

20 We would see this becoming very
21 feasible once it gets incorporated in the MDS
22 widespread. But in the meantime, we have a lot

1 of people and now that we developed this, a
2 number of our members are switching over and
3 starting to use this and the therapy companies
4 are starting use it.

5 And we're starting to work on
6 providing this measure should it get through NQF
7 to managed care companies who are very interested
8 in this.

9 MEMBER THOMAS: And finally, again,
10 the AOTA submitted comments that talk about how
11 mobility is one thing but is a real precursor for
12 deciding whether a person is ready to go home and
13 be independent. That involves things relating to
14 sequencing and problem-solving and temporal
15 appropriateness and memory and a whole host of
16 other things that really aren't included in this
17 measure.

18 You've already said that there are
19 other measure sets that could add some of this?

20 MR. GIFFORD: Yes, I mean we're not
21 saying this is the only measure for post-acute
22 care. This is a measure to look at the

1 effectiveness of therapy on mobility and we're
2 not claiming it any other way.

3 It does correlate -- I think if you're
4 looking -- really the goal is how many people are
5 going home and we do have that measure that's out
6 there which is, I think, a better measure to
7 capture all that.

8 And then I think there are other --
9 clearly there are other purposes for post-acute
10 care and you would need other measures to look at
11 that. I don't think you would smush them all
12 into one measure.

13 CO-CHAIR PARTRIDGE: Becky?

14 MEMBER BRADLEY: Earlier on some of
15 the other measures, we talked about the
16 importance of inter-rater reliability and the
17 training of the clinical staff that were
18 collecting this information.

19 Can you describe a little bit how
20 staff is trained and how you assess your inter-
21 rater reliability among these measures?

22 MR. GIFFORD: So, one we relied on the

1 PAC demo and the test they did with reliability.
2 In doing this, we developed a detailed training
3 around the program, particularly where there were
4 variations in the care focusing on where there
5 were variations in the CARE tool from the current
6 MDS scales or other scales they use.

7 We required them to all go through a
8 webinar training. We taped the webinar training
9 to go through. And then they had to take a post-
10 test that was a detailed scenario-based testing
11 and they then had to actually rate on the CARE
12 tool for each of those.

13 I think there were, I think 12
14 clinical scenarios for mobility and 12 for self-
15 care. And if you were going to be doing either
16 setting, you could do both. And you had to get,
17 I think, it was an 85 percent pass rate which
18 means you had to score it exactly right.

19 And there was a lot of discussion
20 amongst the therapists as to what would be right
21 and oh, well, maybe I would rate it a little bit
22 that way but we had a panel that did it and they

1 had to get it right and if they didn't they had
2 to, you know, go back and get that test and do
3 that.

4 And then once the therapists submitted
5 their first assessment, it was reviewed by a
6 coordinator for each of the companies to make
7 sure that they were filling out the items
8 correctly and that they had some basis for it.
9 And they compared it to the other tool.

10 And so, before they did that, they
11 passed that, they could not submit the data for
12 this analysis.

13 MEMBER BRADLEY: So, is that a
14 requirement ongoing for the organizations that
15 they do that continued testing and training so
16 that you continue to have inter-rater reliability
17 going forward?

18 MR. GIFFORD: You know, it's an
19 interesting question because we were just doing
20 it for this. We envisioned that it would be
21 incorporated into the training of the MDS which
22 CMS does and everything else. We have provided

1 this training to CMS.

2 But what's more interesting, maybe
3 Ellen can comment, is a number of the therapy
4 companies and others have taken our training and
5 using it and -- do you want to comment on how
6 they're using that training to do that -- so and
7 actually, it's sort of happening on its own. We
8 weren't going to make it a requirement, but many
9 are.

10 MS. STRUNK: Just to follow-up on what
11 Dr. Gifford said, the industry and professions
12 are very interested in trying to gather
13 information and realizing that we're coming from
14 a place where everybody has their own definitions
15 of things and there's no ability to compare.

16 And so, we find ourselves in the
17 situation we're in today with not being able to,
18 you know, explain and justify the care.

19 So, there is a great interest in the
20 industry out there to have something that is
21 compatible across everyone. So, as Dr. Gifford
22 said, we've had hundreds of therapists, it's a

1 three hour training.

2 It's free, it's available and we are
3 just trying to highly encourage anyone who uses
4 the tool to go through the training and go
5 through it on a regular basis so that we can feel
6 confident in the information.

7 MEMBER KAPLAN: I just want to correct
8 myself because I looked harder at the validity
9 evidence that you provided and it looks like,
10 although we don't have the facility level
11 reliability, if you use the patient level of
12 reliability, variables that you've gotten
13 correlations with other things that are purported
14 to measure quality at this level are -- they are
15 correlated in the range of a third to about half
16 of the reliable variance.

17 So, I correct myself. I want to go on
18 record to just make that observation.

19 CO-CHAIR PARTRIDGE: Are there further
20 comments?

21 Are we ready to vote? Nadine?

22 MS. ALLEN: Voting on reliability, one

1 high, two moderate, three low, four insufficient.

2 Voting starts now.

3 All votes are in, 43 percent high, 38
4 percent moderate -- sorry, 44 percent high, 38
5 percent moderate, six percent low, 13 percent
6 insufficient.

7 Voting on validity, one high, two
8 moderate, three low, four insufficient. Voting
9 starts now.

10 We're still missing a vote.

11 All votes are in, 31 percent high, 63
12 percent moderate, zero percent low, six percent
13 insufficient.

14 Voting on feasibility, one high, two
15 moderate, three low, four insufficient. Voting
16 starts now.

17 All votes are in, 25 percent high, 69
18 percent moderate, six percent low, zero percent
19 insufficient.

20 Voting on usability and use, one high,
21 two moderate, three low, four insufficient
22 information. Voting starts now.

1 All votes are in, 31 percent high, 56
2 percent moderate, 13 percent low, zero percent
3 insufficient information.

4 Voting on overall suitability for
5 endorsement of Measures 2613, Care Improvement in
6 Self-Care and 2612, Care Improvement in Mobility,
7 voting starts now, one yes, two no.

8 All votes are in, 100 percent yes,
9 zero percent no.

10 CO-CHAIR PARTRIDGE: And I want to
11 thank the association for your patience, for your
12 presentation, both your written materials and
13 your presentation today.

14 We apologize again for keeping you for
15 so long. But thank you for coming.

16 MR. GIFFORD: Thank you. The ends
17 justify the means.

18 CO-CHAIR PARTRIDGE: We're going to
19 give -- Sarah is going to give us a status
20 report. How are we doing? Well, we cleared the
21 first --

22 MS. SAMPSEL: So, we have five

1 measures left and they are split between
2 inpatient rehab and long-term care. But it think
3 it's all the same -- it's RTI and CMS.

4 So, we'll have them come up and we'll
5 start and move through those and see how far we
6 get.

7 We will be kind of keeping an eye out,
8 you know, we fully recognize a few folks have to
9 leave in the next hour or so and, you know, as
10 was mentioned earlier, at the point that we lose
11 quorum which is losing two more people, then
12 we'll have the discussions and vote later. But,
13 we'll see how these go.

14 CO-CHAIR PARTRIDGE: Okay, 2635 is at
15 the intermediate rehab level and we're going to
16 turn to Anne for her presentation or
17 introduction.

18 MS. DEUTSCH: Great. So, high, I'm
19 Anne RTI. Poonam is also with me from RTI and
20 from CMS, we have Tara, whom you met yesterday
21 and Stacy Mandl. And I think on the phone, Tracy
22 Kline, are you there?

1 MS. KLINE: Yes, I am.

2 MS. DEUTSCH: Great, thanks.

3 So, for efficiency, I thought it would
4 be helpful to kind of talk about what the item --
5 what the measures have in common and talk about
6 CARE tool in general, clarify a few issues that
7 have come up and then I'll get into talking about
8 each of the different measures. So hopefully,
9 that helps.

10 So, again, the items that we are
11 talking about as part of these four measures for
12 inpatient rehab facilities are care items. We
13 have split the items up into self-care and
14 mobility and the reason that we did that is
15 actually consistent with what Dave Cella had
16 mentioned earlier.

17 So, there was a lot of research done
18 on a lot of functional assessment instruments in
19 the past looking at adding motor-type items and
20 cognitive items together as well as bowel and
21 bladder.

22 And the research showed that those are

1 really different constructs or different concepts
2 and they really need to be split up.

3 And that's especially important when
4 you're looking at very heterogeneous patients
5 across different types of inpatient rehab
6 facilities and potentially long-term hospitals.

7 So, that's one of the reasons we ended
8 up doing self-care and mobility as separate
9 quality measures.

10 So, and, you know, cognitive, we
11 absolutely believe is very, very important. We
12 think that's actually should be measured in a
13 different quality measure.

14 I also wanted to clarify that the way
15 that the items are scored, for example, with
16 walking, if somebody walked extremely well but
17 they have a -- this individual, let's say, they
18 have a cognitive problem, and therefore, requires
19 supervision, the care score would reflect this
20 cognitive problem.

21 So, even though we consider them kind
22 of motor items, self-care and mobility, there is

1 a cognitive component to each of the items. If
2 somebody has cognitive problems, they will not
3 score independently on any of these items.

4 So, again, seven self-care items were
5 selected. As mentioned earlier, additional items
6 were tested as part of the post-acute care, post-
7 acute payment reform demonstration and the items
8 that didn't have good reliability or didn't
9 really measure to the construct well were not
10 included in this particular measure.

11 We have 15 mobility items to speak to.
12 I think, Peter, you had a comment about range of
13 ability being measured. So, we do have low
14 functioning items, things like bed mobility and
15 so we do go to a low end.

16 And then we also go to a high end by
17 looking at things like whether the person can
18 from a standing position, pick up an object from
19 the floor. And that's really important because
20 those are the kinds of things that individuals
21 sometimes fall when they're doing those kinds of
22 things after being hospitalized.

1 We also have things like car transfers
2 which, now a days, is a daily activity whether
3 the person is driving or not after they go back
4 to the community or take a taxi, getting in and
5 out of a car is important. So, we have some
6 harder items also across.

7 So, we talked a little bit about
8 testing yesterday. We presented in our materials
9 the testing across all post-acute care settings
10 as well as testing related to inpatient rehab
11 facilities.

