NATIONAL QUALITY FORUM

Moderator: Person and Family-Centered Care
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Welcome to the Measure Applications Partnership Person and Family-Centered Care Phase 2 Standing Committee Call.

Please note, today's call is being recorded. And all public lines will be muted during this broadcast.

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Please also note, as we screen share today, you can always enlarge your view by clicking the enlarge button up off the slide window.

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

Suzanne Theberge: OK, thank you. Good morning, everyone. This is Suzanne Theberge. I'm the senior project manager on the project. Thank you for joining us, especially for those of you who are dialing in quite early in your time zone.

So, the purpose of today's call is to assess related and competing measures and determine whether the measures that are related or competing should be harmonized or if one needs to be selected as best in class.

We are going to go over the results of the vote after last meeting's call. And do a quick summary of the algorithm and then dive into the discussion.

So, I would like to turn this over to Chris and Lee to see if they would like to provide any opening remarks before Mitra summarizes the votes.

Lee Partridge: Good morning, everyone. This is Lee Partridge, talking to you from sunny warm New York at long last. This is our last lap on these set of measures. And I know we've got a lot to cover, so I just want to say welcome and I'll turn it back over to Suzanne, and Mitra, and Sarah to take us through today's agenda.

Sarah Sampsel: Hi, this is Sarah. And before we do that, I just want to make one clarification that the introduction indicator, this was a Measure Application Partnership call. And that was an error, it is not. And we just wanted to clarify that this is a consensus development project, Person and Family-Centered Care and just have that on the record.

Suzanne Theberge: Thank you, Sarah.

Mitra, do you want to summarize the votes, and then we'll do the committee roll call?

Mitra Ghazinour: Sure. Good morning, everyone. This is Mitra Ghazinour. I'm a project manager supporting this project. And I would like to provide a quick summary of the results of the votes before we start diving into the related or competing measure discussion.

So first of all, I would like to thank the committee members on behalf of my team for putting time and effort in completing the survey in a short period of time, we really appreciated that.

So, there were 19 votes that were casted for two measures out of 14 measures, and the remaining 12 measures received 18 votes.

Based on the results of the survey, all 14 measures which the committee reviewed and discussed on the last call were recommended for endorsement.

So, I'll be quickly providing the percentage of agreements to support each measure for endorsement. And by percentage of agreement, I mean, the sum of high and moderate response option.

So, starting with measure – with the first measure, 0701, functional capacity in COPD patients before and after pulmonary rehabilitation. So, 100 percent of the votes supported the element of reliability for this measure and the overall suitability for endorsement.

The next measure, 2624, functional outcome assessment. Approximately 90 percent of the votes supported the reliability criterion for this measure and 84

percent supported validity. The overall support for suitability for endorsement was approximately 90 percent.

Next measure, 2631, percent of long-term care hospital patients with an admission and discharge functional assessment, 83 percent of the votes supported performance gap criterion, 89 percent for reliability and approximately 89 percent for validity. The overall support for suitability for endorsement was 83 percent.

Next measure, 2633, inpatient rehabilitation facility functional outcome measure, change in self-care score for medical rehabilitation patients. 83 percent of the votes are supported the element of reliability for this measure. And there was 89 percent support for validity. The overall support for suitability for endorsement was approximately 89 percent.

Next measure, 2635, inpatient rehabilitation facility functional outcome measure, discharge self-care score for medical rehabilitation patients. 89 percent of the votes supported reliability for this measure. And there was approximately 95 percent support for validity. The overall support for suitability for endorsement was 94 percent.

Next measure, 2653, average change in functional status following total knee replacement surgery. 83 percent of the votes supported reliability for this measure. And there was approximately 89 percent support for validity.

The overall support for suitability for endorsement was 83 percent.

Next, we have the group of FOTO measures, functional – measures, 0422, two measure 0428, functional status change for patients with knee, hip, foot and ankle, lumbar, shoulder, elbow, wrist and general orthopedic impairments.

And 94 percent of the votes supported performance gap criterion. Approximately 89 percent on votes supported reliability and 95 percent supported validity for this measure. 72 percent of votes supported feasibility criterion and approximately 67 percent voted for usability and use. The overall support for suitability for endorsement was 94 percent.

The last measure is 2643, average change in functional status following lumbar spine fusion surgery. 100 percent support for reliability and validity. Approximately 95 percent of votes supported feasibility and usability and use criteria for this measure. The overall support for suitability for endorsement was 100 percent.

At this point, I would like to stop and turn it back over to Lee.

Lee Partridge: OK, thank you, Mitra.

Excuse me. Sarah, I think we want to move now to roll call.

Sarah Sampsel: We do. I think we could pause quickly where we are on the agenda and see if anybody had any questions or comments based on those recommendations, and yes, I'm talking about the committee members.

Lee Partridge: OK. Any comments, thoughts?

Male: No comments.

Male: No comments.

Sarah Sampsel: OK, then I think we've given everybody some time to get in. So, Nadine, are you doing roll call?

(Off-mike)

Nadine Allen: Sure. Katherine Bevans? Samuel Bierner?

Samuel Bierner: Yes, I'm here.

Nadine Allen: Rebecca Bradley?

Rebecca Bradley: I'm here.

Nadine Allen: David Cella? Sharon Cross?

Sharon Cross: I'm here.

Nadine Allen: Dawn Dowding?

