NATIONAL QUALITY FORUM

Moderator: Person and Family Centered Cate
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I'd also like to draw your attention to the links area to the side of the slide window. You'll find a link there to presentation slides and resource information relative to today's program. Clicking on the links will open them in a separate web browser window and will not disrupt your viewing of the presentation.

And now it is my pleasure to welcome you to today's meeting. (Suzanne), let's get started.

(Suzanne): All right. Thank you. Good afternoon everyone, and welcome to the post comment call. We will be using this time to discuss the comment received on the measures, as well as the additional information submitted by the developers in response to your questions.

We are going to do a quick roll call, and then I'll turn it over to Lee and Chris to get the discussion started.

So (Mitra Ernie), do you want to do the roll call?

(Mitra Ernie): Sure. Katherine Bevans? I think she's on the web. Samuel Bierner? Rebecca Bradley?

Rebecca Bradley: I'm here.

(Mitra Ernie): David Cella?

David Cella: I'm here.

(Mitra Ernie): Sharon Cross?

Sharon Cross: I'm here.

(Mitra Ernie): Dawn Dowding?

Dawn Dowding: I'm here.

(Mitra Ernie): Sherrie Kaplan? Carol Levine?

Carol Levine: Here.

(Mitra Ernie): Brian Lindberg?

Brian Lindberg: Here.

(Mitra Ernie): Sherri Loeb? Ann Monroe? Lisa Morisse?

Lisa Morisse: Hi. And this is Lisa Morisse? I will be here on the phone only.

(Mitra Ernie): OK. Liz Mort? Ether Neuwirth? Len Parisi?

Len Parisi: Here.

(Mitra Ernie): Lee Partridge?

Lee Partridge: I'm here.

(Mitra Ernie): Debra Saliba? Christoph – Chris Stille?

Christopher Stille: Chris Stille is here.

(Mitra Ernie): And Peter Thomas?

Peter Thomas: Present.

(Mitra Ernie): Carin van Zyl?

Caril van Zyl: Here.

(Mitra Ernie): Thank you.

(Suzanne): All right. Is there anyone else who maybe just joined or was on mute?

Katherine Bevans: This is Katherine Bevans. And I'm sorry I missed. I was on, but missed. I was on mute.

(Suzanne): OK. Great.

Katherine Bevans: Thank you.

(Suzanne): All right. Well, thanks everyone for joining us today. With that said, I think I will just turn it over to Lee and Chris to get the discussion started. Then we can – for their welcome and then we'll dive in.

Lee Partridge: And Lee is going to, excuse me, welcome everybody and turn it over to Chris because he's going to have to stop about two thirds the way through and go see patients, so we don't want to keep him from that. So Chris, I'm going to turn it over to you to take us through the first part of our agenda.

Christopher Stille: OK. I believe that we're going to get an overview from (Mitra) about the document that we all received in the last couple of weeks or the couple of documents about the comment and the teams, which put together those comments. And then I am not sure if we're going to be going individual measure by measure, where we're going to take them into group. I believe we're going to take some as groups after that time. And we will see where we get.

(Mitra Ernie): Thank you, Chris. This is – Hello everyone this is (Mitra). And so the draft report of the committee recommendation overall are well aware what's posted for the 30 days public comment period from March 2nd to 31st.

During this time, we received a total number of 94 comments from six member organizations and four members of the public. A good portion of the comments were repeated across similar measures. The member organization that provided comments were from different groups including purchasers, providers, health (sense) and professional.

So, I'll be reviewing the major themes that emerge from the member and public comments. And during the next agenda item, (Sarah) will be reviewing major specific public comments, as well as additional information received from the major developers.

So in the interest of time, I'll go quickly over these things.

So the theme number one request for reconsideration, support for not recommended and consensus not reached measures. Many of the comments requested the committee reconsideration and recommendation of

endorsements for the measures that were recommended or the committee did not reach consensus on. Their action on for their support pointed to the major gap measures giving a particular area or measures that focused on patients centered outcome.

So the committee requested this additional information to have a more comprehensive review of the measures. And this additional information can be discussed on today's call. And the committee did have an opportunity to revote on these measures.

Theme number two, additional gap area is identified through the comments.

So there were many comments regarding gaps in the person and family centered portfolio of measures. The list of gaps included measures that determine how the provider improved the patient's life regarding mobility, measures for in-patient rehabilitation facilities that evaluate outcomes based on functional improvement, measures that aside to pediatric population, as well as other younger population in hospital and ambulatory care setting. Measures that taking more inclusively of functional status, such as measures that pair condition specific or body part specific functional status measures with global measures, such as the (Promise) 10 or PHQ-9.

Measures that ensured the system has captured personal growth, measures that demonstrate whether a provider has collaborated into the individuals to develop tools that reflecting individual needs, values and preferences for daily living, measures of function that measure against the individual tools over time in relation to his or her environment as the last measuring preservation in function, measures that focus on meeting expected outcomes of the intervention and reducing further deterioration that is on focused on improvement, especially for population in home health and long-term care facility. And lastly patient centered measures of maternity check.

Moving on to theme number three, harmonization creating composites. So a number of comments focused on harmonization and creating composite measures. So two sets of comments suggested that measures develop by UDSMR need to be harmonized and other comments suggested a number of

home health measures also need to be combined into a composite measure. And then lastly, there was a comment on the FOTO measures that indicated and suggested considering combining all the FOTO functional status measures into a composite that include taking patient preference into account.

Theme number four, consent. There was consent about unintended consequences and discrimination. So several comments raised consents about unintended consequences of a particular measure or the possibility that the used of the measure may lead to discrimination in care or patient profiling, particularly for patients that are unlikely to improve due to the nature of the disease, yet they still need therapies to prevent further losses in function.

So NQF is fund – is – although NQF is not able to monitor for unintended consequences directly, but they do encourage the submission of this information via the quality provision system.

And in terms of the committee saw the issues of unintended consequences and cherry-picking patients for inclusion in measure they were discussed during the in-person meeting and the committee's kind of encourage major developers and implemented to consider implications of measurement, including potential unintended consequences.

Moving on to theme number five, age exclusion. So the commenters noted that the recommended measures in this project mostly focused on older population. And there were comments requesting that measures focusing on pediatric population maternal health agreement of reproductive age and younger patient in hospitals and ambulatory settings is also need to be considered.

So, the NQF response used that – this particular phase of person-family centered care is focused on functional status measures. And however, we do have pediatric measures in the (PFCC) portfolio, which will be reviewed in the future spaces of the project. In addition, NQF has a number of other maternal and child health measures in the NQF portfolio, which will be reviewed by other committees of NQF.

So the last theme is IMPACT Act. One comment is appreciated NQF awareness and consideration of the goals of the Impact Act around cross setting measures and appreciated continued transparency, as well as publicly available information regarding next step with respect to cross setting measures.

So this concludes the themes from the public comments. And now I would like to turn it over to Chris and Lee.

(Sarah): So, Chris, this is (Sarah). What I think we should do here is just see if anybody had any high level of reaction to the themes. But I just wanted to reiterate that we'll go – we'll basically be going to the vast majority of these themes as we go through each of the measures since we had so much of this – so many additional request for information and outstanding information. So, Chris, we'll just ask if you can see if anybody has any overall comments.

Christopher Stille: Sure. Yes. I think these are some great themes. And I was wondering if there are any comments.

Peter Thomas: This is Peter Thomas. I would just say that, well, some of these things are new or, if I recall, they appear to be somewhat new. We did cover a number of these themes in our discussions that struck me as we reviewed these measures. So they're not all brand new, and I presume that that wasn't the intent to necessarily have them all be new. But I recall discussions about a number of these different themes throughout our two day meeting. That's my only initial comment.

Christopher Stille: Thanks, Peter. And this is Chris, and I have one more comment, as well. The – I think that all of the things that were raised in the themes were valid whether or not they lead to reconsideration is another story. And we need to kind of go back and ask the NQF staff potentially what the discussion was and discuss briefly among ourselves some of the reasons that we accepted or didn't accept the measure before we move forward with the consideration.

Lee Partridge: And Chris this is Lee. Are you talking about some other ones in which we didn't recommend or?

Christopher Stille: Right, specifically that, right.

Lee Partridge: Yes.

(Suzanne): Yes and exactly. And so I think as we, you know, I think this is why this phase of work was a little bit more challenging, at least we had so many of these measures that, you know, do warrant reconsideration and one of the steps of the process is not only obtaining the additional information as the committee requested, but also, you know, listening to public comments, and so that's what – part of that is pulling that together.

And so, as we walk through measure by measure, you know, it will be up to the committee to determine do you want to revote, does it want reconsideration based on either the public comment or the additional information, so we will lead to that.

Christopher Stille: Sure. Sure. I guess I have a question now about how we're going to do things. Are we going to do things according to theme or according to measure? And if we're doing them according to measure, I knew a little bit of guidance as to what document to go by.

(Suzanne): Yes. I think what we're going to do and maybe in or (Mitra) is you will pull up the document called PFCC 2 measure summary additional info and public comment two and that was – I think, that was sent out to you all, at least a week ago, because it was a couple of days after the rest of information, but basically it's a table that went through the measures that either we're not recommended or those measures that where our consensus does not reach.

And so, we pulled together the measure number or the suite of measures, your original committee vote, highlighted where you either did not reach consensus or the vote went down, the additional information you were looking for, which is what is the developers would have sent and then the public comment summary, but only the public comment not the respondent.

So, I think what we'll do, Chris, is we'll go ahead and walk to see that and I can help you with that.

Christopher Stille: OK. And I just founded it as you were talking.

(Suzanne): OK. Great. So then I talked long enough.

Christopher Stille: Perfect.

(Suzanne): So – And what we want to do to, which I don't think Chris and Lee may not have been aware of, we want to start measures 0701, which is page three of that measure summary table I just mentioned.

Christopher Stille: OK.

(Suzanne): And we want to – Have all the committee never saw on that document or do you need any additional guidance on finding it?

David Cella: I got it, Cella.

Christopher Stille: OK. Right. The measure title is Functional Capacity in COPD Patients Before and After Pulmonary Rehabilitation kind of …

Katherine Bevans: This is Kate, so, you know, kind of – as a recollect – I'm sorry. Go ahead.