12 Again, the development including
13 expert panels. We had patient representatives on
14 each of our panels.

15 So, we have four measures. The first
16 one is the mean risk-adjusted change in mobility
17 score between admission and discharge for
18 inpatient rehab facility and Medicare patients.

19 The second one is mean risk-adjusted
20 change in self-care score between admission and
21 discharge for inpatient rehab facility and
22 Medicare patients.

1 The third one is the percentage of
2 Medicare inpatient rehab facility patients who
3 meet or exceed an expected discharge mobility
4 score.

5 And the fourth one is the percentage
6 of Medicare IRF patients who meet or exceed an
7 expected discharge self-care score.

8 So, the items in the two self-care
9 measures are the same. The items in the two
10 mobility measures are the same. We're just
11 aggregating the data differently at the measure
12 level.

13 And the reason that we do that is
14 based on previous research where I created kind
15 of fake public reporting report cards. We went
16 out to consumers and showed them mean change in
17 function scores, self-care mobility. It was
18 fictitious data that we made up.

19 And consumers really didn't understand
20 what that meant. They understood measures that
21 are reported as percentage much better.

22 And so, we felt it was important given

1 that there's different stakeholders that have
2 interest in this data, that for consumers, the
3 percent measures would really be more
4 understandable. And for the industry inpatient
5 rehab facilities in this case, looking at mean
6 change in scores is actually what they are used
7 to looking at. So, that's why we have the two
8 sets of measures.

9 So, in terms of importance, I want to
10 address, you know, this is the reason inpatient
11 rehab facilities exist, improvement in function.

12 I think we mentioned in our
13 application that there are differences in outcome
14 in the literature that people have reported in
15 terms of race/ethnicity, also length of stay has
16 gone down in inpatient rehab facilities over time
17 and function has actually gone down as length of
18 stay.

19 So, it's really important to pay
20 attention to the financial incentives that are
21 lowering length of stay and could impact the
22 functional outcomes of patients.

1 So, we don't really have a numerator
2 denominator, so we -- similar to readmission
3 measures that have been presented, we have an
4 observed value that we create, an expected value
5 that's a risk adjusted value and then we multiply
6 the national average so you get a risk-adjusted
7 value.

8 Our risk-adjustment model, we spent a
9 lot of time, we've got a lot of feedback. We did
10 a public comment and got tons of feedback from I
11 think it was -- I don't remember how many people,
12 but, you know, we have a document, 300 pages of
13 public comment and everything that people
14 suggested we test, we tested in our regression
15 models to see if they were important risk-
16 adjusters.

17 We considered both clinical,
18 statistical literature when we put our models
19 together. We were very thoughtful, I think,
20 about our exclusion criteria.

21 So, for example, inpatient rehab
22 facilities admit patients with locked-in syndrome

1 sometimes in tetraplegic complete. And those
2 patients would not be expected to improve in
3 walking and so, we have exclusion criteria when
4 it is clinically appropriate these patients be
5 excluded.

6 Our expert panel was very supportive
7 of all of these exclusions because, as Peter
8 mentioned, unintended consequence, we don't want
9 people to have limited access because they're not
10 going to improve on these particular items.

11 So, this is a clinician-rated
12 instrument, not patient reported. CMS has
13 historically provided training, I know that's
14 come up. And as part of quality reporting
15 programs has done auditing.

16 Let's see, I want to bring the work
17 comments that were submitted, so I want to
18 address those comments.

19 So, somebody wrote in and said it was
20 data are based on a cross section study, that's
21 not accurate. It's actually a prospective cohort
22 study that we conducted. So, that's why we have

1 admission/discharge data.

2 We also link claims data so we could
3 look at readmission rates and all that related to
4 the data.

5 We did not use CART regression, so I'm
6 not sure where that comment came from.

7 We used a generalized linear model
8 with general estimation equations.

9 There was a comment that we only had
10 20 or 30 rain injury patients. In fact, we had
11 403, so I'm not sure where that comment is from.

12 Let's see, I guess Dave Cella made a
13 comment earlier about the raw versus Rasch. So,
14 I just wanted to address that because we chose
15 similar to the previous measure, we chose to do
16 the raw sum scores.

17 And that was based on research that I
18 was involved in that looks at minute of the
19 assistants and the raw scores, as Dave Cella
20 suggested, actually were more correlated with
21 minutes of assistance than the Rasch measures.
22 So, happy to provide a reference if people would

1 like that.

2 But, basically, minutes of assistance
3 is our gold standard. Minutes of assistance is
4 ratio level data integral level so that is an
5 appropriate gold standard I think.

6 I think that's it. So, did you want
7 to add anything else?

8 MS. MANDL: All right, I've been
9 asked, this is Stacy Mandl from CMS.

10 I've been asked to clarify on the
11 submission of data for Medicare beneficiaries.

12 Currently, through regulatory
13 requirement, through regulation, the data for the
14 IRF-PAI to CMS is required on Medicare
15 beneficiaries. And so, therefore, and the cohort
16 for this particular measure is going to be
17 Medicare for the IRF-PAI data that comes in.

18 Thank you.

19 MS. DEUTSCH: So, I'll pass it back to
20 the chairs.

21 CO-CHAIR PARTRIDGE: All right. So,
22 would we want to start with 2635 as our

1 discussion?

2 And it's Ann and Dawn.

3 MEMBER MONROE: I was concerned that
4 it was Medicare-only. I think that's a limited
5 look at the world and could result in a lot of
6 duplication of effort on the part of the
7 facilities, but that is what it is.

8 I want to ask you about, when I read
9 this, I had trouble distinguishing what it was
10 you were really trying to measure.

11 Was it how well the therapies or the
12 work within the IRF had done by the time someone
13 left or was it that the score when they left was
14 a predictor of how they would do in the
15 community?

16 And you said that in a couple of
17 places, but if that's going to be the case, then
18 I need to better understand why you think the
19 five today is a predictor of success in the
20 community and what you did to answer that
21 question.

22 Because this one seems, in my mind,

1 that you're taking a longer view than some of the
2 others we've seen which has changed from pre- to
3 post-. Is that clear? Do you understand what
4 I'm saying?

5 MS. DEUTSCH: So, we are looking at
6 the change between admission and discharge.

7 MEMBER MONROE: Right, but --

8 MS. DEUTSCH: So, that's consistent
9 with the other measures that have been presented.

10 MEMBER MONROE: But one of the things
11 you say in here is that because that score at
12 discharge, I thought, is predictive of success in
13 the community.

14 MS. DEUTSCH: Right.

15 MEMBER MONROE: And so, I'm asking for
16 the connection between the score at discharge and
17 success in the community.

18 MS. DEUTSCH: Yes, so that was part of
19 the general literature overview. And we did do
20 analyses and maybe, Poonam, you can look this up
21 specifically, but we looked at what the
22 relationship between the discharge scores and

1 whether people went back to the community or not.

2 So, a patients who were --

3 MEMBER MONROE: Or how well they did
4 in the community, is that different than going
5 back?

6 MS. DEUTSCH: Well, so we reported
7 like, I think in our supplemental material, the
8 average scores of patients who went in the
9 community versus those who didn't to show that
10 relationship.

11 And that reference to doing well in
12 the community is just part of our literature
13 review. We didn't -- so that's just part of the
14 evidence from the literature, not specific
15 analyses.

16 Does that help?

17 MEMBER MONROE: Well, it answers my
18 question, I guess. Because, to me, the outcome,
19 when you talk about it as an outcome measure,
20 you're really saying it's not patient outcome in
21 terms of their success in their functioning in
22 the community, it's the outcome is how they left.

1 Right? Which I would wonder is perhaps not an
2 outcome measure but, I don't want to pursue this
3 too.

4 MS. MCMULLEN: So, one of the many
5 uses of this measure is to be able to assess an
6 individual as they traverse the care continuum.

7 It's our idea of standardization, so
8 you'll see that presented in the panel the last
9 two days. We had two LTCH measures, we have
10 these four IRF measures and under the IMPACT Act,
11 you know, we have to standardize in all these
12 settings and things of that nature.

13 These measures are developed in a way
14 that from admission to discharge, we are able to
15 see a change in functional independence in either
16 self-care or mobility so that we, through these
17 measures, have uniform outcomes so we can link
18 all these outcomes.

19 So, if someone enters into an LTCH,
20 they move into and IRF, they move into a SNF,
21 they go into a home health agency and their
22 service is in that setting, that we're able to

1 follow them and to assess the complexity within
2 those changes.

3 So, simply at this very point in time,
4 these measures were created for those linking
5 purposes among other purposes. It was for the
6 purpose of standardization.

7 So, you'll see that the one LTCH
8 measure with the vent, but with the four RIF,
9 they are created there so we have those uniform
10 outcomes.

11 I don't know if that helps with some
12 of the outcome and kind of conceptualizing the
13 form measures and why they're developed, but it
14 was for the sake of uniformity.

15 MEMBER DOWDING: I just have a query
16 because this particular measure we're talking
17 about, just for the benefit of the people around
18 the room who may not have read it in detail, is
19 that, with this particular measure, you're
20 calculating an expected score on discharge on
21 admission and then comparing their actual score
22 on discharge to that expected score. And that's

1 different to the mean change in function or self
2 care at discharge. That's very different in
3 terms of conceptualization, and it depends a lot
4 on the accuracy of the risk-adjusted expected
5 models. It's not a normal risk adjustment. The
6 risk adjustment is actually saying what do we
7 expect this person to do on discharge, so that's
8 quite a different conceptualization, if I've
9 understood it right because I might not have
10 understood it right. It's quite a complicated
11 thing to get your head around.

12 MS. DEUTSCH: So there's four
13 measures.

14 MEMBER DOWDING: Yes.

15 MS. DEUTSCH: So there's two self-care
16 measures and two mobility measures. So for one
17 self-care measure and one mobility measure, we're
18 looking at change in function.

19 MEMBER DOWDING: Yes, because that's
20 not this measure. This is the expected change --

21 MS. DEUTSCH: I was kind of describing
22 all four together at first, and then you're

1 right. I mean, there's two that are change, and
2 those are risk-adjusted values. And then we
3 also, secondarily, have this percent of patient
4 who meet or exceed a benchmark, which in this
5 case is the risk-adjusted value. So there's one
6 self-care measure for that and one mobility
7 measure for that, yes.

8 MEMBER DOWDING: Yes. So why have we
9 got four? Why don't we just have the two and
10 change? Why have we got this very complicated
11 expected risk-adjusted model, which, actually,
12 for the discharge self care isn't actually that
13 bad, but for the other ones the actual predicted
14 values are pretty low. So I would be really,
15 really unhappy if I was an IRF and I was being
16 expected to reach a functional score which only
17 predicted 30 percent of patient outcomes. So I
18 don't understand why we've got four, why we don't
19 have the two. And it's just, you know, why are
20 we over-complicating things, in my view.

21 MS. DEUTSCH: So I guess, I mean, the
22 data collection isn't different for the two

1 measures.

2 MEMBER DOWDING: No, I know, which,
3 again, my reason is why are you calculating two
4 different scores, which, essentially, you're
5 using the same data? I just don't understand why
6 we have four and not two. It's just a --

7 MS. DEUTSCH: Right. So as I
8 mentioned, in other research that I've done we
9 actually prevented change scores to consumers. I
10 went out to some, you know, day programs for
11 elderly, and the consumers that we presented,
12 they did not understand what a change score was.
13 They did understand quality measures that were
14 reported as percentages, so I think it's really
15 the issue that we have different audiences for
16 these quality measures and so they have a
17 different understanding and ability to understand
18 some of these things, I think.

19 CO-CHAIR PARTRIDGE: Anne, it seems to
20 me what you're talking about is we've got the
21 same data, we can furnish either, we can present
22 it to you either way, and it's really a question

1 for the ultimate user which way they want to go.
2 And so I think I'm echoing Dawn's question: do we
3 have to have separate measures, or can we have a
4 single measure with the option to report?

5 MS. DEUTSCH: I wouldn't know how to
6 fill out an NQF application and not make it
7 complicated by doing it two ways, and so that's
8 why we presented it as two different quality
9 measures.

10 CO-CHAIR PARTRIDGE: Helen and Sarah?

11 DR. BURSTIN: It's a good question.
12 I mean, it probably is a complexity of our form
13 that makes that hard to do. We do sometimes have
14 measures that are submitted with two rates in the
15 same measure. I think, just given the complexity
16 that I think was just pointed out, that's
17 probably hard to do. I mean, one question might
18 be should they at least be paired so that you at
19 least have an option of when you see one you see
20 the other, which might be one way of getting
21 around the idea of looking --

22 MEMBER DOWDING: And that also goes to

1 my anxiety about what then these are used for
2 because if you have two different measures,
3 they're using the same data but just analyzing it
4 slightly differently, which one of the IRF
5 facilities are actually going to be held
6 accountable to and which one their pay going to
7 be accountable to? It can't be both because
8 you're using the same information. And, again, I
9 would be very worried about the expected change
10 one, them being held accountable to that one,
11 because of the variation in the predictive models
12 that you're using.

13 MS. MANDL: This is Stacy from CMS.
14 I'd like to jump in on the policy question.
15 These measures aren't used for pay for
16 performance. They're not, we're not seeking
17 endorsement for measures for use for pay for
18 performance. That's a whole other ball of wax.
19 It's the same data elements used to be able to
20 calculate the two variations of the same measure.
21 Consumer feedback, which moves beyond what Anne
22 has suggested, is it's an exponential request

1 that the consumers be able to use this data. The
2 facilities need the data, as well, for other
3 purposes. They're very separate but both very
4 meaningful.

5 But I just wanted to just make sure
6 that the data coming in and the completeness of
7 the data coming in and the accuracy of the data
8 coming in is of the same data. So I just wanted
9 to clarify. These are penalty for failure to
10 report programs. Thanks.

11 MEMBER BIERNER: So I don't have a
12 concern with it. I think it will be very useful
13 for us, as an institution, to report to our
14 consumers, the clients that we seek to attract,
15 to present it in the percentage format or the
16 benchmark kind of format for public purposes and
17 then the other format for internal or for
18 reporting purposes.

19 So I like this score overall, but my
20 question is compare for me what you see as the
21 differences between this and what we've heard
22 earlier from the uniform data system measure,

1 which is using this Rasch format. Compare to me
2 how you think yours is better or in what way it's
3 different from that.

4 CO-CHAIR PARTRIDGE: We aren't in that
5 discussion, but, if you want to answer the
6 question, go ahead.

7 DR. BURSTIN: We typically look at
8 comparison to other measures after something has
9 been approved, so we probably don't need to do
10 that right now.

11 MEMBER BIERNER: Well, then tell me
12 about the six-point scale that you use.

13 MS. DEUTSCH: Yes, sure, sure. I'll
14 talk about the instrument, the items. So six-
15 level scale. Six is independent, five is setup
16 or clean-up, level four is supervision/minimal
17 assistance, level three is moderate assistance,
18 level two is substantial assistance, and level
19 one is dependent. Basically, as part of the
20 post-care payment reform demonstration and
21 instrument development, we had a lot of expert
22 panels. We reviewed all of the existing

1 instruments: the OASIS, the FIM, IRF-PAI, you
2 know, MDS. We asked for input. We also looked
3 at literature, you know, what fit within what
4 construct, what was reasonable in terms of
5 scoring.

6 So for example, we got a lot of
7 feedback that supervision takes a lot of time
8 with patients, especially at the time of
9 admission, the cognitive scores. So supervision
10 is actually coded level four on the CARE tool,
11 which is different than the FIM. And that was
12 the rationale.

13 Also, you know, the FIM allows up to
14 25 percent effort from the patient for level one.
15 But in talking to clinicians, they felt that
16 having a dependent score that was truly somebody
17 dependent was really important. So then if
18 somebody came in totally dependent, perhaps, you
19 know, minimally conscious, and then they made
20 some improvement, there would be documentation on
21 the CARE tool. They would go from a one to a
22 two.

1 And so, you know, again, this goes
2 back to what Peter said. Somebody who comes in
3 very low level, are you going to see improvement?
4 And in this case, that was the feedback that we
5 heard from clinicians. They wanted to have that.
6 So does that help?

7 MEMBER BIERNER: Yes.

8 MEMBER BRADLEY: And maybe I
9 misunderstood the representative from CMS that
10 addressed the payment. Did I understand you to
11 say that, for payment for IRF, they would
12 continue to use the IRF-PAI? Would the uniform -
13 - with the FIM embedded in that and going
14 forward. So is that what you said? I'm sorry.
15 I didn't understand that.

16 MS. MANDL: I'm not sure I'm
17 understanding.

18 MEMBER BRADLEY: So right now, for
19 payment purposes, there is a tool, the IRF-PAI,
20 inpatient rehabilitation hospitals are required
21 to use, and it has a scale already embedded in
22 that that drives our payment system.

1 MS. MANDL: No. What I was referring
2 to is the question about Medicare only. Our data
3 source is the IRF-PAI, and it's submitted, the
4 regulation dates way back for multiple purposes,
5 including care planning, as well as payment. But
6 that's the regulatory requirement, and that's
7 what drove -- when responding to the questions on
8 the form for NQF, what's the population, it's
9 Medicare. So that's all I was referring to.

10 MEMBER BRADLEY: So I guess my
11 question is is that scale going to continue to be
12 used? Because here this, I guess, not so much
13 competing measures but inter-rater reliability.
14 So if they're using a seven-point scale for the
15 payment on the IRF-PAI and then a six-point scale
16 of the same types of items and collecting
17 different measures, it seems like it would be
18 very confusing and the possibility of clinicians
19 getting confused about do I use a six-point scale
20 here or a seven point because the measures are so
21 similar but different.

22 MS. MCMULLEN: Right. So we can't

1 speak to what will happen with IRF. As it stands
2 today, we have the scales that we use. We've
3 developed these measures, the CARE measures, to
4 see, and even out of the Post-Acute Care Payment
5 Reform Demonstration and the development of the
6 CARE tool, the idea was to see if standardization
7 could happen between multiple different types of
8 assessment items within multiple different types
9 of assessment instruments. And we have, CMS has
10 been moving in the way with RTI as our contractor
11 to be able to develop measures to see if
12 standardization is possible. So that's where we
13 are today is we're presenting these measures for
14 consideration of endorsement, and these are the
15 first set of standardized measures that we've
16 been developing.

17 MEMBER BIERNER: Can I just say that
18 the six is actually more intuitive for most of us
19 who've worked in rehab and for a lot of
20 therapists and others than the seven have been,
21 so, actually, the terminology is more
22 conventional. So I like the six.

1 CO-CHAIR PARTRIDGE: All right. I see
2 Sherrie's card and I see Peter's hand up, so
3 Sherrie?

4 MEMBER KAPLAN: This is, you know, the
5 same old, same old. So on table one, these are
6 average Cronbach's alphas at the patient level by
7 facility. They're not the ICCs that we've been
8 talking about.

9 MS. DEUTSCH: Correct. So our data
10 are from the Post-Acute Care Payment Reform
11 Demonstration, and we only had data for either
12 six or nine months from the facilities, so we
13 weren't able to compare data over time. The
14 measure time frame is 12 months.

15 MEMBER KAPLAN: But you said something
16 about generalized estimation equations, and then
17 I was thinking, well, where are the splines? You
18 know, where are the nice little facility-level
19 error bars on the splines?

20 MS. DEUTSCH: We can get those for
21 you.

22 MEMBER THOMAS: I want to go back to

1 the two different measures that you are using for
2 both mobility and self care. So it seems to me,
3 and I just want to get your point of view, it
4 seems to me that it's probably, it seems to me to
5 be more accurate to assess the change in function
6 between admission and discharge, assuming that
7 some gaming, I suppose, could take place,
8 etcetera, than to come up with an expected
9 functional level and then see how you achieve
10 that, whether you exceeded it or didn't exceed it
11 or hit it. So it strikes me as being less
12 reliable to introduce that kind of subjective,
13 somewhat subjective, kind of expectation of how
14 well a person is going to do, and it's got all to
15 do, I'm sure, with all kinds of comorbidities and
16 all kinds of things.

17 And I guess my concern is what's to
18 prevent providers from expecting low and
19 exceeding high and looking really good in terms
20 of how well they do?

21 MS. DEUTSCH: So to address your first
22 comment, so certainly looking at change. We've

1 got much more granular data. We're taking
2 advantage of every piece of data that we have.
3 So you're absolutely right, there is more detail.