(Mitra Ernie): I'm sorry. I went through that document and would it might be correct in an observation that most of the comments was around – we really need this measure and not so much addressing concerns the committee may have had regarding reliability and validity data. It seems to me that's the main reason most of those measures were not recommended.

Christopher Stille: Right. And that includes this one. It looks – it – within a great zone of consensus around reliability.

(Suzanne): Right. And so, you know, consider to step back a little bit. So this is one of the measures that the kind of NQF of nomenclature that we would use as consensus not reached, but if you look down, the recommendation for endorsement was 16 yes and 1 no, and you would ask for additional information on reliability.

This measure would still go forward with consensus not reach. However, we do give the developers an opportunity to bring additional information back once they have some clarity on what you were looking for. And there was this kind of full suite of measures, where you all were looking for additional testing at the program facility level versus a lot of these where is the testing provided may have been at the data element level or at a different level.

Christopher Stille: OK.

(Suzanne): So basically – Yes. So basically, what happened on this one is you all had asked for the additional information or one had said do you wanted to see additional information on reliability testing that developers provided that information so that it should be out in your folder as well.

And then in additional on that left comment, you know, those are just the public comments we received on the measure. We support the endorsement of the measure and then this other one, although potentially obvious by the condition the denominator specification should include age specifications including exclusion. And so those would be the type of comments were looking back for from developers.

So I guess that's – what goes back to committee at this point is from the information provided in the separate document did – they provide enough additional information. And then what we would ask you to do on any measure where consensus is not reached we will ask you to revote on this measure.

Christopher Stille: OK.

(Suzanne): So this is your opportunity to ask questions based on the additional information that the developer provided.

Christopher Stille: OK. And where can the additional information be found? I'm guessing that a lot of us probably didn't have a chance to look at it.

(Suzanne): So that's out in your committee folder under this meeting.

Christopher Stille: OK.

Lee Partridge: I wonder if anybody on the committee had a chance to actually look at the document, particularly some of our committee members who raised some of the questions about – the question was whether or not it's been adequately tested at the facility level, as I recall. And I have read it. But as all my colleagues know, I'm not a methodologist.

(Suzanne): And what we could also do is ask – so first on, maybe (Nur Mitra), the document is the AACVPR_0701 NQF response letter. And we can ask the developer to have – to make some brief comments on what they provided.

So we have the line open for our developers.

(Todd): Yes, I'm here if you want me to speak. I didn't know that they were …

(Crosstalk)

(Sarah): Yes, go. Why don't you go ahead and just provide a couple of comments. Is this (Todd) or is this.

(Todd): This is (Todd)

(Sarah): OK. (Todd), can you just go ahead and kind of make a couple of comments on what additional information you provided?

(Todd): Sure. Thank you for the chance. Basically, you know, we're looking at six-minute walk test distance, which has been studied extensively in the medical literature as far as its reproducibility and reliability sort of a well-established outcome measure, and patients with pulmonary – chronic pulmonary diseases, COPD specifically. So I think in terms of reliability and reproducibility that measure any given individual or patients is very well-documented in the literature.

What, I think, NQF asks about was that sort of reproducibility or reliability at the program level. Now, obviously, we can take the same patient and have them do a six-minute walk test in multiple programs. But what we could do is we look in our registry data and share you based on program size, for instance,

among small programs, medium and large programs define by how many patient they enroll in the annual basis and see a distribution of how this walk test occur and whether people increase their walk test distance by the 25-meter threshold that is generally considered to be clinically important, and that's the table that we included in our response letter. What we show is that across the borders is really very reproducible.

So we really get all programs about 80 percent of their participants increase their six-minute walk test distance by 25 meters after completing cardiac rehabilitation, and that doesn't vary much depending on whether you look at small programs, medium programs or large programs, the range is anywhere from about 79 percent to about 86 percent. So it's really a fairly narrow range in terms of a median number of patients who increased their walk test distance. And we showed some date on the distributions regarding the 25th percentiles et cetera and there's not a lot of variation.

So our hope is that this shows some consistency across different programs within our registry of how patients respond with pulmonary rehabilitation.

Lee Partridge: OK.

Christopher Stille: So then, I get the issue then, this is Chris. The issue is specific program and facility level analysis needed to reach your consensus, because it sounds like it's implied, but maybe the analysis won't work or run, I'm guessing.

(Todd): I don't understand the question, I mean, well – you talked about – do you want to know every single program with their number is?

Christopher Stille: Well, comparing programs and programs. I think that's what people were talking about is …

(Todd): Right.

Christopher Stille: … you know, if you carve it up by program rather than, you know, by individual, when it comes to the initial …

(Todd): Right. So the data that we show in the supplemental document is by program.

Christopher Stille: OK.

(Todd): It's the – what we do – I mean, I could show you all, you know, 125 programs, but basically, it's – we try to group them into a small, medium and large based on the size and then showed it within those strata, you know. Among all small programs, you know, the average is 86 or the median was 86 percent improved.

Christopher Stille: OK. I got it.

(Todd): For me, 79 percent for large 82 percent. Now, well, we can show you program by program. But I mean I think in general …

Christopher Stille: OK.

(Todd): … what this is showing you is that, you know, when you look at it by – at the program level …

Christopher Stille: OK.

(Todd): … the median improvement is fairly reproducible. I mean it's fairly reproducible, really. It's got a pretty narrow range.

Christopher Stille: You said it's a pretty narrow range, right?

(Todd): Yes, 79, 86 percent median improvement. So …

Christopher Stille: OK.

(Todd): … you don't see a lot of variation, you know, at least in those strata.

Christopher Stille: Yes.

(Todd): And we have a nice distribution of programs, you know, 17 fit in a small group, 50 in a medium, 50 in the large. So it's not like they're all in one bucket.

Christopher Stille: That's good. Thanks for that explanation. I did so hard when we don't have something that we're actually looking at on a phone call, great.

(Todd): I think, you know, I think that what the data suggest is that, you know, program to program is fairly reproducible in terms of if you'd ask what percentage of patients will improve their six-minute walk test distance by 25 meters, I think irrespective to what program you look at, it's going to be roughly 80 percent will, at least in the current situation.

Christopher Stille: Great. OK. Great. Other group comment?

Rebecca Bradley: Yes. This is Becky Bradley and I apologize. I'm not that familiar with the six-minute walk test. Is this a self-reported measure or out as the improvement …

(Todd): No, ma'am. This is a highly standardized measure, where – in fact there are very specific instructions given by the American Thoracic Society regarding how to conduct the test. It's done in the center, so the patient arrives. There are very specific instructions of how you ask them to do the test and then the distance is measured by the staff.

Rebecca Bradley: OK. So …

(Todd): They really walk on the track for six minutes and it's timed. At the end of six minutes based on, you know, before they go on the track, they can figure out how far they walk.

Rebecca Bradley: And then you will see the test with various intervals during their …

(Todd): Yes, mainly at baseline and on point of completion.

(Rebecca Bradley): OK.

(Todd): But it could be done in more variables. What we're looking at here is from – basically pre-rehab to post-rehab. And that's, by the way, used in clinical trials as an outcome, et cetera. For instance, in the pulmonary hypertension world this is actually an outcome measure to determine whether medicines improved outcomes in pulmonary hypertensions. So it's a very standardized well-studied measure.

Rebecca Bradley: Thank you.

Female: This is also a small that was a primary outcome in the National Emphysema Treatment Trial whenever they tested lung volume reduction surgery.

Rebecca Bradley: Thank you.

Christopher Stille: OK. Any other discussion? OK. So, just the procedural thing when and how do we decide to revote or not.

(Sarah): (Suzanne) did you want to – I mean, this is one – this is a consensus not reach measure. So technically, you have to revote. And basically, what will happen when we get to the next steps – portion of this call (Nadine) will go over and (Mitra) will go over the timeline for that, but …

Christopher Stille: OK.

(Sarah): … (Suzanne), do we need on this call for the committee members to say if they want to revote or not on reliability or do we …

(Suzanne): Yes.

(Sarah): OK. So basically, what we need – so – I'm sorry. (Suzanne), go ahead. Why don't you give that overview?

(Suzanne): Sure. Yes. Basically on consensus not reach measures, the committee needs to revote on their overall recommendations for endorsement. You are also welcome to revote on whichever criteria the measure didn't hit consensus on. And then if you didn't vote on anything else, then you would need to revote on that.

So, its – the committee can kind of discuss and, you know, either the co-chairs can kind of make the call or the committee can weigh in and say, "Yes, we would like to revote on reliability," or, "No, we would not."

Lee Partridge: Suzanne …

(Suzanne): But then …

Lee Partridge: This is – yes, go ahead.

(Suzanne): … maybe we'll send the survey after the call and that's how you'll actually do the voting.

Lee Partridge: Got you.

Christopher Stille: OK.

Lee Partridge: Since we have a lot, this is Lee, since we have a number of this, this afternoon, I wonder if we could just adopt the role that either Chris or I whoever is chairing at the end of each measure we discuss, just pause for a minute and say, "Does anybody object to a revote?"

Christopher Stille: Yes. I think that sounds reasonable.

(Sarah): I think in terms of NQF process it would be – we would prefer that you revote.

Christopher Stille: Yes. So, right. So we would get any objections through review, revote assuming that we will revote unless people see otherwise.

Lee Partridge: Right.

(Suzanne): That would be great.

Christopher Stille: OK.

Lee Partridge: Will you set to vote up so that we get that, in these instances, where, for example, we have a lap-sided vote on three of the elements but not the fourth, you know, just put to up automatically the one we didn't reach consensus on and then the overall?

(Suzanne): Exactly.

Lee Partridge: And we'll get both of them in the survey.

(Suzanne): Yes.

Christopher Stille: OK.

(Suzanne): Yes.

Christopher Stille: All right. So, do we have any objections among the group to revoting on measure 0701?

Male: No objection.

Christopher Stille: Hearing none, we will revote.

Lee Partridge: OK.

(Sarah): OK.

Christopher Stille: So, OK. Let's go.

(Sarah): Let's go back now to page one of that summary document. And so this – we'll go back to measures and – first of all, thank you all. I think (Todd) had other commitment. And so they asked us to go first today. And so (Todd), thank you so much for that additional information and your explanation. And I believe we will follow-up with the developers, since I'm not sure all of you on that team are able to stand the call. We'll follow up with you all next week after the revote.