4 I think the percent measures, it's
5 just to make it more understandable to consumers,
6 again. So I can't speak to reliability. We
7 didn't have enough data to be able to test it.
8 And, certainly, I think that it's a great
9 question and we should do that. But in terms of
10 the expected value, I mean, the self care, I
11 think, is like 85 covariance. And we look at
12 comorbidities. We look at, you know, the
13 clinical condition. We included interactions in
14 our models. We tried to adjust for as much as we
15 could. Our mobility, I think, has 85 covariance
16 and our self care has, like, 74. So, I mean, we
17 did a lot of work on the risk adjustment to do as
18 good a job as we can. Does that address it,
19 Peter?

20 MEMBER THOMAS: It does. Thank you.

21 CO-CHAIR PARTRIDGE: Are we ready to
22 vote? Yes? The staff's suggestion is that we

1 take a look at two by two, 2635 and 2633, both of
2 which are the met or exceeded with respect to
3 self care.

4 MEMBER DOWDING: Can I just clarify?
5 Are we going to discuss reliability and validity
6 of these particular measures after --

7 CO-CHAIR PARTRIDGE: Yes, importance
8 first. Is that acceptable? Okay. The two that
9 relate to -- no, no, I'm sorry. Met or exceeded
10 and the other self care one.

11 MEMBER BIERNER: Self care, self care.

12 CO-CHAIR PARTRIDGE: Self care, self
13 care, yes. I'm having trouble reading my own
14 notes. Okay. Nadine?

15 MS. ALLEN: Voting on measure 2635 and
16 2633, discharge self-care score and change in
17 self-care score evidence: one yes, two no.
18 Voting starts now. All votes are in: 94 percent
19 yes, 6 percent no.

20 Voting on performance gap: one high,
21 two moderate, three low, four insufficient.
22 Voting starts now. All votes are in: 13 percent

1 high, 75 percent moderate, 6 percent low, 6
2 percent insufficient.

3 Voting on high priority: one high, two
4 moderate, three low, four insufficient. Voting
5 starts now. All votes are in: 56 percent high,
6 38 percent moderate, 6 percent low, zero percent
7 insufficient.

8 CO-CHAIR PARTRIDGE: Scientific
9 acceptability. Either. Reliability and
10 validity, Dawn?

11 MEMBER DOWDING: Okay. Well, this is
12 specifically with 2635, which is the one that I
13 was asked to review in detail, which is the
14 expected versus actual discharge, self-care
15 discharge scores. And I just, I mean, I read
16 through it a couple of times and you've got
17 really good data on the reliability and validity
18 of the CARE scale. I mean, we've demonstrated, I
19 think, fairly comprehensively that it's a
20 reliable and valid way of connecting data, but
21 that's not the measure we're being asked to
22 endorse. We're being asked to endorse your

1 calculation of a score related to somebody's
2 function at discharge compared to what their
3 expected score would be based on this risk-
4 adjusted predictive model, and I couldn't see any
5 data on the reliability and validity of that
6 measure.

7 MS. DEUTSCH: So let's see. We sent
8 some supplemental information that had the
9 relationship between discharge scores and
10 discharge to community. I'm sorry. Oh, and also
11 the relationship between the CARE scores and
12 length of stay, so that kind of speaks to some
13 validity issues. At the scale level, you know,
14 we presented several scale-level analyses. So,
15 like, the discharge score is basically what the
16 items as a group together and whether people meet
17 that benchmark or not.

18 So we provided reliability. I called
19 it scale level because it's the group of items.
20 So does that help?

21 MEMBER DOWDING: Well, I mean, I don't
22 have a problem with the score or the status.

1 It's this whole distinction between the scale
2 that you're using to develop the measure and the
3 measure itself, and the measure itself is this
4 expected versus actual function at discharge.
5 And that's the measure we're being asked to
6 endorse. So we're not being asked to endorse how
7 good the CARE scale is. We're being asked to
8 endorse your ability to measure this at
9 discharge.

10 And I didn't see the additional data,
11 so I apologize. Can we bring it up so we can
12 have a quick look to see how the -- because
13 that's predicted validity, but there's still no
14 data on the reliability of that measure. Does
15 that make sense?

16 MS. DEUTSCH: So are you asking for
17 facility-level reliability?

18 MEMBER DOWDING: Yes.

19 MS. DEUTSCH: Yes. So we didn't --
20 yes, this is similar to what Sherrie asked. I
21 mean, we don't have multiple years of data, so
22 we're not able to do that. So, I mean, I think

1 NQF provides guidance that the measure can't be
2 high, but it certainly can be moderate if you
3 provide item level and scale level --

4 MEMBER DOWDING: And I think that the
5 care-level data is exceptional. It was more a
6 query than anything else because, I mean,
7 conceptually, I'm just having trouble getting my
8 head around this expected versus actual. And for
9 this particular measure, the actual predictive
10 model, I think, is 0.53 prediction, so it's not
11 too bad. I would be concerned about the other
12 one.

13 MS. DEUTSCH: Great. Believe me, I'd
14 love to have more data.

15 MEMBER DOWDING: Yes, I'm sure you
16 would. I'm sure you would. I mean, it would
17 help if we could see the predictive stuff.

18 CO-CHAIR PARTRIDGE: We're all taking
19 a deep breath up here because I think this issue
20 has come up 16 times over the past two days, and
21 we're all extremely uncomfortable with trying to
22 assess a measure at the level of a specific

1 provider entity without having that data.

2 MEMBER DOWDING: Yes, I mean, I sort
3 of feel quite uncomfortable about being asked to
4 endorse a measure for which we have no
5 reliability data. I mean, it's just, you know,
6 the scale measure is one thing, but it's going to
7 be used at the facility level as a measure and
8 being fed back to patients, and we don't have the
9 data to assess it. It's not, it's just not
10 there.

11 CO-CHAIR PARTRIDGE: And in some
12 situations, we have had the capacity to go back
13 and get it. In this particular situation, I
14 think it's very clear we don't.

15 MEMBER KAPLAN: Can I weigh in here,
16 though? Because --

17 CO-CHAIR PARTRIDGE: Sherrie?

18 MEMBER KAPLAN: -- they do have some
19 data. You've obviously got generalized
20 estimation equation data that have splines with
21 error bars around each facility's performance
22 that, actually, we could use to see how good we

1 are at, you know, discriminating versus errors in
2 the distribution of facilities. So if you could
3 give us those data, that would actually help a
4 lot.

5 MS. DEUTSCH: Sure. And, I mean, we
6 did present facility-level data, a mean, median,
7 range, from the facilities we had.

8 DR. BURSTIN: A brief comment. I
9 mean, I think sometimes what we see, as measures
10 get out into use, we start getting a lot of this
11 information. And so, you know, as we continue to
12 explore what are requirements are for these
13 issues, it's not simple, by any means. You know,
14 one question might be, for example, by the annual
15 update or something like that, can we ask that
16 some of these additional data be brought back.
17 You are a standing committee. You will still
18 have standing in a year. There may just be ways
19 for us to fully recognize there's only so much
20 they can when the measures are not yet in play.

21 MEMBER KAPLAN: But aren't you guys
22 exploring at NQF tiering approvals, too, levels

1 of, like, you know, phase one, you know, tiering
2 for these purposes or those, generating data
3 versus accountability?

4 DR. BURSTIN: Not yet. Right. And
5 that's, I think, what we're finding to be the rub
6 these days is that, you know, with the increasing
7 influence of pay for performance, the anxiety
8 about pay for performance, there is higher
9 expectation of wanting to see some of those data.
10 We get that, and that's what we're exploring.

11 But, again, there are opportunities,
12 with you being a standing committee, to
13 potentially get that information as they gather
14 it and bring it back to you for additional re-
15 view at a later date.

16 MEMBER BRADLEY: Could I just ask
17 then, so it sounds like you're hoping to gather
18 more data. How many IRFs do you have using this
19 tool right now and how will you collect that data
20 so that you have enough data to bring back?

21 MS. MCMULLEN: So we can't speak to
22 future direction of measurement use at this point

1 because, as you know, I mean, with the IMPACT Act
2 or whatnot, we're in a tough, difficult time
3 line, and CMS is basically in the planning stages
4 of figuring out how to specifically meet that
5 mandate. At the current time, the data that we
6 do have is from the CARE tool, the PAC PRD
7 demonstration. It is our full intent in the
8 future to be able to collect data on this so we
9 can come to the table with measure-level data to
10 be able to present a more accurate case for the
11 outcomes and how appropriate the outcomes are for
12 this specific area and domain.

13 But there's a lot, there's a lot up in
14 the air right now because the IMPACT Act is not
15 only our only mandate that we're faced with right
16 now. We were given about two mandates within a
17 month and a half. So to the future direction at
18 this time, we can't speak to, but when CMS knows
19 a future direction they will absolutely make that
20 known.

21 MEMBER BRADLEY: Okay. So I guess
22 then you really don't have the capability of

1 collecting a lot of the ongoing data at this
2 point in time.

3 MS. MCMULLEN: I don't know if it's
4 about the capability. I think the capability is
5 always there. It's just the plans for CMS and
6 what CMS intends to do in terms of collecting
7 that data, and I -- definitely above my paygrade
8 -- can't speak to that. Sorry.

9 CO-CHAIR PARTRIDGE: The question
10 before us, again, and it's common to both
11 measures, is we don't have facility-level data.
12 They can supply some data which might make
13 Sherrie Kaplan happy and, thereby, perhaps some
14 other member so of the Committee happy. And we
15 have faced this issue before. So I think, unless
16 people object, we're ready to proceed on. Again,
17 it would be both. And Nadine? We believe it
18 works for both because it's the common issue.
19 The facility issue is common, yes.

20 MS. ALLEN: Voting on reliability: one
21 high, two moderate, three low, four insufficient.
22 Voting starts now. All votes are in: zero

1 percent high, 47 percent moderate, 13 percent
2 low, 40 percent insufficient.

3 Voting on validity: one high, two
4 moderate, three low, four insufficient. Voting
5 starts now. All votes are in: 7 percent high, 47
6 percent moderate, 7 percent low, 40 percent
7 insufficient.

8 Voting on feasibility: one high, two
9 moderate, three low, four insufficient. Voting
10 starts now. All votes are in: 27 percent high,
11 53 percent moderate, 20 percent low, zero percent
12 insufficient.

13 Voting on usability and use: one high,
14 two moderate, three low, four insufficient
15 information. Voting starts now. All votes are
16 in: 20 percent high, 47 percent moderate, 20
17 percent low, 13 percent insufficient.

18 Voting on overall suitability for
19 endorsement of Measure 2635, discharge self-care
20 score for medical rehabilitation patients, and
21 Measure 2633, change in self-care score for
22 medical rehabilitation patients: one yes, two no.