(Todd): Great. Thank you very much.

Christopher Stille: Great. Thanks.

(Sarah): So now, let's go back to the FOTO measures. So page one of the summary document are measures 042220428, and just kind of talk a little bit about overall committee process on this measure and then a couple of the other ones.

So we have a total – with the number of measures where the measures were not recommended, basically (P) is the measure failed early in the process.

So in this case with the FOTO measures, as you might recall, the measure failed at performance gap, which is one of the important criteria. And then we

did kind of a scenario situation so that we could provide the developers some additional information on what you all would want to see as additional information for them to supply in order for you to reconsider the measure.

And so under additional information requested column is a list of additional information you all requested. And basically, it was a lot of the testing data, specifically interclass correlation coefficient at the clinician in clinic levels.

And, you know, as a reminder, I believed in the original submission of the FOTO measures a lot of the information was provided with specifically about the tool versus the overall measures.

And then, you know, there were a significant public comments summary on this – the suite of measures, as well. And basically, this is an example of where (Mitra) had said we received, you know, a total 94 comments, but a lot of them are repetitive due to the number of measures. So these measures – these comments were all repeated for each of the eight measures.

Again, this is a situation where the folks from FOTO provided additional information, and they provided an overall summary memo to you all. And we actually sent that out a few weeks before the call and ask you all to provide – to see if there was any additional information then on what they are planning on providing to us if there was anything additional you would want to see, and we receive no feedback from any of few. So basically, what FOTO submitted is what they submitted.

And, you know, it was a lot of information, so we didn't summarize it. But there is a PDF document in your folder. It's called – it's titled 031915 Additional NQF Data FOTO.

And I don't know. (Ben), are you on the phone? Or is someone else from FOTO on the phone that you just wanted to make some comments?

Linda Resnik: Yes. This is Linda Resnik from FOTO. Can you hear me?

(Sarah): Yes, we can hear you, Linda. Go ahead.

Linda Resnik: Oh, yes.

(Sarah): And we would just ask you if you could be brief but to the same degree, you know, kind of how we did the last …

Linda Resnik: Yes.

(Sarah): … developer? If you could do that, that would be great.

Linda Resnik: OK. As you can see, I think, you have the table of contents of our response documents in front of you. We prepare the response to the specific comments that were raised in the initial review. And we provided a document on the gap analysis, which showed a clear link between treatment processes and outcomes. And we also provided specific revisions to a measure classification as what was crafted to make them clearer.

We decided one major change that we would withdraw our request to lower the age limit, from 18 to 14. We also had a request to provide more descriptive data on the patient toward in a general orthopedic measure. We had shown only the cervical patient data, but we've provided data from all of the other patients.

And we have conducted a reliability analysis at the provider level, both at the clinic and the clinician level using the (Adams) Method and present it to the (ICC) and get best information. That's section five provide a reliability shows, you know, that we have adequate reliability of 0.7 or higher for our quality analysis at the provider level.

And we've also looked section six. We've looked at provider classification and the validity of those. And we provided evidence to show that providers classified as better than average, greater percentage of their patient improved by clinically important amount and providers who are less than average in performance a fewer percentage of their patients would improve by clinically important amount.

So that was section six, where we looked at the validity of provider classification. We know there are a lot of materials here. We will also ask to

demonstrate the amount of variance at each level of the patient, the clinician and the clinic.

And then in section seven, we show the result of the components of various analyses, which shows how much variance and the outcome is attributable to each level.

And then in section eight, we show the relationship between intensity and frequency of therapies as it is in the functional status discharges had been request by one of the committee members to examine that.

And then lastly in nine, we show more information from our risk adjustment model including the beta coefficient and estimates of marginal means by gender, age, and payer loop to address some other questions about demonstrating disparities data and then interpreting our outcomes.

So, we are here. We can answer any specific questions. So that's the highlight of all of the materials that we provided in the supplemented documents.

Christopher Stille: Right. Thank you. That's a great summary. I am wondering once again whether how many committee members have had a chance to take a look at the individual things, but it does sounds like a lot of the numbers that were requested, both about gap and reliability and validity were provided, so we need to take a look at those. So …

Linda Resnik: Right. Initially, we did respond to the public comments. I believed you have our responses there in your grid that shows the public comments and our responses.

Christopher Stille: Right.

Linda Resnik: … at the same time now or …

Christopher Stille: Yes.

Linda Resnik: … make a comment as we discuss those.

Christopher Stille: Sure. Well, that's the summary of public comments. Most of them – most of those are related to importance, which the committee didn't have a problem with. The one about age range is well noted. And I applaud your decision to withdraw from the 14 to 18 age range as a pediatrician if you like. Population was different as well. And certainly, it needs the measure but the needs the data specifically on kids on that age range, so.

Linda Resnik: OK.

Lee Partridge: Linda this is Lee Partridge. You provided us with a wealth of information, which actually I enjoyed reading, but I need a little bit of help in understanding, actually, mechanically, how you do the risk adjustment, I noticed. Then I think you know from our earlier discussion we were particularly interested in some of the variables that you used gender and pair source being, probably the two major ones.

When you actually calculate this numerical change, do you then go into a table similar to the one you presented with us and add or subtract according to the information you have about that patient?

(Crosstalk)

Linda Resnik: … let me see if I understand your question. So …

Lee Partridge: It's around the risk adjustment, which I understand you do. So your – before you present the final figure, how do you do the risk adjustment?

Linda Resnik: So, when we are aggregating the data of it to the provider level, we run the risk adjustment models for each patient of that provider. I mean …

Lee Partridge: Right.

Linda Resnik: And so that takes into account all of the attributes of that – of their patient. So, its gender controlling for, you know, all of the other things in our model. And based on that, we're able to see if patients change as expected or as predicted, or more or less.

However, I think your question is FOTO also, and this is not part of our quality measure that submitted here, but FOTO does show to providers individual prediction values based on the characteristic of that person, so that would say for women, say, for example, of this age with this impairment, we would – this is what we would expect the outcome to be at the end of treatment. So this is a sort of a separate question.

So does that address your question?

Lee Partridge: Almost. As you may know, the National Quality Forum has had a lot of discussion about how we risk adjust measures, particularly with regard to those elements in the patient's profile that relate to their sociodemographic characteristics.

So, I noticed, for example, that you've – in some of these tables, the Medicaid beneficiary will – has a higher number of five as opposed to a two for Medicare benefit. Does that mean that when the patient – when you're aggregating the data on that patient, you, in essence, lower your expectation for improvement by five points now that was your predicted score would be five points lower for a patient A, whose Medicaid as supposed to patient B, you take off only two? I don't want to deliberate.

Linda Resnik: Yes, yes, yes.

(Crosstalk)

Linda Resnik: That would be how the model works. It's that coefficient. If they have Medicaid, they would be compared to the reference category. And their predicted value (consolidating) for all other things would be 4.6 a lumbar point lower. So that's how we predict based on similar patient.

Christopher Stille: OK.

Lee Partridge: Thank you.

Christopher Stille: Great.

Katherine Bevans: Chris, could I ask an additional question? This is Katherine Bevans.

Christopher Stille: Sure.

Katherine Bevans: OK. A quick question in the supplemental documents table 1B-2B, where the demographic information of the patients are presented, the minimum age is noted as 14. So I just wanted to confirm that the subsequent analysis on the clinic level reliability in particular were conducted without – with the new age exclusion put into place, so 18 plus.

Linda Resnik: Yes. Thank you for that. Yes. Thank you for that question. Yes, they were. We did those, excluding the 14 to under 18, so those are 18 plus.

Katherine Bevans: OK. So that table probably should not, I guess, not include those 14s or need adjustment that removed.

Linda Resnik: Yes. Yes.

Katherine Bevans: The other question I have is I was wondering if you could comment on the – I'm sorry paging down for the report – the kind of standout reliability at the provider level now table five A …

Christopher Stille: Yes.

Katherine Bevans: … in particular for the hip measure having of relatively low percentage of correlation greater than 0.7 overall and in particular showing a little bit of concern about reliability to provider level particularly when there are small number …

Linda Resnik: Yes.

Katherine Bevans: … providers. It just seems to standout from the others, so I'm wondering if you could comment, just for our folks on the call. It's 48.4 percent overall having correlations greater than 0.7 for the hip whereas others are, you know, closer to the mark that we may want, you know, 70 percent.

Linda Resnik: Yes. So, it's our recommendation based on this data. You're right. The reliability particularly for the hip was lower at the clinician level. But based on this, we have established a threshold of how many patients per clinician we

fill or necessary in order to calculate a quality ranking. And hip is a small percentage of the patient in the data set. And I think as we – as our data grows, we will have to revisit that to see if there will be a different threshold.

But we have now used these reliability analyses to make recommendations about the minimum number of patients per providers that would be required in order to make – to be in the quality ranking. And if they were not sufficient number of patients per provider, we would not include them in the ranking.

Katherine Bevans: OK.

Linda Resnik: Based on this table.

Katherine Bevans: A lot of the information here. Are those threshold presented in the supplemental material?

Linda Resnik: Yes. That's – Those are – There's a section on provider reliability, which is section 5 and …

Male: Table five.

Linda Resnik: … table five A.

Katherine Bevans: OK.

Linda Resnik: So that's shows you the, you know, by number of patients per (either) for the clinic level and the clinician level to show the threshold, and that will inform our procedures for who will get this included in the quality ranking.

Katherine Bevans: Sorry. I'm just – I'm not seeing the indicator in this table as the cut point. So you would say to a clinic if unless you have 20 plus clinicians, or so, for hip that …

Linda Resnik: Right. That's – It's not in the table, but we have in narrative.

Katherine Bevans: Got you. Thanks.

Linda Resnik: Above that, we have specified now what are requirement would be. And then in the specification documents, which we would rise for each measure, we would put these updated figures in there based on this table, but we haven't – the table just showed the data. There is an …

(Crosstalk)

Katherine Bevans: So, I guess there's a lot of information, so thanks …

Linda Resnik: I know there are a lot there.

Katherine Bevans: Thank you.