1 Voting starts now. Still missing a vote. All
2 votes are in: 67 percent yes, 33 percent no.

3 DR. BURSTIN: Any of the developers
4 who have to stay around for this, please feel
5 free to partake.

6 MS. SAMPSEL: Operator, can you open
7 the line for public comment?

8 OPERATOR: All right. If you'd like
9 to make a public comment, please press star and
10 then a number one. No, no public comments at
11 this time.

12 MS. SAMPSEL: Okay. Thank you very
13 much. We're taking a break for lunch.

14 (Whereupon, the above-referred to
15 matter went off the record at 12:23 p.m. and went
16 back on the record at 12:55 p.m.)

17 CO-CHAIR STILLE: Welcome back. Let's
18 get started.

19 CO-CHAIR PARTRIDGE: We are going on
20 to voting. I think she's going to take root
21 here.

22 CO-CHAIR STILLE: Sure. Yes, I think,

1 you know, we need to have some just sort of
2 discussion about stuff, but then we're voting.
3 No, I don't think we need any more from you, I
4 don't think.

5 CO-CHAIR PARTRIDGE: But don't go
6 away.

7 CO-CHAIR STILLE: But don't go away.
8 We appreciate your presence.

9 CO-CHAIR PARTRIDGE: Yes, that's our
10 third.

11 CO-CHAIR STILLE: Yes.

12 CO-CHAIR PARTRIDGE: It's the last one?

13 CO-CHAIR STILLE: It is. It is the
14 last one. Okay, all right. The first one we're
15 going to consider is -- do we have a quorum? We
16 have 14. They're just somewhere in the room
17 eating. Okay.

18 The first measure we'll consider is
19 2634, inpatient rehab facility functional outcome
20 measure change in mobility score for medical
21 rehab patients. And I and someone who is sick
22 are the primary discussions, so I'll talk about

1 that.

2 Essentially, it looks at the change in
3 mobility score between admission and discharge,
4 does risk adjustment, and that's for IRF Medicare
5 patients. So all those clauses and caveats in
6 there. And let's see. In general, I'll just
7 sort of summarize some of the comments and add a
8 couple of things myself. The rationale for
9 having a measure of this is important medical
10 rehab for almost everyone. Enhancing mobility is
11 a primary goal, so it seems to be supported.

12 There is a good score distribution and
13 definitely room for improvement, given the
14 numbers that are there. And there are some
15 disparities that are also mentioned with race,
16 ethnicity, insurance type, and region of the
17 country. So that is good.

18 Other things. Well, there's a lot of
19 validity and reliability things that we could
20 talk about, but I think, in terms of the face,
21 you know, it's Medicare patients only, so that's
22 a little bit of a limitation in terms of the

1 group. It's IRF only, but it is what that is.
2 And so, in terms of importance, I think it's got,
3 you know, pretty good stuff on the surface.

4 So other thoughts and comments about
5 importance?

6 CO-CHAIR PARTRIDGE: Again, this is
7 the same pair of measures as we discussed just
8 before our lunch break. The companion is 2632.

9 CO-CHAIR STILLE: Thirty-six?

10 CO-CHAIR PARTRIDGE: I'm sorry.
11 Thirty-four and thirty-six. Only in this case,
12 we're talking about mobility, rather than self
13 care.

14 CO-CHAIR STILLE: Right. So 36, which
15 I didn't review in detail, is the difference from
16 expected, I guess, right?

17 CO-CHAIR PARTRIDGE: Okay. Any comments
18 or questions? Any comments or questions? Peter?

19 MEMBER THOMAS: Okay. So can we just
20 assume that all of the prior discussion we had on
21 the self care that applied, you know, just kind
22 of incorporate by reference, so to speak?

1 CO-CHAIR STILLE: Sure.

2 MEMBER THOMAS: I'm not sure that
3 fully does justice to airing those issues, but I
4 had the same basic concerns that I had in the
5 first one with this one and the same questions.
6 They weren't all concerns. They were just.

7 CO-CHAIR PARTRIDGE: Becky?

8 MEMBER BRADLEY: I just wanted a
9 little bit of clarification. Since it's Medicare
10 only, were the disparities you found related to
11 insurance payments? I wasn't sure how -- was it
12 within the insurance, like managed Medicare
13 versus Medicare, or could you just address the
14 disparity?

15 MS. DEUTSCH: All right. Can you hear
16 me now. So that was literature that we cited, so
17 Tim Reistetter at University of Texas Medical
18 Branch did that study and he looked at,
19 basically, public versus private. So it wasn't
20 from our data. That was from the literature.

21 MEMBER BRADLEY: And just help me
22 understand because some of the measures aren't

1 limited to Medicare patients with the CARE tool
2 and some are. Can you explain why this one is
3 and some of the others that were presented
4 earlier are not?

5 MS. DEUTSCH: So the IRF ones are
6 limited to Medicare only, and, again, Stacy
7 provided the rationale. The Long-Term Care
8 Hospital Quality Reporting Program was
9 established as an all-payer program, and so,
10 obviously, when we're able to get all-payer data,
11 we want the measure to be all-payer. So anything
12 -- no, that's it.

13 CO-CHAIR PARTRIDGE: Are there any
14 other questions or comments before we vote on
15 importance?

16 CO-CHAIR STILLE: Peter?

17 MEMBER THOMAS: Forgive me. I just
18 wanted to say, in case people weren't aware of
19 it, that you talk about these measures as being
20 quality measures or pay-for-performance measures,
21 but I think there's an assumption by many people
22 around the room, probably rightly so, that

1 today's quality measure will eventually become or
2 is likely to become some kind of a pay-for-
3 performance measure. But in IRFs, there's
4 currently requirements for pay for performance.
5 There's a two-percent reduction in payments if
6 you don't submit certain quality data, and I
7 don't know how these specific measures factor
8 into that, but I was trying to figure out what
9 that connection might be.

10 MS. MANDL: So the Inpatient
11 Rehabilitation Quality Reporting Program was
12 established with Affordable Care Act, Section
13 3004. It is a penalty for failure to report.
14 It's not a pay-for-performance program. So I
15 just wanted to clarify that. So does that --

16 MEMBER THOMAS: It's helpful. That's
17 helpful. The larger comment I made, I think,
18 still stands, but thanks for clarifying that.

19 MS. MANDL: Sure.

20 CO-CHAIR PARTRIDGE: Are there further
21 questions? Are we ready to vote?

22 MS. SAMPSEL: For a quorum right now,

1 we need 13 of 17, so we had two members that are
2 not participating today. We're still okay. The
3 doors are now locked.

4 MEMBER BRADLEY: Are we voting on
5 these as a pair, like we did --

6 CO-CHAIR PARTRIDGE: We are voting on
7 these as a pair.

8 MS. ALLEN: Voting on evidence for
9 Measure 2634, change in mobility score, and
10 Measure 2636, discharge mobility score evidence:
11 one yes, two no. Voting starts now. All votes
12 are in: 100 percent yes, zero percent no.

13 Voting on performance gap: one high,
14 two moderate, three low, four insufficient.
15 Voting starts now. All votes are in: 23 percent
16 high, 62 percent moderate, 15 percent low, zero
17 percent insufficient.

18 Voting on high priority: one high, two
19 moderate, three low, four insufficient. Voting
20 starts now. All votes are in: 54 percent high,
21 46 percent moderate, zero percent low, zero
22 percent insufficient.

1 CO-CHAIR STILLE: Okay. So now we'll
2 talk about reliability and validity. I think
3 there's a little bit more to talk about in that
4 way, although some of the discussion from the
5 last thing is important.

6 Generally, you know, for 2634, inter-
7 rater reliability was calculated a couple of
8 ways. Item and scale reliability were done and
9 were good. It was tested in a variety of venues.
10 There was content validity that was tested
11 against several other instruments for most of the
12 items. A few didn't have a counterpart.

13 Then I just wanted to kind of go over
14 some of the comments from the rest of the
15 Committee, too, as well as an external comment,
16 which was important. I think Dawn's concern
17 about 2635 extends to 2636, given the expected
18 versus actual score calculation. We don't have
19 good data about that, I don't think. And there
20 was no detail on exactly how that was developed.

21 There was a critique from UDSMR that
22 was concerned with test-re-test reliability.

1 Maybe the developers can talk about that because
2 I know you talked about some of their other
3 concerns for the other one. And maybe I'll stop
4 there and then talk about the validity concern.

5 Are you ready to talk about that
6 quickly? You need a minute? Okay, I'll talk
7 about -- oh.

8 MS. DEUTSCH: Okay, great. So we
9 presented inter-rater reliability, so I guess
10 I'll just generally speak to that overall. So
11 the first inter-rater reliability is kind of this
12 traditional where we had two therapists or two
13 nurses go into a patient's room. They both did
14 an assessment. So let's say Poonam and I worked
15 at the same facility. We would go in and do the
16 assessment. The instructions were people could
17 not talk, but then we'd both independently score,
18 and that was compared. Laura spent the evening
19 yesterday and did a lot of the analyses, and we
20 did both weighted and unweighted kappas.

21 Overall, that was good. We
22 definitely, in the PAC demo, had some items that

1 didn't test as well, and those are not being
2 proposed. So, you know, I just want to be sure
3 you understand that we tested like a whole, a
4 very long instrument, data tool, but not
5 everything is being moved forward. Because
6 perhaps Poonam and I were both trained at the
7 same facility, you know, whether Tara and Stacy
8 at another facility might be scoring the same was
9 important. That's why we did the standardized
10 patient videos, reliability, so that we were able
11 to test if the four of us all came to the same
12 agreement, and those of us who were PTs, nurses,
13 you know, did we agree with each other? So
14 that's why we did different types of reliability,
15 so I feel like we've done a fair bit of
16 reliability and our results were very comparable
17 to anything that's out there in the literature
18 with the existing.

19 CO-CHAIR STILLE: The only thing that
20 I didn't see that was, the only thing I saw in
21 the critiques that I didn't see in your thing was
22 test-retest reliability. But, yes, I agree there

1 was lots of other reliability things that you
2 guys --

3 MS. DEUTSCH: Yes. So with function,
4 a patient can change. Like somebody with
5 arthritis, they can be very limited in the
6 morning and very independent in the afternoon.
7 So function changes, so you can't really do test-
8 retest reliability when somebody is changing. So
9 I think that's not something that's generally
10 done with function data. It's just not possible.

11 CO-CHAIR STILLE: Yes. And, yes,
12 Peter and then Dawn.

13 MEMBER THOMAS: Dawn first.

14 CO-CHAIR STILLE: Well, Dawn first and
15 then Peter. Okay.

16 MEMBER DOWDING: Okay. I'm just going
17 to sound like a stuck record again. It's, again,
18 just to highlight my concern that the reliability
19 and validity data we have is at the level of the
20 care scale and not the measure we're being asked
21 to endorse, which are the two, the expected
22 versus actual and the mean change. And we don't,

1 you know, we need the data on that, I think.

2 Well, I need that data on that to be happy to
3 endorse it. And, again, just to reiterate those
4 concerns.

5 MS. DEUTSCH: Can I respond to that?

6 So just maybe I can ask the NQF staff. My
7 understanding is that the rating, if you don't
8 have facility-level data but you have item
9 reliability data, that it can be moderate. It
10 just can't be high. So this is very acceptable,
11 and a moderate would be the appropriate. Is that
12 --

13 MS. SAMPSEL: That is correct. So
14 that's consistent. This is an outcome measure.
15 These are both outcome measures, not patient-
16 reported outcome measures, meaning that when you
17 go through the algorithm your choices would be
18 moderate and low.

19 CO-CHAIR STILLE: Okay, good. And
20 then Peter. Right, sorry.

21 MEMBER THOMAS: I'm sorry to do this.
22 But can we just return to this expected

1 functional level in terms of mobility and just
2 walk me through a little bit more, just give me a
3 little more comfort that there's a system in
4 place where you really are not going to find a
5 lot of gaming going on or that you accommodate --
6 how do you determine what that expected
7 functional level is? How does that happen?

8 MS. DEUTSCH: So the expected score is
9 calculated based on our regression model. So,
10 for example, you take the characteristics of the
11 patient and then, you know, if the patient is in
12 a certain age category, then you apply the
13 regression coefficient that we reported on our
14 risk adjustment model and, basically, you know,
15 add up the scores that you get and the intercept
16 and based on whether people have comorbidities or
17 not, and the expected score is calculated based
18 on summing the regression coefficients based on
19 that person's characteristics.

20 MEMBER THOMAS: And, like, what was
21 the sample for that, for those coefficients to be
22 created?

1 MS. DEUTSCH: Right. So we had, after
2 the exclusion criteria, we had what? About
3 4,776.

4 MEMBER THOMAS: Okay. And that's all
5 considered valid and reliable in terms of
6 expounding upon those, the experience of that
7 sample group?

8 MS. DEUTSCH: Yes. I mean, we ran the
9 analyses and we feel the estimates are pretty
10 stable. I mean, we would always like to have
11 more data, and I think any quality measure
12 developer would love to test this out over and
13 over again just for maintenance and that. So I
14 certainly would love to have more data and get
15 additional data, but I do feel like we have a
16 decent sample for this.

17 MEMBER THOMAS: Great, thank you.

18 MEMBER MORT: So just since this has
19 come up a few times, the data elements that
20 you're using either in the risk adjustment model
21 or in the observed or expected calculation, are
22 those all derived from staff data elements put in

1 the medical record or are any of those from
2 coding sources, administrative data sources?

3 MS. DEUTSCH: Sure. So most of the --
4 like age, we actually, I think we used the claims
5 data for that. But a lot of it comes from the
6 chair assessment data, but we did use
7 comorbidities from the claims data. In part, we
8 don't know that, necessarily, every inpatient
9 rehab facility codes the same way. And
10 consistent with other, like, readmission
11 measures, we went back to acute care. So if
12 there was somebody who was listed as having
13 diabetes in the acute care claims record, we
14 accepted that, even if it wasn't maybe in the IRF
15 claims record. So we did use claims data from
16 the IRF stay, as well as the acute care stay, in
17 addition to the assessment data.

18 MEMBER MORT: And that would be the
19 way it would continue to be analyzed. You go
20 back to the incident in admission that led to the
21 IRF stay and you pull ICD-9 comorbidities from
22 that database? That's --

1 MS. DEUTSCH: Yes, so ICD-10. Right.

2 MEMBER MORT: ICD-10. Excuse me,
3 excuse me. So my comment about reliability,
4 Peter, just is that the gameability, in my mind,
5 is highest when it's totally relying on
6 administrative data alone. And these data
7 elements come from two sources. The fact that
8 you go back to the incident and hospitalization
9 to look for additional comorbidities suggests
10 it's pretty thorough, but, regardless, it's the
11 same data used for either the risk adjustment or
12 the O-to-E calculation. So if there's bias in
13 it, it's biased in either methodology is how I
14 understand it.

15 CO-CHAIR PARTRIDGE: Okay. Any
16 further? Becky? Sorry.

17 MEMBER BRADLEY: Just to help me
18 understand it because I know there is a great
19 interest in using this tool. How long does it
20 take to get to the data pool that you would like
21 to see to use for expected scores? I mean, is
22 that years, is that months, to have enough data

1 collected to be able to provide the information
2 for the predictive piece that seems to be
3 missing?

4 MS. DEUTSCH: So if you're asking what
5 the time frame is for the measure, each measure,
6 there's a time frame, so what patients are
7 included. So we have in our application 12
8 months of data would be used. Is that, is that
9 what you were asking?

10 MEMBER BRADLEY: So it would take 12
11 months to build a database to have the predictive
12 number, the predictive validity and reliability
13 that --

14 MS. DEUTSCH: So we're proposing
15 creating the quality measure at the facility
16 level with 12 months of data, and that's
17 consistent with other measures. Some measures 24
18 months.

19 CO-CHAIR STILLE: Okay. And for the
20 testing, did you use like a retrospective data
21 set from a few years ago or.

22 MS. DEUTSCH: The data were collected

1 between 2008 and 2010.

2 CO-CHAIR PARTRIDGE: If there's no
3 further discussion.

4 MS. ALLEN: Voting on reliability: one
5 high, two moderate, three low, four insufficient.
6 Voting starts now. All votes are in: zero
7 percent high, 77 percent moderate, zero percent
8 low, 23 percent insufficient.

9 Voting on validity: one high, two
10 moderate, three low, four insufficient. Voting
11 starts now. All votes are in: 8 percent high, 69
12 percent moderate, 8 percent low, 15 percent
13 insufficient.

14 CO-CHAIR PARTRIDGE: Moving on to
15 feasibility. Any discussion on this element?
16 Sam?

17 MEMBER THOMAS: I just want to ask do
18 you have any data on how long it takes to
19 administer or to grade this instrument?

20 MS. DEUTSCH: So clinicians are
21 assessing patients on these activities pretty
22 typically. Some of the items are things like car

1 transfers that are done at best-practice
2 facilities. I'm not sure that I could say 100
3 percent of IRFs are looking at things like car
4 transfers at discharge, but the best-practices
5 facilities recommended all of these items.

6 So the assessment is happening anyway
7 in most cases, and so, in terms of, like, the
8 documentation piece, I'd have to look up the
9 specifics, but, I mean, there's basically taking
10 the information and then thinking through what
11 the score is and documenting it. And so there's
12 seven self-care items and 15 mobility items.

13 MEMBER THOMAS: So any member of the
14 rehab team, a therapist, nurse, physician, any
15 member could conceivably do this grade and
16 there's not a restriction on that.

17 MS. DEUTSCH: Correct.

18 CO-CHAIR PARTRIDGE: If there are no
19 further comments on feasibility, we want to vote.

20 MS. ALLEN: Voting on feasibility: one
21 high, two moderate, three low, four insufficient.
22 Voting starts now. All votes are in: 46 percent

1 high, 38 percent moderate, 15 percent low, zero
2 percent insufficient.

3 Voting on usability and use: one high,
4 two moderate, three low, four insufficient
5 information. Voting starts now. All votes are
6 in: 46 percent high, 38 percent moderate, zero
7 percent low, 15 percent insufficient.

8 Voting on overall suitability for
9 endorsement of Measure 2634, change in mobility
10 score for medical rehabilitation patients, and
11 Measure 2636, discharge mobility score for
12 medical rehabilitation patients: one yes, two no.
13 Voting starts now. All votes are in: 85 percent
14 yes, 15 percent no.

15 CO-CHAIR PARTRIDGE: Take a deep
16 breath. Move on to our last measure, and our
17 friends to our left are up again.

18 MS. DEUTSCH: All right. Thank you.
19 Okay, great. So this last measure is change in
20 mobility for patients admitted to a long-term
21 care hospital on a ventilator. So just in terms
22 of the background, I mentioned, I think

1 yesterday, that long-term care hospital patients
2 are very, very sick and they are often having
3 limitations in mobility, as well as self care,
4 mobility in particular. There are risks for
5 additional limitations to develop because
6 somebody is basically on a ventilator and not
7 able to move around a lot sometimes.

8 So this measure is a risk-adjusted
9 change in mobility measure between admission and
10 discharge. And, again, it only applies to long-
11 term care hospitals who are admitted on a
12 ventilator.

13 We looked at our PAC PRD data and
14 selected items that we thought made sense based
15 on that data, what's feasible to collect in a
16 long-term care hospital for these very sick
17 patients. We presented this to our technical
18 expert panel, so we only have eight mobility
19 items just because it's not feasible to expect
20 people to go up and down the stairs, for example.
21 So we have bed mobility items. So we have some
22 low-functioning, items that work for patients

1 with low function, as well as transfer items, so
2 important things like getting on and off a
3 toilet, as well as up to walking. This is
4 consistent with items that are reported in the
5 literature for patients in long-term care
6 hospitals. The period of time for the measure is
7 24 months just because it takes a longer time to
8 have enough patients who are admitted with this
9 particular condition.

10 So in terms of importance, I kind of
11 mentioned that these patients are very high risk
12 for having further decline in their function, so
13 that's important. And also Congress has actually
14 weighed in on this. There is law, the Bipartisan
15 Budget Act, that was passed in 2013 that requires
16 Medicare to establish this quality measure by
17 2016. And the reason that that is such an issue
18 is that there's a lot of payment reform happening
19 in the long-term care hospital, so it's important
20 to have a counter in terms of measure and quality
21 when there's, again, pressures related to payment
22 reform.