Christopher Stille: OK. Any other comments? I do think we need to keep moving. Those were great discussions, and thanks to all.

(Suzanne): So, Chris, I would – I think this is an area where, you know, obviously FOTO has provided a lot of additional information. It's obviously NQF preference that the committee revote these measures.

Christopher Stille: Yes.

(Suzanne): And we'd want to know if there are any objections.

Christopher Stille: Right. So, any objections before we continue to move on?

Lee Partridge: No objections to revote, but I assume part of revoting we'll have a chance to review to provide specifications.

Christopher Stille: Yes. And in fact that's sort of some important homework for all of us before we do go to that revote as to actually go over all of those things.

Lee Partridge: Thanks.

(Sarah): Yes. Section two has the specifications – proposal for the specification revision, so I refer you to that section.

Christopher Stille: OK. Great. Thanks. Well, should we continue to move on?

(Sarah): Sure. So the next measure that still folds under this measure not recommended area that you all failed at the point where we got two reliabilities. So this is a measure that has importance is measure number 2643 the average change in functional status following lumbar spine fusion surgery. This is a Minnesota community measurement – measure. So I believe either (Colette) or (Pauline) or – I'm sorry – (Paulette) or (Collin) are on the phone.

And what you had requested or what the committee had requested on this would be the interclass correlations at the scale and practice level, additional information on standard error of measurement. And they wanted to – and you all wanted to understand how to interpret the performance scores.

This is another area where there were a number of public comments, and certainly into the port of the measures based on this being an area of critical importance to patient. So, we'll ask if anybody from Minnesota Community Measurement is on the phone.

Jasmine Larson: Hello? Yes, this is Jasmine Larson from Minnesota Community Measurement. Thank you.

(Sarah): Sorry, Jasmine, I didn't know.

Jasmine Larson: That's OK. No problem. I actually do have (Colette) here, as well as the statistician who did the additional analysis requested by the committee.

(Sarah): So did you just want to, as the other developers, you just want to introduce us – introduce the committee what you provided. And, you know, in the meantime, we'll pull up those documents and just give you that opportunity to do that as well.

Jasmine Larson: Certainly. You know, I just believed that we did submit, I think, six different documents so it might be cumbersome to try to click through them, but I will just start with the one that had, you know, four questions on it, I think. And we responded some merited, and then we included charts and tables with the actual details of the analysis that was submitted.

So, you know, first, you know, similar to the first developer that summarized their response, (I remember they were pressed for an) interclass correlations that was the scale and the practice level for this measure. And I should, you know, while this conversation right now is focused on measure 2643, which is the knee measure, you know, these responses are also applicable to measure 2553, which is the biometric – I'm sorry – 2643 is spine 2653 is knee. So, if you'll just allow me to kind of blow those lines for a little bit, that would be great.

You know, in regards to the interclass correlation of the scale and practice and level, these measures used tools that Oxford Knee Score and Oswestry Disability Index that are established instruments with really strong and published evidence of their psychometric properties they are widely used in clinical practice, and also have published minimally clinically important difference for them.

Interclass correlation measures the performance and variations that is attributable to the object of the measurement, in this case the patient.

And in the case of these two measures, while the patients are attributed to clinic, (ICCs), you know, required randomly selected objects from measurement and the requirement that cannot be meant for the two measures and either the patient or the clinic level, therefore we weren't able to perform an interclass correlation as the practice level although that interclass correlation is well-established in the literature at the tool level.

There was additionally request for information regarding standard of error of a measurement.

And, you know, I think, I'm just going to quickly move to the end of the narrative, which I think it gets that – the underlying question is about ability for these measures to discriminate between groups. And their deviation is not necessarily the way in which you discriminate between groups, but instead confidence interval calculated for each medical group.

And when confidence level that is calculated at the medical group for the data set should be in two measure. The 95 percent confidence interval can be use

to determine statistically significant different performance at the medical group level and follow-up analysis using the (innova) technique clearly demonstrates that there are medical groups that can be statistically significantly differentiate it. And, you know, that is all demonstrated then in the chart and the table that were provided additional attachment for the group consideration.

Christopher Stille: Great. Thank you. Comments from the committee? I think our primary psychometricians are unfortunately not on the call, but we'll definitely want their input as we go to revote.

(Crosstalk)

Katherine Bevans: Katherine is on the call.

David Cella: I'm on the call, and Katherine is on the phone – on call. I didn't have any comments. I mean, I …

Christopher Stille: Oh, I'm sorry, David.

David Cella: It's a reasonable response to see that.

Christopher Stille: OK. Good so we have two or three, that's great.

David Cella: I mean, I just – I think that the concern about interclass correlations from site level data was something that was sort of thematically expressed across the number of reviews, not by me, but by another reviewer.

And I don't – you know, I think we're – I don't think I would necessarily tag that issue to anyone. It's a sort of a general concern about whether sites can get reliable data. And individual and site level that can be then use for comparison to sort of general issue, you know, that would, I believe, cut across just about any performance measure, but I think they respond to the questions about the performance measure itself.

Christopher Stille: Good. So I'm wondering in the – I'm going to scroll down to 2653, just to see if there's anything different, but I wonder if we could consider the decisions to revote together.

(Suzanne): So, you know, what's interesting with this, as follow-up to the in person meeting is with 2643, which was the spine limit, we're just talking about the vote to stop that reliability and as not recommended, where the votes on 2653 were a little bit different and it came down to consensus not reach.

So this should be, you know, definitely an area we would hope that the committee goes back and review all of the information. As Jasmine indicated, they submitted six additional documents that those are the responses on what they understood was opened after that meeting, as well as look at the public comments.

And then certainly since one of this was not recommend and the other it was consensus not reach would ask that you look at them, you know, kind of entirely, but we'll have to revote on both of them.

Christopher Stille: Sure. I was just looking at the public comments on 2653 to see if there's anything actually different.

Lee Partridge: I don't think so. In both instances, there is considerable interest on the part of the purchaser community in these measures because they are commonly performed procedures. Both the purchasers and the patients are interested in knowing what performance information is.

I think also in this one, Chris, if you remember, you know, Minnesota is in the process of implementing so that they had test data, but it wasn't huge numbers.

Christopher Stille: Right. And they have mentioned that there was going to be more ready in the few months, right?

Lee Partridge: That's right.

Jasmine Larson: This is Jasmine, just to clarify. It's the spine surgery measure that was test data only, and yes we will have much larger data set here in the coming months.

The knee data is a larger data set.

Lee Partridge: Right.

Christopher Stille: OK. OK. So, I think we need to have two decisions, one is should we consider the idea of revoting together and the other is should we revote. Is that OK with people?

Brian Lindberg: Sure.

Christopher Stille: OK. I'm hearing no dispute. Any disagreement with considering vote together at this point? I mean we'll consider them separately when we revote. OK.

Peter Thomas: Yes. No objection.

Christopher Stille: Great. I'm hearing no objection. Then the next question is any objections to revoting? OK. So, then, it sounds like we will revote. We agreed to revote on 2643 and 2653. And hopefully, give the Minnesota people a few minutes on this call.

Jasmine Larson: Thank you.

Christopher Stille: OK. Thank you.

(Suzanne): OK. So …

Christopher Stille: Great. So where we go now?

(Suzanne): Yes. So let's go down – hopefully, go back to that table to the bottom of page three. The next measure where consensus would not reach is 2624, and that was the functional outcome assessment measure. This is a measure where consensus would not reach that reliability, validity. And then the overall recommendation for endorsement was 10 to 9, so that's stellar.

Additional requested information was, let's see, information or consideration of change (specification) establishing a link between the assessment and the care plan, data that clearly links the care plan was a collection of the outcome data, more information on iterate reliability and then greater clarity on how each element of the process definition is actually measured in the field that's

when coders are, you know, somebody is trying to code the measure what are they looking for to be able to pick up numerator and denominator hits. Only one comment on this that was we support the endorsement of the measure.

And I believe, you know, this is – we have two measures that were somewhat similar in looking at a change in functional status and a tied to care plan, and this was the first measure during the in person meeting that we had discuss.

So, I don't know if, you know, anybody else recall the other particular details but we did go back out to the developer and asked for more information specifically the inter-rater reliability information to boost your information on reliability and validity.

Christopher Stille: OK.

(Suzanne): And I believe this is a CMS measure, so I'm sure who might be on the phone?

Sven Berg: So this is Dr. Sven Berg. I'm the Chief Medical Officer for West Virginia Medical Institute, the parent company for Quality Insights of Pennsylvania who is a measures developer and we have a number of other people on the line as well.

(Suzanne): Great.

Sven Berg: So you asked us three questions, and really question one and question three seem to be related and then question two has to do with inter-rater reliability. In terms of the link between assessment and care plan, we went back and looked specifically at the specifications for the measure. And for performance met, it's a requirement to have the G-code, G8539 as met in order for that performance to be met.

And in order to document G8539, one have to assess a functional outcome – you have to document a functional outcome assessment. You can standardize tool and want to have to have a care plan based on the identified deficiency on the data of the functional outcome assessment, and that that's documented.

And so, the specification of measure actually is the requirement that we believe that the committee was looking for. And when our evaluators would go and evaluate the records to see whether or not the records actually supported the documentation, that's what we were looking for. So we do believe that there is a link based on the G-code between (inaudible) and the care plan.

And again, in question three, what were the coders looking for, they were then looking that the criteria for G8539 was met, that the care plan was based on the functional outcome assessments. Again, we'd like to stress that this is not an outcome's measure itself, it is a performance measure. And so, we're not looking for specific outcomes from the measure.

In terms of inter-rater reliability, again, it's performed by two of obstructor who review each of the data elements that comprise the G-code. For example, on the G-code 8539 as defined, the abstract to review the medical record to determine, one the date of the assessment, two that the assessment tool was a standardized or validated tool, three that deficiencies were documented and four, that the care plan reflected the findings of the assessment on the data review assessment. And that was documented on the data review assessment.

And so our inter-rater reliability was based on looking at those criteria and whether the reliability was that or that the agreement between raters and again, as – and it was provided in the initial package but again just for your summary, the crude numerator agreement where they want 0.3 percent and a problem suggested capital was 0.64. And so this demonstrates, according to some – this demonstrates according to some statisticians who looked at the cap that would demonstrate substantial agreement between the raters.