1 We have several exclusion criteria.
2 This was based on input from the expert panel, as
3 well as our public comment, so it's similar to
4 measures we presented before. Incomplete stays,
5 we only included people 21 years and older. We
6 have a risk-adjustment model that we presented,
7 and, again, we used generalized linear models
8 with general estimation equations. We calculate
9 an observed over expected times the national
10 average, so you get a risk-adjusted change score.

11 I think you've heard enough from me on
12 other things, so, Stacy, do you want to talk
13 about standardization?

14 MS. MANDL: Sure. So, again, this is
15 Stacy from CMS. It's come up a couple of times,
16 and I thought I would just use this as an
17 opportunity between the two measures to sort of
18 touch on this concept of uniformity and
19 standardization at the data element level.

20 So here's a great example where a law
21 was passed that requires a measure. Data elements
22 and the importance of having data elements that

1 are standardized, especially at the assessment
2 level, really helps to make sure that you have
3 apples to apples. I get it. It's very critical to
4 have the trainings in place and all of the
5 iterative trainings in place and so forth because
6 of that, but it's far better to have that than to
7 have a measure that doesn't specify the data
8 element level to the level of detail that we do.

9 I just wanted to touch on that. And
10 it's such an important concept that Congress also
11 just passed another law called the IMPACT Act
12 that requires that for multiple purposes, not
13 just for quality reporting but also for the
14 purposes of transferability of information,
15 interoperability.

16 So I just wanted to just sort of touch
17 on that why, yes, we're hearing you loud and
18 clear at facility, but at the data element level
19 there has been testing. So I'll hand it back
20 over.

21 CO-CHAIR STILLE: And I'm the
22 discussant for this one, as well. I think,

1 overall, I think it's a very interesting measure.

2 I appreciate the discussion of law in need of a
3 measure because my primary quibble is we don't
4 have a whole lot of data yet. You know, it's
5 103 patients, basically, to kind of look for --
6 am I look at the --

7 MS. DEUTSCH: Four hundred and fifty-
8 five.

9 CO-CHAIR STILLE: Okay. So the 103
10 must have been a subset. So a still relatively
11 small number, but not that many patients need
12 ventilator support, so it was probably hard to
13 get a sample that was big enough. So we need to
14 get more data as times goes on with that.

15 I had a couple of comments and sort of
16 worries about exclusions. One, I need some input
17 from the commissions that are used to dealing
18 with adults. But it seems maybe inappropriate to
19 exclude all progressive neurologic conditions,
20 especially the ones that go up and down. MS and
21 Parkinson's I'm wondering, in particular, you
22 know, a lot of patients with MS and Parkinson's,

1 they do great, they do terrible, they do great,
2 they do terrible. Even if they need to be on a
3 ventilator, they may not need to be on a
4 ventilator in six months to a year if they do
5 better. And so I was sort of wondering about the
6 reasons for some of those exclusions.

7 MS. DEUTSCH: Do you want me to
8 address that or are you asking --

9 CO-CHAIR STILLE: If I could hear from
10 another clinician, that would be good. And then
11 -- yes. So maybe Liz?

12 MEMBER MORT: Well, the neurologic
13 deterioration or conditions that lead to either
14 fluctuations or deteriorations over the long term
15 are highly variable. I'm hesitating. I can
16 understand why they excluded that population. On
17 the other hand, I wonder, of the 300,000 people
18 on ventilators every year, what proportion of
19 that --

20 CO-CHAIR STILLE: Exactly. That was
21 my point.

22 MEMBER MORT: -- and it might be

1 worthwhile taking a look at the data to see how
2 many patients, what proportion of the 300,000
3 ventilated patients annually fall under those
4 categories and which categories. There might be
5 some that you would leave excluded, like ALS for
6 example, but others that you might include. So I
7 think it's worth exploring with a bit more
8 detail.

9 CO-CHAIR STILLE: Great.

10 CO-CHAIR PARTRIDGE: Becky?

11 MEMBER BRADLEY: In keeping with the
12 idea of developing measures that cut across all
13 settings, I was just curious because there are
14 people on ventilators at home and people on
15 ventilators in nursing homes and in inpatient
16 rehab, why was this one limited, especially since
17 you're trying to collect data on as many patients
18 as possible, why did you limit it?

19 CO-CHAIR STILLE: Go ahead.

20 MS. DEUTSCH: Okay. So I have a
21 question from Chris and then went from Becky, so
22 I'll deal with Becky's first and then we can come

1 back to the other.

2 So inpatient rehab facilities have
3 very few patients overall, and it's a select
4 group of IRFs that admit patients with
5 ventilator. So I don't think we would get a big
6 enough sample. So, I mean, if I could just say,
7 you know, anybody on a ventilator, I'd love to
8 include in this measure, great. But then
9 facility-level analysis would be very difficult
10 at the IRF level. It would be very difficult at
11 home care. I just, there wouldn't be many home
12 care agencies that would have a whole lot of
13 data.

14 So long-term care hospitals, part of
15 this law that was passed that I mentioned before,
16 they basically say, you know, patients who are
17 chronically critically ill, include patients
18 admitted on a ventilator. And there's criteria
19 within the law in terms of what chronically
20 critically ill is, but ventilator is their prime
21 example. So that's really where patients are at
22 this point, in terms of the post-acute care

1 world. So does that help, Becky?

2 MEMBER BRADLEY: Well, it helps
3 understand because I do recognize in inpatient
4 rehab, you know, you don't have that many. But
5 if you're looking at where they're best served
6 and being able to take them from one level of
7 care to another and share information and, you
8 know, hands off providers, it seems like it would
9 be useful if that is the intent of developing a
10 core measure that cuts across all.

11 MS. DEUTSCH: So that's actually a
12 great comment. So I think this goes to Stacy's
13 comment. Standardizing assessment data cross all
14 the post-acute care settings would allow us to do
15 research studies to examine exactly this point
16 and be able to risk adjust. So without the data,
17 you just cannot, you know, do this at this point.

18 So this would really open up the door
19 to be able to do research and then, you know,
20 potentially develop quality measures, as
21 appropriate. And then you'd be able to look at
22 function, you know, our people who are home and

1 have, you know, on ventilators, do they actually
2 do better? So great, great point.

3 MS. MANDL: CMS thanks the comment.

4 MS. DEUTSCH: So can I answer, Chris,
5 your question, unless, Sam, did you also want to
6 weigh in?

7 MEMBER BIERNER: I mean, I understand
8 or I assume that your reason for excluding some
9 of these was because some of them have a variable
10 course and, for the purposes of creating this
11 instrument, you know, you don't want to introduce
12 unnecessary variability into your study. I would
13 hope that, you know, over time, if this gets
14 implemented, then one could use it and see what
15 kind of data one gets from that population. But
16 I assumed it was excluded mainly for the purposes
17 of developing the instrument.

18 MS. DEUTSCH: Yes, that was exactly
19 the point. In fact, we talked with our expert
20 panel about these diagnoses in particular, and
21 they said, well, if the person is admitted to an
22 IRF they should be included in that measure

1 because IRFs should be focused on functional
2 improvement. But if somebody is admitted to an
3 LTCH they may or may not have necessarily the
4 same prognosis, and so it's really unfair.

5 And to Peter's, I know, Peter, you
6 have brought up several times potential
7 unintended consequences. If you have patients
8 who you know may not do well on a particular
9 measure, they might be excluded from access to
10 that level of care, which may be very
11 appropriate. So that was really the rationale,
12 and we did present data from our sample. We had
13 12 patients who had ALS, which was 1.59 percent.
14 The multiple sclerosis/Parkinson's, it was fewer
15 than 11. CMS data use agreement, we can't report
16 raw data when it's less than 11, but a very small
17 percentage.

18 CO-CHAIR STILLE: Okay. So, I mean,
19 that just points out that it's really important
20 to potentially change the measure if you're
21 looking at it in different settings, you know.
22 Include it in one group, exclude it in another

1 group, because they're different people.

2 MS. DEUTSCH: This is all about goals
3 of care.

4 CO-CHAIR STILLE: Yes, yes, great.
5 Okay. My only other question was I didn't see a
6 whole lot of data, and maybe there aren't, about
7 a performance gap at this point so.

8 MS. DEUTSCH: Yes, I mean, there's not
9 a lot of literature about long-term care hospital
10 patients, in particular ventilator patients. And
11 I think our literature review speaks to the idea
12 of early mobilization being a pretty new concept
13 in providing care, and so it's just a really
14 early thing and we're just trying to get ahead of
15 the curve and make sure patients are getting the
16 best care possible and functioning as
17 independently as possible.

18 CO-CHAIR STILLE: Other comments on
19 importance? Becky and Liz, can you put your
20 things down? Thanks. Unless you had another
21 point? Okay.

22 MS. ALLEN: Voting on evidence for

1 Measure 2632: one yes, two no. Voting starts
2 now. All votes are in: 100 percent yes, zero
3 percent no.

4 Voting on performance gap: one high,
5 two moderate, three low, four insufficient.

6 Voting starts now. All votes are in: 8 percent
7 high, 62 percent moderate, zero percent low, 31
8 percent insufficient.

9 Voting on high priority: one high, two
10 moderate, three low, four insufficient. Voting
11 starts now. All votes are in: 23 percent high,
12 77 percent moderate, zero percent low, zero
13 percent insufficient.

14 CO-CHAIR STILLE: Okay. So in terms
15 of reliability and validity, again, it's a little
16 bit tough because there's not a whole lot of data
17 out there. So I want to rely on the
18 psychometricians in the group to talk about
19 whether it's enough for what we have right now.

20 There is item-level reliability for
21 the items that feed into the overall assessment.
22 There's not much data on the reliability on the

1 whole measure. And I'm a little bit out of my
2 depth when it comes to talking more
3 sophisticatedly than that. So, Dawn, please,
4 thank you.

5 MEMBER DOWDING: I don't think I'm any
6 more expert, but I just want to clarify because
7 it's a bit unclear from the description. This
8 isn't a change score. This is another one of the
9 ones where you're calculating an expected
10 functional score at discharge and comparing that
11 to what the observed score actually is.

12 MS. DEUTSCH: So this is a risk-
13 adjusted change score. It's mobility. So we
14 calculate an observed change for the eight
15 mobility items. So we look at the discharge
16 score minus the admission score. So we calculate
17 that as the observed. We apply the risk
18 adjustment data to the patient-level data to
19 calculate an expected. We then divide or create
20 a ratio from observed over expected, and then
21 that ratio is multiplied by the national average,
22 which is similar to what we did with the IRF

1 change in mobility.