So, we're open to any additional questions that you have and we appreciate the opportunity to provide this additional information for you.

Christopher Stille: OK. Thank you very much. Comments from the group?

Lee Partridge: This is (Lee). This doesn't actually go to reliability or some of the questions you just addressed. It's more a question related to usability. This is essentially working from a patient record, right?

Sven Berg: That's correct.

Lee Partridge: So, in that sense, it is slightly more expensive measure to use than one that would be developed using electronic records or registries. I just want to be sure I was right.

Sven Berg: Yes, I can't disagree with that. This was developed as a non-eMeasure and this is not a measure that has yet and converted to any measure. That's correct.

Lee Partridge: And we have lots of those. I just wanted to confirm in my own mind that that's we were talking about here.

Sven Berg: That's correct.

Christopher Stille: Although – this is Chris, just a quick idea on that. I suspect that among eMeasures this would be one that might be easier to convert because it is a findable document. So, I'd make this a candidate for one of their earlier eMeasures that you were so inclined.

Sven Berg: Thank you. And we certainly can make that recommendation to CMS for their consideration.

Christopher Stille: Great, thanks. Other thoughts?

OK. So, again, you know, we'll have to go back as a committee and take a look at some of the new data but it sounds like there's a lot there to look at. And any objections to revoting or further clarifying questions?

Hearing none.

(Suzanne): OK.

Christopher Stille: OK. Thanks and we'll revote and move forward.

(Suzanne): So the next measure is 2631 and this is Percent of Long-Term Care Patients within Admission and Discharge Functional Status Assessment and a Care

Plan That Addresses Function. Just as a reminder, this is the measure that we talked about in the post-meeting call as well, because the developer had provided additional information but it just – it seemed to have not – that have been reviewed prior to the in-person meeting.

So, this is also a measure that went through and after the vote post-meeting, went through as consensus not reached and consensus was not reached for performance gap. So when the reliability, validity and then the overall recommendation for endorsement which means it does through the public comment.

As with some of the measures, this is a measure where we requested additional information here, performance data, data on the care plan aspect of the measure, some considerations on the title of the measure and understanding again the link between the functional assessments and setting a care goal. I believe the vast majority of this information was provided but again, discussed after the call.

And then during public comment, there were some additional comments from the UDSMR and we also received a comment that says, we support the endorsement of this measure.

So, as we've done with the other measures, (Anne), are you on the phone?

(Anne Deitch): Yes.

(Suzanne): OK. Were you going to talk or?

(Anne Deitch): Sure. Yes.

(Suzanne): OK.

(Anne Deitch): So, thank you. So, yes. This is (Anne Deitch) from RTI. And – So we did send a memo addressing several measures so this particular measure 2631 is the initial part of the memo. And so, as follow up is – we just mentioned as follow up to the in-person meeting and follow up phone call. There were it seems some lingering questions about the relationship between the function

items and their goal that's recorded as part of the documentation that there's a care plan.

And so, we did in the memo a follow up, provide you kind of a mock-up of what it would look like. And so in table 1, we have a several examples including one where the patient had an eating score of four on their rating scale which would suggest the person needed supervision or touching assistant and then we put a goal in there that the person would become a level six which mean they would become more independent. They would actually reach the level of being independent at level six on our rating scale.

And so, that demonstrate several relationship between the activities that are being assessed and the goal and so there is a direct relationship.

Do you want me to be going Chris or should I offer the opportunity for questions?

Christopher Stille: Yes I think, we may have a lot of questions on this one so let's yes, let's have a little background for it.

(Anne Deitch): OK. So does anybody in the committee have any questions at this point about the additional information about the relationship between the functional activities and the goal?

Dawn Dowding: Hi, it's Dawn Dowding here. I just want to clarify that the, I mean, I guess I already struggled with this because I know it's really important measure but – and I can see the theoretical relationship between the admission score and the discharge goal. But just to clarify throughout the members on the committee, we still haven't put that into practice so we still don't know she's not be commit that data from the documentation that people have so we can see the relationship but we have yet don't know if it's practical to collect it.

(Suzanne): And so, perhaps Dr. Levitt or Dr. (McMullen) can speak to that in terms of the feasibility, I mean, the – I guess …

Alan Levitt: Well, we certainly have, this is Alan Levitt from CMS, I mean we certainly have, you know, qualitative information from the PAC-PRD and the

relationship is there and certainly from a clinical standpoint of the relationship between the assessments from the goal of care is certainly committedly warranted.

(Anne Deitch): Yes and this is (Anne) so this – I guess if you're asking about feasibility, this measure was finalized in the long-term care hospital quality reporting program last year. So it is set to be implemented April 1, 2016. So does that address of your concern?

Dawn Dowding: Yes it does, so basically from April the 1st next year, LTCH will be collecting this data.

(Anne Deitch): Correct.

Dawn Dowding: OK, thank you.

(Anne Deitch): OK, should I go on then Chris?

Christopher Stille: Were there more things on this measure that you're going to talk about?

(Anne Deitch): Yes, yes.

Christopher Stille: OK, go ahead, yes.

(Anne Deitch): OK. So the next area that we were asked to provide additional information was related to the importance. So we did have three clinical practice guidelines that we provided information about here as well as the links.

In terms of performance gaps, we also address that in terms of the 24, or I'm sorry the 28 long-term care hospitals that were part of the Post-Acute Care Payment Reform Demonstration that Dr. Levitt just mentioned. So on average, we had 92.42 percent of providers who did submit complete admission and discharge data.

In the narrative, I did also describe that the facilities that participated in this particular project were volunteer to basically agreed to collect complete data. So we do have a high percentage but we believe that, that that's in part

because we had again these volunteers, who had agreed to submit complete data.

In addition, the data were submitted electronically into our computer applications that made it very hard for anybody to leave any data blank. And so there was a special override that the clinician providers could actually use to allow missing data to be part of a record but it was very challenging for people and so we made it. As part of the demonstration we wanted complete data so we made it hard for people to submit records that weren't complete.

We also highlighted that during the site visit to the 28 long-term care hospitals that we saw that clinicians were collecting different types of functional assessment data across those settings and that part of what we're trying to do is to standardize the data collection which is consistent with the IMPACT Act that we've mentioned earlier and we are often trying to make sure that some fundamental functional assessment activities are assessed for all patients. And as I mentioned we saw across the 28 LTAC that there were a variety of different assessment of activities that were happening.

So I'll stop there if there's questions about that?

Lee Partridge: (Mitra) this is (Lee), have you got this up on the screen, I think?

(Mitra Ernie): Yes, the document is on the screen.

Lee Partridge: Yes, I was looking for the gap data. Right.

(Crosstalk)

Lee Partridge: Table two, right?

(Mitra Ernie): Yes.

Lee Partridge: The first one is the presented habit – isn't there one that actually gives us something of a clue as to how many actually had a care plan that fit? I think the next table down maybe?

(Anne Deitch): So, as part of the post-acute payment reform demonstration, we collected admission discharge data, we didn't collect data about the goal. So that is the – a piece that we are missing?

Lee Partridge: We don't really know then, we know that the percentage of data – what hospitals directly that looks like in the sense of collecting the data regularly both the admission and discharge but we don't have data on the extent to which the actual care plan was build on the admit and how it looked when they were discharged, is that right? And …

(Anne Deitch): We only have the qualitative information from our site but …

Lee Partridge: OK, I think that was one of the questions that we also we're talking about on the 28th of January and I have a note from my reading of your response so I didn't think we got it, but I just wanted to be sure that I was not missing something. Thank you.

Dawn Dowding: Sorry this is Dawn Dowding again, could you just qualify for me what the – so I'm with my reading of the data you've submitted is that virtually all of the long-term care hospitals that participate in the demonstration project had complete assessment and discharge data so there isn't actually much evidence of a performance gap, is that right or am I reading this wrong?

(Anne Deitch): So in the graphic, you need to look at the vertical access, that it – each of the – I think we had 23 of the 28 long-term care hospitals that did submit these data but as I mentioned, this were volunteers and the computer application, the software, basically that were seeing used made it really hard for people to allow missing data to be submitted.

So you're right, I mean their – most of the facilities did submit complete data and we actually have a table that we provide on page seven that shows when the data were missing that (inaudible) items were missing. And so, let's see, so this is table three on page seven so wash upper body, rolling left to right and fit to lying were some of the items that had a higher percentage of missing data at an individual item level. And walk 50 feet with few turns also with one of the areas where there was higher percentage of missing data and item level.

Katherine Bevans: This Katherine Bevans and – oh, I'm sorry did I – would you do want to say something, Dawnin response or?

Dawn Dowding: Oh, you go ahead, Katherine.

Katherine Bevans: Thanks. I was wondering where you mentioned that you have some qualitative information from the demonstration size as well given that the specifications are having admission just entered discharge data as well as a specified goal. What do we know at this stage about the feasibility and – or even, you know, the gap in performance when we consider that additional specification that is the goal? I mean, I know you weren't able to measure that but, you know, quantitatively, but do you have any qualitative information about how that may increase gap or decrease gap between sites?

(Anne Deitch): Yes. So, I mean, if we add an additional – so the quality measure is setup that we require admission and discharge function assessment data on all patients and then on admission, we're also are requesting at least one goal for one of the self-care or mobility activities.

So we've been able to present the data for the admission and discharge assessed data being reported that's adding an additional (inaudible) data …

(Anne Deitch): I got some background noise.

Christopher Stille: Things are breaking up, could people put their phone on mute if they're not talking please?

(Anne Deitch): Great. Thank you. So by adding an additional requirement of a goal, we would obviously expect that fewer facilities would be able to meet the requirement of having admission discharge assessment data as well as a goal for each patient established toward admission.

So, from the site business, from the 28th LTAC that we visited for the post-acute care payment reform demonstration, it was very variable how the information was documented in medical records and again, we did not see a

consistent set of assessment items that were being collected across all patients. So that's where we also feel that there's a gap.

(Becky Ramirez): This is …

(Anne Deitch): So we're …

(Becky Ramirez): I'm sorry. This is (Becky Ramirez). I just – I guess I'm not clear on the usability issue because it – in some previous conversations, it was mentioned that there's such a variation in the types of patients in the LTAC facilities. Can you explain or help me understand how this will be used to kind of – for performance when there is so much variability and use it by diagnosis so you would kind of parcel this out by outcome by diagnosis or – help me understand what the LTACs will gain in terms of using this for performance measure.