2 MEMBER DOWDING: Yes. And I guess my
3 question is, given the small population on which
4 you have got data for and given the, unless I'm
5 reasoning it wrong, your predictive model only
6 predicts 26 percent of the variant, so there's a
7 huge amount of noise in that model, why have you
8 gone for that very complicated calculation for
9 this score? Why haven't you gone for a simpler
10 change in function score? Because I guess I'm
11 really supportive of this, and I understand that
12 you don't have a huge amount of data. But given
13 all of that, I would have expected to see a less
14 complicated calculation than a more complicated
15 one. And, also, could you also give us some ideas
16 about the number of patients that we use to
17 develop the predictive score? Sorry. That's a lot
18 of.

19 MS. DEUTSCH: So our sample was 455
20 for the model. So our observed over expected
21 times the national average is the same that we
22 had presented for IRF. I guess it's a pretty

1 standard thing. I mean, I'm an epidemiologist.
2 It's an epidemiology 101 risk adjustment. It
3 really is important to risk adjust. We tried all
4 kinds of comorbidities. We actually tried every
5 HCC or groups of HCCs that we could. And, again,
6 we went back to acute care, so I think -- if you
7 have that question.

8 So, I mean, we tried our best to risk
9 adjust, and I guess I feel like it is critical to
10 risk adjust. So I guess --

11 MEMBER DOWDING: I mean, I'm not an
12 expert in this, but there are other ways of risk
13 adjusting which don't involve a predictive score.
14 I mean, it's this whole business about expected
15 versus observed. You can risk adjust the change
16 without having an expected score that you then
17 calculate. I mean, I'm not an expert, but we've
18 seen other measures where they've done risk
19 adjustment which doesn't involve this expected --

20 MS. DEUTSCH: I think all of the
21 measures we've heard about today used observed
22 and expected.

1 CO-CHAIR STILLE: So it's risk
2 adjusted, as opposed to proportion passing a
3 certain expected, difference with expected, so I
4 think the number is a little different then.

5 MEMBER BRADLEY: Well, I guess, if
6 we're looking at a quality measure and a
7 performance measure and we were kind of shooting
8 in the dark with an expected, how will that
9 expected score be used for performance
10 improvement or in a facility level?

11 MS. DEUTSCH: You're asking how it
12 would be used, the performance one? So the
13 facilities could get a report and realize that
14 they are different than a national benchmark, so
15 they would get their facility data and there
16 would be national benchmark data ranges, and so
17 they would get a sense about whether they're
18 performing better than the national average,
19 worse than the national average, and so they
20 could respond to that, obviously, if they think
21 they have room for improvement.

22 MEMBER BRADLEY: Well, and I guess

1 that's where, not being a statistician, I would
2 be concerned because if we're not certain that
3 that predictive score is reliable, we may be
4 spending a lot of resources trying to adjust on
5 something that hasn't really been fully tested
6 for reliability from the predictive standpoint.

7 MS. DEUTSCH: So I think, I mean, our
8 score was about 26 percent. I guess I don't know
9 if NQF staff can comment about, relative to other
10 measures, how that -- because, I mean, I've
11 definitely seen worse.

12 MEMBER BIERNER: Well, I mean,
13 compared to just, maybe not just specifically
14 other measures, but that would mean the lower end
15 of the, you know, lower end, beginning of
16 moderate level, for R-squared value. But I would
17 assume that, because you have a relatively small
18 sample size, that, over time, you would revise
19 this regression model based on your data. So
20 then we'd expect that we'd get updated as new
21 data comes in, and every year or two years or
22 something it would be updated.

1 But in terms of how it would be used,
2 I would assume that it would allow facilities to
3 compare their population and their performance to
4 others in their region or nationally. And so it
5 would become more useful over time as more data
6 is accumulated.

7 MS. DEUTSCH: Yes. And this was
8 finalized in the Long-Term Care Quality Reporting
9 Program this August 2014, so this is being
10 implemented April 1, 2016. So there will be more
11 data available, and I guess, in terms of R-
12 squared, if you had a really, really high R-
13 squared, that means that you're explaining all
14 the variants. And so, you know, we think there's
15 facility input that makes a difference here. So
16 we definitely would love to do a whole lot more
17 and try to get a higher R-squared, but we did try
18 everything that we got in terms of suggestions
19 from public comment, as well as our expert panel.

20 MS. MANDL: I just want to add there's
21 only 400 LTCHs in the whole United States, if
22 that matters.

1 MEMBER MORT: Since we're talking
2 about the O-to-E, 400 patients in your sample
3 size, obviously, is small. And as you revise it,
4 you'll have more patients in that sample. I had
5 a comment about a slightly different aspect of
6 it, which is mobilizing patients on vents is a
7 relatively new area of focus clinically, so
8 expected based on current practice is not where
9 we necessarily want to be. So I think you want
10 to beware of having people focus on a goal that
11 probably isn't aspirational, and that doesn't
12 necessarily relate to some of the other things
13 that we've been working on for a long time. We
14 have a better level of understanding about where
15 we can expect patients to get. Do you know what
16 I mean?

17 MS. DEUTSCH: Yes. So this is
18 absolutely an area that's evolving, and that's
19 part of -- I think NQF has maintenance
20 endorsement renewal and all that that's needed,
21 and I think CMS is looking at measures, every
22 single measure every year to make sure that it's

1 keeping up with the evidence. So absolutely.

2 CO-CHAIR PARTRIDGE: Ready to vote?

3 MS. ALLEN: Voting on reliability: one
4 high, two moderate, three low, four insufficient.
5 Voting starts now. All votes are in: 8 percent
6 high, 54 percent moderate, 23 percent low, 15
7 percent insufficient.

8 Voting on validity: one high, two
9 moderate, three low, four insufficient. Voting
10 starts now. All votes are in: zero percent high,
11 69 percent moderate, 15 percent low, 15 percent
12 insufficient.

13 CO-CHAIR PARTRIDGE: Discussion on
14 feasibility? Liz, is that a card up or --

15 MEMBER MORT: No, I'm sorry.

16 CO-CHAIR PARTRIDGE: All right. I
17 think -- Nadine?

18 MS. ALLEN: Voting on feasibility: one
19 high, two moderate, three low, four insufficient.
20 Voting starts now. All votes are in: 23 percent
21 high, 69 percent moderate, 8 percent low, zero
22 percent insufficient.

1 Voting on usability and use: one high,
2 two moderate, three low, four insufficient
3 information. Voting starts now. All votes are
4 in: 23 percent high, 54 percent moderate, 8
5 percent low, 15 percent insufficient information.

6 Voting on overall suitability for
7 endorsement of Measure 2632, change in mobility
8 among patients requiring ventilator support: one
9 yes, two no. Voting starts now. All votes are
10 in: 92 percent yes, 8 percent no.

11 CO-CHAIR STILLE: Great job, everyone.

12 (Applause.)

13 CO-CHAIR PARTRIDGE: And our deep
14 thanks to the team at CMS and RDI. We appreciate
15 your patience, your willingness to sit through
16 two days. Peter has some comments.

17 MEMBER THOMAS: I just want to
18 underscore what Lee said at the very beginning of
19 this yesterday morning with the comparison
20 between the staff preparation of the measures
21 last time around and this time around and pay a
22 huge compliment to the staff of the NQF for

1 putting together the materials in the way you did
2 and the staff review and eliminating the prep
3 call and instead focusing on the way you did it
4 this time. We could have never have gotten
5 through this 28 measures if it were done the
6 other way, and so I strongly endorse sticking
7 with this approach, even though it's a lot more
8 work for you, I know, in going through it. But,
9 boy, it just made this -- this is a long process
10 to get through 28 measures as it was, but it made
11 it so much easier. And I just wanted to say
12 thank you very much.

13 (Applause.)

14 CO-CHAIR PARTRIDGE: We're going to
15 open the mic for public comment. I'm going to
16 turn first to the people in the room behind me.
17 Please, just introduce yourself and then go
18 ahead.

19 MS. HART CHAMBERS: So I think we have
20 it now. Okay, thanks. So I'm Jayne Hart
21 Chambers with the Federation of American
22 Hospitals. I thank you all for your hard work

1 over the last two days. I was unable to be here
2 in person yesterday.

3 But this is a challenge looking at
4 this particular set of measures, and the
5 discussion that Peter raised about the difference
6 between public reporting and accountability
7 programs and what's considered a value-based
8 payment program on public reporting. It's going
9 to be very difficult if some of these measures
10 are deployed in different ways. And to have a
11 measure deployed in the IRF Quality Reporting
12 Program where there still is the opportunity if
13 you don't report appropriately or get all your
14 data in on time or whatever to be penalized and
15 have a different measure in a pay-for-performance
16 program will create a lot of confusion. And I
17 just encourage, as we go forward, to try to find
18 ways to create measures so that we have a smaller
19 measure set that's more simplified that can get
20 at the issues that are really important to both
21 patients, providers, and improving care. I mean,
22 ultimately, what we're trying to do with quality

1 measures is improve care.

2 So, you know, we're making steps. But
3 I am very concerned that we still have a lot more
4 to do. Thank you.

5 CO-CHAIR PARTRIDGE: Thank you, Jayne.
6 On the phone?

7 OPERATOR: If you'd like to make a
8 public comment, please press star and then the
9 number one. There are no public comments on the
10 phone line.

11 CO-CHAIR PARTRIDGE: Okay, thank you.
12 As we all know, we did not have a chance to
13 discuss today related and competing measures. We
14 will do that, and staff will be back in touch
15 with us about when.

16 For the balance of this day, we have
17 a little bit more than an hour. We propose to go
18 into executive session, have a chance to debrief
19 from these two days of work, chat a little bit
20 about our staff here at NQF about ways that we
21 think this process is terrific and ways that we
22 think it might be improved. And then we'll go

1 home by subway.

2 So thank you all for coming behind us,
3 and we'll stretch a little bit and then regroup
4 at 2:00 and say goodbye to Chris and hope he
5 makes it to the airport.

6 DR. BURSTIN: And a special thanks to
7 Chris and Lee for really leading what was a
8 pretty difficult couple of days. So thank you.
9 Great chairing.

10 (Applause.)

11 (Whereupon, the above-entitled matter
12 went off the record at 1:54 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Person- and Family-Centered Care
Phase 2 Standing Committee Meeting

Before: NQF

Date: 01-22-15

Place: Washington, DC

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