(Anne Deitch): Sure. So the goal of this measure is basically to ensure that basic daily activities are assessed for every patient admitted to a long-term care hospital so that that information can be used to think through the plan of care for the patient. We are hoping that clinicians will be setting a goal for patients. We hope, actually they'll be making lots of function goals for patients but we're only requiring at least one be documented on the assessment instrument, a long-term care data set.

The other requirements that we're asking for is a discharge functional assessment on fundamental daily activity. So these are things like bed mobility, walking, cognitive functions, bladder continence. And it's important also obviously at discharge because some patients are going home and we want to be sure that there's a safe transfer home that they're functionally able to take care of themselves or their family members can take care of them.

And then many patients may be being transferred to another site of care. So for example, if the person is going on an inpatient rehab facility or perhaps a skilled nursing facility, we want to be sure that the function assessment data are transferred over in a standardized way at some point in the future so that the information is usable by the next setting and they are able to basically keep working with that patient to improve their function as much as possible.

Is that OK, (Becky)?

(Becky Ramirez): Yes. I guess I'm just trying to put in context also because you referenced the IMPACT Act. So a patient going – it's really an assessment, it's not a facility-level performance measure.

(Anne Deitch): Oh, from the standpoint, we're not comparing the end results of care. We're not comparing change in function and in part, you know, there is a lot of changes that are going on with long-term care hospitals. They are, as you previously mentioned, there is a change in the payment that will be affected I believe it's later this year. And so, I think there will be a change in potentially in the text locations admitted in the future.

So we will certainly as part of this measure be able to better understand the changing population and whether goals of care change over time, we'll be able to (glean) that from the data.

(Anne Deitch): OK, thank you. So that's clarified.

Peter Thomas: Can I follow up on that kind of discussion please, this is Peter Thomas.

(Anne Deitch): Sure Peter, go ahead.

Peter Thomas: Anne tell me, it is maybe a little out of left field but you know, we keep hearing about things around bundling of post-acute care and, you know, trying to de-emphasize the setting in which post-acute care is provided. I'm just wondering the utility of this measure in a world where you've got a bundled payment system. Does it become irrelevant or does it follow that type of acuity, the patient with these types of conditions that are fairly high acuity.

(Anne Deitch): So I'll let CMS answer that, perhaps Dr. Levitt or Dr. (McMullen).

Alan Levitt: Yes. Well, this Alan Levitt. I mean, certainly no matter where the setting would be for the bundling of a patient at that setting, they would still always require an admission assessment and discharge assessment and a goal established. This is something that we would certainly universally want to see it for us all in settings.

Peter Thomas: OK. So the fact that it …

Alan Levitt: You know, what with the acuity of the patient.

Peter Thomas: OK. So the fact that it seems tied to LTACs at this point doesn't necessarily preclude it from being used in other ways down the road.

Alan Levitt: Correct, it could really apply to really any setting from hospitals to doctor's office. But certainly in this setting in LTACs and again either LTAC patients despite their acuity have, you know, therapy needs and goals and receive therapy while they're in the outset.

Peter Thomas: All right. Thank you.

Christopher Stille: This is Chris just one more thing looking at the summary of the in-person meeting. There was a little concern about the nomenclature about phase validity that documentation of a goal related to the assessment does not really equal to a care plan and there was an agreement by the measure developers to revise the measure title to address this but I don't see any change in the measure title.

(Anne Deitch): So, can CMS, Dr. Levitt, (McMullen) please address that?

Alan Levitt: Again, if anytime a goal is really being established on a patient who has any sort of deficits or needs, there is, you know, link to that goal of care plan that needs to be established in order for the patient to meet that discharge goal. I mean, just the name itself became an issue that's something we really could, you know, ultimately talk about. But I mean it was kind of established hand in hand that the goal and the care plan would, you know, need to be established then.

Christopher Stille: Right, but what you're looking for is a goal and what you're measuring is a goal.

(Anne Deitch): Yes.

Alan Levitt: Correct.

Christopher Stille: So, you know, I'm just pointing it out because there was an agreement that the measure title would be revised and it hasn't been, so maybe it's implicit that there is a plan that the measure is not measuring a plan, so.

Lee Partridge: Chris this is (Lee). Can I follow up on that a little bit and really going back to (Becky's) question?

Christopher Stille: Sure.

Lee Partridge: That usefulness and a gift maybe, it ultimately relates to importance of this measure. I'm trying – as I understand, I think the purpose behind this measure and (Anne) you have to help me out a little bit, as you have done the research necessary to develop it and also in the demonstration, you believe that there is probably going to be a significant gap down the road among long-term care hospitals, LTCH, when they start looking systematically at whether or not they do admission and discharge assessments, element one.

And then secondly whether or not they establish a care plan that ties into at least one of the goals identified non-admit one of the conditions identified on admission. And that's the – and so the purpose of the measure is essentially to act as an informational tool to the hospitals that they had a need to work on their processes. Am I being correct?

(Anne Deitch): Yes. We from our site visits found that different LTACs were collecting different types of data. And so, one of our goals as you've stated is to make sure that there is data that is collected in a standardized way for these fundamental daily activities for all patients and we do believe that that is not happening across all LTACs at this point in time for all patients.

Christopher Stille: OK. It sounds like the comments are starting to wind down. Anything further from folks?

OK. So for, there may need to be a little bit more discussion among the committee. I'm wondering but certainly sounds like a reason out with new data. It's likely an order. Any objections to a revote at this point?

Male: No objection.

Female: No objection.

Christopher Stille: Great. So thanks for a good discussion. We will revote and I need to drop off probably before the end of the next discussion in the next measure because I have to walk over to the clinic. So, (Lee) if you could take over that would be great.

Lee Partridge: I will be happy to take over and …

Christopher Stille: OK, I'll stay as long as I can.

Lee Partridge: OK. (Sarah) what's up next?

(Sarah): Sure. Next up, I believe still is (Anne). So the next measure that where consensus was not reached for reliability and validity is 2633 and this is In-Patient Rehab Facility Functional Outcome Measure, Change in Health Score or Self Care Score for Medical Rehab Patients. I do believe this goes back to the additional information requested goes back to one of the earlier comments that overall the committee was interested in seeing additional information were available at facility level or the measure level that would be eventually required for reporting.

And so, I think this falls under there and then, you know, again, this is another area where we receive a number of public comments and they were supported as well as there were some other questions about those. But, (Anne) I believe this – I don't know if this was the next measure in your document but if you had any additional comments on this measure.

(Anne Deitch): Sure. Thank you again for the opportunity. So this is the next one on the memo. We actually put together the self care and mobility change measure together so I'll just speak about them together and this actually is on page nine of our memo. So if you I guess look at table four, what we did was we calculated 95 percent confidence interval for each facility in our sample from the post-acute care payment reform demonstration and we present in the table the percent of facility that had facility performance worth financial average

and those that are better financial average for – so in the self care area we had 26.3 percent of facilities that had worth financial average performance and we had 18.4 percent who had facility performance that was better than national average.

So we are able to discriminate we believe with the data. We had some more results for the mobility change measure with 34.2 percent to worth than national average in 15.8 percent. Better the national average.

We also on the – let's say, looks like its on page 11. We present graphically the risk-adjusted change course for staff care for the individual (urge), and so you can see some of the 95 percent conference intervals to across the black line which was the national average and some do not, so that's just the facility and data presentation that I just summarized from table four.

The page – let's say page 12 we have the risk-adjusted change in mobility, similar information presented there. We also did this analysis for the discharge self care measure and the discharge mobility measure, so that's presented in table five. Again, you see similar results. We had 28.9 percent, a facility in (South Carrier) area, who had worse the national performance and 28.9 percent that had better the national performance.

On the mobility side, 31.6 percent had worse the national performance and 18.4 percent had better than national performance. We have the graphics also on page 15 for self-care, so you can see sometimes the line are above the national average, some of them below and some of them overlapped, adjusting they're not different than the national average.

We also did a split half the liability for each of the measures and did significant testing in intra-class correlation coefficient. So we basically randomly support the facility sample in two half when we had 100 or more patient records in the facility data. And so, you can see in table six we present the intra-class correlation coefficient and the range is 0.89 to 0.95 across the four measures for self-care mobility.

Any questions?

Lee Partridge: Silence. So you answered all our questions?

(Sarah): So and (Anne) this is (Sarah). Just to clarify, this, you know, the information you provided also covers – it looks like (this without) full series of 2632, 26 – these 33, 34 and 35 is the entry six, will that be correct?

(Anne Deitch): That's right (Sarah).

(Sarah): Yes. So that committee members as you go back and look at everything even though 2633 and 2635 were the ones that were consensus will not reach. This is a full information on all of those measures. And if you remember during the in-person meeting there were kind of peer and group and talked about together. So this is your opportunity to ask any additional questions.

OK. And so …

Female: Yes.

(Sarah): … just to confirm, again, there were public comments in both of these in 2633 and 2635 as well as 2631 which is the one we spend a little bit more time on with (Anne). And we – in your table, the Excel table that you received before the call you'll see not only the public comments, but then across from each public comment, CMS's response to these comments as well.

But if there are no additional questions, we'll continue moving through.

Female: I think we've warned (Anne) and her colleagues out.

Female: Great. Thank you. We do want to be sure we don't have problem with revoting.

Male: No, no problem.

Female: OK, then we will – this 2633 and 2635 will be revoted.

Female: Great.

(Sarah): So then the next measure IRF is 2653, and that's the Minnesota Community Measurement measure that we already talked about with (Jasmine), and already agreed that we will be revoting on that with 2643.

And then the last thing in this table would be the UDSMR measured, 2286, 2287, and 2321. And I do want to spend a little time here. These were measures that you voted to recommend. However, you ask for additional information. And then we also had received some comments and public comment about grouping these measures even though this is a example of comments that you would also talked about in person. And I know this is from UDSMR had responded already why, you know, they had not made a composite measure of this.

But in follow up to the meeting, you had requested information on disparity's data, intra-class coefficient at facility level means its statistics, and then I already mentioned the public comment. So, what did – we want to give UDSMR an opportunity to make some brief comments even though these measures technically would not be up revote. It's always the committee's discretion if you wanted to, but did want to give UDSMR and opportunity to talk since they did provided additional information.

Female: And do we have UDSMR on the line?

(Paula Neusack): Hi, this is (Paula Neusack) with UDSMR.

Female: OK, go ahead. (Paula) go ahead.

(Paula Neusack): OK. So, to speak to the – some of the comments that had requested us to perhaps merger, combine some of the measures into a composite score. I just wanted to remind everybody that there is – so, you know, there's the motor measure which is the combined health care along with the mobility. So that's already have been submitted and that is available for use that way. We like to have them separated so clinically, it may be appropriate to just look at some of those health cares and so it provides that opportunity for those that would like to use it that way.

In terms of the data that we had submitted, there was the request for us, you know, the disparity's related data. So we had provided a committee some tables with the data by geographic area as well as some of the socio-demographic variables. We also had provided data related to how the particular scoring patterns by facilities.

So, we don't really look at our data according to rater as clinically the way the measures are recorded. Some items might be done by nursing for example, and others maybe done by a therapist. So it's really rater is – and some of the earlier work it was moved at certainly to establish the reliability, inter-rater and intra-rater reliability, and we provided references to some of the earlier work as well. But we did give the scoring patterns with that way you can see the measures are stable across the different facilities in the nation.

Was there any questions related to the data that we provided?

Lee Partridge: Questions?

Since I'm hearing no voices, I don't know what anybody feels. We need to do any revoting on this that we already recommended. Anything that you think we should be saying, perhaps in the final report or information about …

(Paula Neusack): I mean, basically we could provide a statement that would give a very brief in general description if it would be of interest of potential users that the motor would be the composite measure. We can certainly provide some of that language.

(Sarah): You know, (Paula) I think we have that language that we will put in to the report. I think Lee was asking more for the committee if they have any additional comment. Because there were – you know, there were some open items, if there was anything else they wanted to see in the report but as staff we will go ahead and take your …

(Crosstalk)

(Sarah): … the comment response as well. This was discussed in the in-person meeting and make sure that we clarify that and it's highlighted in the final report.

OK. OK. So I think what we want to do now is go ahead and go back to the theme from public comment and see what we haven't discussed yet, so that we can start putting together those responses for the committee.

And so going back while – maybe (Mitra) brings it up on the screen. The first theme of public comment that we have pulled out was request for consideration, support for not recommended and consensus not reached measures. And this includes 2643 and 2653 which were the average change in functional status following knee replacement surgery which is 53 and average change in functional status following lumbar spine surgery, Minnesota community measurement. We discussed those measures already on the call. But the public comment we wanted to make sure it was brought to your attention that public comment was that can committees urge to reconsider and recommend these measures.

We have agreed to revote those measures. I just wondered if there were any additional comments the committee had, questions the committee had, anything else before we would go to revote on those measures.

(Crosstalk)

Lee Partridge: OK. So the other measure that falls in that bucket is 2633 and that was one that (Anne) just spoke about. That's the Inpatient Rehab Facility Functional Outcome Measure: Change in Self Score for Medical Rehab Patients. The comment here was while the measure may not be perfect; it is an important patient-centered outcome. The measure can be analyzed and improved as additional data is collected.

For this measure – those few measures right there like the draft staff response for the committee was just that we would talk about them on this call and we've done that and really don't have a lot. We could say about reconsideration until the vote is – until there's a revote. Right, correct.

(Sarah): So then the next area under this theme was the FOTO measures, and I think this really falls under the same area, but I wanted to bring to your attention that we did received a number of comments supporting the endorsement of the FOTO measures. And again, that, you know, and seem to be a theme of let's not make perfect the enemy of the good and, you know, that they're important on patient-centered care measures and, you know, FOTO did respond with a wealth of information to respond to the additional information requested. And again, this would be your opportunity to ask any additional questions you may have.

Rebecca Bradley: This is Becky Bradley again. I guess there's just a nagging though that kind of runs through my mind when we're talking about these measures that are good measures but not perfect measures in terms of sort of the burden of responsibility on the committee. That is – if we recognize that these are important measures to collect, to gain more knowledge about what's going on in the field across the (inaudible) or whatever the saying is. That's kind of one message.

But the other message is, it was statement earlier that purchasers are very interested in this measure. And by endorsing these measures, does it imply that these measures are ready for use in a pay for performance environment. And if I could just kind of get straight in my mind what the burden of responsibility on the committee is it would help me as I vote on these measures.

(Sarah): Right. So in fact, you know, the committee endorsement and NQF endorsement overall is not really related to pay for performance or accountability or quality improvement. And we talked about this and I can't remember back if it was like while you are still there or not, but Helen Burstin spoke to this a little bit during the in-person meeting, that when NQF is endorsing measures, we're endorsing them as they were submitted and as they meet the NQF criteria for importance and scientific acceptability, feasibility, and usability but not for specific use.

And so, in this case, you know, if CMS or FOTO or whomever goes on and picks up specific measures for use and pay for performance, those would be,

you know, different public comments, different rulemaking, other opportunities for review and that is not under the purview of this committee. This is really just to have that endorsement (feel).

Rebecca Bradley: Thank you, that helps a great deal.

(Sarah): And I don't know Lee – you know, I don't know if the CSAC has talked about this at all. If there's anything you wanted to add to that.

Lee Partridge: Well, actually, we have talked about this issue a lot. Because there is some concern I think probably get alone the same lines that Becky is raising these questions about whether or not we feel a measure is robust enough to be used say, in a really competitive pay for performance kind of environment.

And there has been some discussion over the years of whether NQF should actually be making endorsement recommendations that say, "This is a measure that's very appropriate for internal quality improvement purposes," but probably not robust enough, or not refined enough for there isn't to be used for pay for performance purposes.

We've never actually – the form is never actually adopted that policy. And it's frankly remains an open question. I think in the context of (Becky), in particular the context of the work that the committee is doing right now, much of our work is being conducted against the backdrop of the IMPACT Act of 2014, where the emphasis is really, really – and we have the NQF's role is specifically written into that statute. The emphasis is really on developing on developing measures that can be used by multiple providers in continuity of care. And some of them probably are going to be much more robust because there's much research behind them and development behind them than there is behind some of the others and I think we just have to live with that as we make our judgments. Let's all be perfect as someone of the commenters have said.

(Sarah), anything more?

(Sarah): No. So we – if there are no other questions on that, we'll go ahead and the next theme is – was the theme about the list of gaps. And, of course, for some reason, I've just left for document, but there it is.

So the additional gaps identified and then, you know, (Mitra) run through this full list. The staff response to any of these gaps, is typically – thank you for your comment. I appreciate you highlighting that concern and we will add that in the front. Other report, there's a list of gaps that have already been identified, either to phase 1 when we are talking about experience of care or anything that came up there. But in this case, in this report, there had also been some gaps in person family-centered care identified by the measure's application partnership and some work – previous work that NQF have done and we will add these to that list as well.

I did want to give the committee an opportunity to respond, react, you know, and say, "Yes, we think that's a great idea" or, you know, anything else you might have regarding additional gap there is identified.

Female: For some of you who are out there in the field everyday in particular, are there – is this gap list missing anything? No?

Female: OK. And, you know, and just as a recollection for some of you who are on phase one if you recall, you know, we've heard this gap about measures related to adolescence come up before, that came a lot during some of the CAHPS discussions that we had in the last phase. And so we'll continue to monitor that. But again, you know, some of these measures can periodically fall into other portfolios, but we will put this out in the final report so that folks that are interested in this measure development or are in the process developing measures we'll know that these are certainly areas that have been identified.

So the third theme was harmonization in creating composites. And so we just – we recently run UDSMR was presenting, talk about 2286, 2287 and 2321. And the fact that actually the 2287 the change in motor score is already the composite of 2286 and 2321. And then the other area was that 0167, 0174 and 0175, we have received the comment that there should be consideration of

(sweeter) composite measure. And CMS did respond that they're exploring composite functional measures for future development.

And then the last area, looking at composites or at least bringing all the measures together would be with all of the FOTO measures. And again, the opportunity to take this effort body parts and perhaps creates some kind of composite. So, did not know – you know, obviously when it's creating a composite, this is something that NQF could comment on, but we don't force the issue and we just let the developers to take that into consideration.

Is there anything else the committee would like to comment or note on any of the kind of series of measures where there might be opportunities for composites?

OK. So in this next area theme for concerns about unintended consequences and discrimination. I think we received for 0176, 0177, and 0688 we received one comment, 2612 and 2613 received two comments, and then 0167, 0174 and 0175 each received three comments. And, you know, I think we talked a little bit more about unintended consequences and discrimination during the in-person meeting. And the developers did provide some responses based on the comments.

And I just wondered if the committee had any questions or additional feedback regarding our proposed committee response for talking about unintended consequences and the potential for discrimination?

Lee Partridge: Brian and Peter in particular. Do you have any comments about this issue?

Peter Thomas: Well, yes. We talked about this fair amount during the meeting.

Brian Lindberg: We did.

Peter Thomas: And I certainly made my points at the meeting and I'm glad that it's reflected here and I'd love for some of these concepts to be included in the final report. But as I read this, you know, I think that the issue is critical. I am glad that it's on this list. I don't have a whole lot to modify or add. I just I'm glad that you're planning on putting in the final report because I think it's a really

important issue, the cherry-picking issue and the risk selection or adverse selection I should say is something that worries me about many of these quality measures and how they're actually applied.

Is that helpful at all or is that just …

Lee Partridge: No, that is helpful. And I think we've had a good discussion of this so far. I think CMS is very sensitive to this issue and indicated that they also share the concern.

(Sarah): Yes. And I think we should mention that I can't remember when – I think it was Brian sent out some additional information he had told upon the issue and specifically the Jimmo versus Sebelius case that we, you know, after we had sent the report out to you all for comments, Lee had indicated – she really wanted to see that area pumped up a little bit.

And we, you know, we – so we do have the additional information that Brian provided as well this public comment that we certainly can add to, not only the measure specific portions of the report, but then that front section maybe a couple more paragraph on the subject. So, that it is highlighted, you know, this is what you said Peter this is a critical issue.

Peter Thomas: Yes, I mean as I read through all the developer response on the comments on page six and the top of page seven, you've got the concept down, you've got from there.

So, I don't have a whole lot of additional – I just to underscore one last time. It just the notion of improvement of function is a great one and we shall be striving for that. But some people – the best they can do is to lessen the deterioration of their function or to maintain their function and if that's, if you just got a quality measure that's only measuring improvement, then you're really going to out providers in the position of not really wanting to serve those patients because they're not going to look good in terms their quality measure. And that really is concerning when you look at this, yes, that settlement, the GMO settlement and the whole notion of providing care to people who won't necessarily improve but still need that therapy.

Alan Levitt: Yes, this is Alan Levitt from CMS and, you know, we are interested in looking at stabilization measures in particular in that measure development and we've heard that especially from the home health community. So that is something that we are, you know, is the priority for us, not measure development.

Peter Thomas: Great. I know one of the reason I didn't speak up initially was because I really though that you captured it well. So, I don't have a whole lot more to add.

(Sarah): Well, we're glad to hear that as well. OK, so then the next scene moving on, would be scene five and that's age exclusion and I think, you know, overall this comments were – the measures that we were seeing focused an older population and specifically those patients who might be in rehab facilities or long-term period, et cetera which, you know, just I think for the most part are of the older population and certainly not that the intent was these are discriminatory measures, but more of this is what we received in and these are the population that were a focus for functional status.

So, really comes back to gap and, you know, it was NQF's intent to have this phase folks on functional statues. So, that it just happened, but if you look back and what we suggested some of the commenters do is look back on the phase one report and then, you know, in the future additional areas that will be looking at for person and family centered care since in phase one, we really did have a good spectrum, we child caps as well as some older adults in that as well as the full adult spectrum in phase one. And this just was the consequence of this measure site.

And then other measure care had to do with the – or they have common here had to do with the issue of the FOTO measures and suggesting the – not go down to 14 and under or 14 and older and that's already been taken off the table. So, does not need to be addressed. But then again, developers did respond specifically CMS explaining the reason for how their measures are specified and just wondered if the committee had anything additional on age that we needed to capture.

Lee Partridge: Any comments? Well, if not, I'm going to speak up because I'm very pleased that doc-fix Medicare doc-fix bill that became law last week. Happily includes some funding for some new measures in the pediatric world as well, because the bill also incorporates an extension for children health insurance program. And I hope that we can persuade – I know Dr. Levitt this isn't your department, it's the Medicaid side, but I hope we can persuade them to put a few of those dollars into functional status measures for adolescence because all of as who have teenage or grandchildren know about sports injuries.

So, (Sarah)?

(Sarah): Yes?

Lee Partridge: Are we done?

(Sarah): Scene six was about the IMPACT Act …

Lee Partridge: OK.

(Sarah): … and this was really, you know, our response here is just is going to be thank you for your comments. This is obviously something we talked about in the in-person meeting and, you know, kind of goes back to a number of the measures that we were discussing.

And unless there was anything additional the committee to wanted to talk about, you know, this were just really more of applauding the committee for recognizing the important of the IMPACT Act and certainly seeing the alignment these measures.

Peter Thomas: Or disalignment, sorry to be negative but, you know, I mean, the fact is you've got a very turbulent time for post-acute care and in fact that may lead to some very significant realignment on the post-acute care side and some of these measures maybe a bit of a mismatch with some of the new payment and delivery models and mechanism and so maybe a little too early to tell but we may want to signal that potential as well.

Lee Partridge: OK. Great. So, (Nadine) are you going to tell us our next steps and (Sarah) talk about May 1st.

(Sarah): Yes, I just wanted to go through the rest of this memo and see if we did, if we miss anything. But I think for the most part, you know, the measure specific comments typically are up to the developers to respond and, you know, just wanted, you know, for the committee members who had looked at the memo and looked at the in-person risk or the proposed committee responses if anything had jumped out, did anybody as phasing out that we needed to, you know, going to put in their report or summarize. But, I think for the most part all of these issues or things that we had talked about and, you know, just let us know if there are any gaps in how we've documented anything.

And if none, then I will go ahead and ask, I don't know if (Nadine) or (Mitra) or (Suzanne) was going to talk about next steps when will the committee see the survey timeline et cetera.

(Nadine): So, the survey will be sent out to you for the committee by close of business today for directly after this call. And you will have until Friday for the business to complete the survey. Please be advised to look at the additional information that you received from the developer before attempting to complete the survey. And I'm casting your vote after which on Monday, we will be sending the committee and the measure developer the results of the vote. And will further discuss on our May 1st call relating and complete the measure in which will be sending out additional information next week.

Female: OK.

(Sarah): OK. So, just a couple of notes there what I will suggest, you know, I think this call has probably generated some reminders and everybody has had back to the in-person meeting about some of the discussion we had and the additional information that was requested.

I do encourage the committee members as you're going through any of these measures for a revote where you would ask for additional information to go back and use your measure NQF here and algorithm and specifically the

reliability and validity ones to make sure that you're following the steps appropriately on how you would classify or vote on the measure.

You know, we fully recognize that the committee wanted additional information and testing done at the measure level or the facility level, our clinician level, whichever way that the measure would be aggregated. But would want to, you know, remind that when you go to the algorithm there is the "yes, no" and if it was wasn't provided at the facility level when you get a "no" then there is a next step down and that is – was it provided at the data element level and looking at the result of those criteria as well.

So, we really do hope that all the information that the developer have provided, proceed in-person meeting have clarify a lot of this questions for you. And you are always welcome to send an e-mail to staff or even to the full committee if you need to generate a little discussion about that you're looking at.

As (Nadine) indicated, we will be sending out the links to the survey after the call and you have until Friday to respond. We'll send out a general reminder as we get closer to Friday and then those of you who still haven't responded you'll – I'll start increasing the frequencies of the reminders that you get. They will be more specific so we don't want to do any public shaming here.

And then the other thing that as (Nadine) indicated on our next call on May 1st, as you might recollect, we don't talk about related and competing issues until we see which measures are recommended. We only have to talk about those issues that the measures the recommended. So we really needed to make it through this call and make it through the next result which is why it is so imperative that we receive your votes by Friday so that we really can put together the materials to talk about related in competing because you will then have to vote on those again as well on the need for harmonization discussion for our harmonization are related and competing.

And so the developers who are on the call, for the most part, I believe you've already provided your information on why the measures may or may not be harmonized et cetera. So we hopefully won't have to do a whole lot of

additional follow up with you on that. But we can't do any of that until we have the votes on which measures are recommended to look forward.

Lee Partridge: And that (Mitra), (Nadine) and (Suzanne), since we do not have some of our committee members on the phone this afternoon, they haven't had a chance to participate in the discussion, I wonder if I could make a suggestion. I found your March 26 memo to the committee that give us a table of the measures and then cross referenced to the documents that were submitted by the developers extremely helpful.

I mean, I just sat down and click through those links. And particularly for people who couldn't be with us this afternoon. They might find that very helpful once they're – they see that the measures are up for revote. Just remind them to look.

(Nadine): We will include that in our e-mail.

Lee Partridge: Yes.

Peter Thomas: Could someone give – I am afraid that I'm getting on a plane later on today and I won't be back until noon on Friday. And I'm wondering if someone could give me a sense for done correctly and done well. How long do you think it would take to fill out that survey?

Lee Partridge: Peter it takes about 10 minutes because you just – I assume it's just can be yes no. Oh, I'm sorry, it just it's we do not going to have – you're not going to ask for why we vote as we do, am I correct (Nadine)?

(Nadine): That's correct, we are just asking for yes no high, low, moderate.

Lee Partridge: Right.

(Nadine): Similar to what we did at the in-person meeting.

Peter Thomas: OK, I got you. So everything that we said today, we'd like to revote, no objection to revoting. We'll have in front of us and we'll then do the same thing but we'll just do it electronically.

(Nadine): Correct.

Lee Partridge: That's correct.

Peter Thomas: OK. Very good, thank you.

Lee Partridge: Doesn't take much time, only problem is when if you want to go back and reread the material and try to decide in order to make you the final decision.

Peter Thomas: OK. Very good, thank you.

Lee Partridge: Any other questions?

Peter Thomas: So what else do we need to prepare for the May 1 meeting?

(Sarah): So what will happen once we have all your votes back is you will get another memo that will summarize where all of the measures are and will identify for you who are – which you'll have to discuss for related and competing. And we have actually prepared a table that we'll just need to re-look at that summarize each of the measures side by side and why they might be related or competing. So it will basically be a memo and then the algorithm, the NQF algorithm for choosing related or competing.

Lee Partridge: And then when …

(Crosstalk)

Female: It's not as much information.

Lee Partridge: But when we determine that the measure is really are competing, we will then try to reach consensus around which of the measures we believe shouldn't be endorsed if we can.

(Sarah): Correct.

Peter Thomas: OK.

Lee Partridge: OK.

Peter Thomas: Great.

Lee Partridge: Well, (Sarah) if we've done all that you had on our agenda today.

(Sarah): We have so.

Lee Partridge: And I just want to – I want to thank everybody …

Female: We do need to do public comments.

Female: Oh, I'm sorry. We do need to do public comments.

Lee Partridge: Yes, but I know. So, open up for public comment.

Operator: You do have a public comment at this time, please star and then the number one.

Your first comment comes from the line of (James Calan).

Lee Partridge: Hello?

Operator: (James), your line is open.

Lee Partridge: Go ahead.

Operator: Please unmute your line.

Again, if you would like to ask a public comment, please press star one.

There are no further public comments at this time.

Lee Partridge: All right. In that case, I think we can formally adjourn. Am I correct, (Sarah)?

(Sarah): You are correct. We just wanted to thank everybody for putting these three hours aside. I'm glad we didn't have to use all three and again, watch your e-mail for the survey link and we would appreciate everybody voting by Friday.

Lee Partridge: Right. And have a good week everyone. Thank you.

(Sarah): Absolutely.

Male: Thank you.

Male: Thanks everyone.

Female: Thank you.

(Crosstalk)

Operator: This concludes our call, thank you. And you may now disconnect.

END