Dawn Dowding: I'm here.

Nadine Allen: Sherrie Kaplan?

Sherrie Kaplan: I'm here.

Nadine Allen: Carol Levine? Carol? Brian Lindberg?

Brian Lindberg: Here.

Nadine Allen: Sherri Loeb?

(Off-mike)

Nadine Allen: Lisa Morrise?

Lisa Morrise: I'm here.

Nadine Allen: Esther Neuwirth?

(Off-mike)

Nadine Allen: Lee Partridge.

Lee Partridge: I'm here.

Nadine Allen: (Inaudible), I'm sorry, Peter Thomas.

Peter Thomas: Present.

Nadine Allen: Carin van Zyl?

Carin van Zyl: I'm here.

(Off-mike)

Nadine Allen: Chris Stille? OK, thank you.

Sarah Sampsel: So if we – Carol Levine, we saw you online, are you on the phone and just on mute?

(Off-mike)

Sarah Sampsel: OK. Suzanne, that gives us 10 members.

Nadine Allen: I've counted 11, Sarah. So, we have 11 members on the line.

Sarah Sampsel: OK.

Suzanne Theberge: OK, so we haven't quite achieved quorum. Quorum is 14 for this committee, but we have, I think, achieved more than half the committee so I think we can get started on the discussion since we'll be voting after the call, that's OK.

But, I guess we should just go ahead and get started, given the limited amount of time we have remaining and hopefully, some other folks will join us, I know a few people did say they would be dialing in a bit late.

Lee Partridge: Yes, I think Chris will join us in about two minutes.

Sarah Sampsel: OK, great. So, first of all, our apologies for the numerous e-mails and kind of changes of plans over the past weeks, but we have really hoped we'd be able to do the related and competing votes online while we were speaking, but we're alerted to a couple of issues where we have committee members who will want to vote and we'll listen to the transcripts or we'll read the transcripts and listen to the recording, and thus we would miss their vote if we just did it online.

So, we'll be following up afterwards and provide more detail on voting after we have our discussion and public comment.

But, I think Nadine or Mitra, can you go ahead and move to the related and competing information so that we can start that as soon as I'm done?

And, so basically, from this point on, our discussion will be on related and competing measures. And as you may recall, we have conversations about

related and competing after the measures have had their final vote in the situation of this committee or the phase of the work, we had a number of measures that had not been – voting has not been completed prior to this past week, which is why this discussion and these votes will be riding behind – have been riding behind a little bit.

Staff did, as of – back in January, identify potentially related and competing measures. And we've resurrected a lot of that work because of the short turnaround time year by using the votes from prior to this year that Mitra just went through. And we also used the original preliminary statement from the measure developers for any of those measures that were identified as related and competing.

So, what we're going to do is, first of all, walk through the decision logic to identify related and competing to give you the background on how we chose, but this will also help you when we go to voting on each of these. And then, I will walk through the sets of measures one by one regarding why staff identified as related or competing where they had each part of that algorithm.

And then, we will give the committee – actually, we'll then give the developer, each developer two to three minutes to discuss those specific measures and respond to if they're related or competing or why they think they're not, or, you know, kind of additional information that would help the committee, and then the committee will discuss the priorities of related and competing and determine if they agree with the staff assessment.

Only those measures that are identified as competing will go to the offline vote, but we'll talk about that more as we go through, and I'll remind you how that works.

The reason we changed this, you know, again, was to create quorum. And in order to have quorum, we felt that we needed to do these votes offline which is why we won't be doing them online. And then, this is also could be approach we took for Phase 1 so this is the consistent approach with how you did it late year in 2014.

So with that, if you can go back up to that algorithm.

OK. So, what – and this, again, should not be new to any of the committee members because we used this during the first phase of the work. But the first thing that NQF staff does is look at the entire suite of measures and, you know, in the very beginning, we always assume they're all going to be recommended, but again, they'll have the conversations until the actual votes are in.

But we categorized the measures and we asked ourselves the questions, does the measure adjust the same target population or the same measure focus or as another endorsed or a new measure.

So basically, what we're looking for here – and I'll just relate it to this project is, we were looking for things like, you know, if the self-care measure that would be – the self-care measures would be considered same focus, do they have the same target population. So, are we just, you know, is it self-care in a SNF, is it self-care in a long-term care, and are those two measures like that and therefore, would identify to us that they might be related or competing.

Once we've identified as the or, so either related or competing, we talk about, does the measure adjust both the same target population and the same focus. If that answer is yes, we go (inaudible) because those measures would be determined as competing. If they're considered related, which would be either the same target population or the same measure focus, those would be related measures.

You'll see in the right hand column on step number three for the related measure, we will just ask the committee to discuss if you agree that they're related. And, we would want to have your input to determine if the measure should be combined or stratified, or recommendations that components of the measure could be harmonized.

It's certainly possible, and I believe this happened in our last phase, that the measures can't be harmonized or they can't be put together, that there's strong justification by the developer as to why there are differences in those measures and that's OK, we're not forcing the situation, we just want to have the conversation so that as the measures moved through, the NQF for

endorsement process were able to explain why there's the need for two different measures.

And then, in step number four, if we've determined that the measures are competing, and in this case, they're maybe the same focused area but a different care setting or when you could categorize the measures as competing with the rationale of different care settings, and then, we would, again, want you to have the discussion about harmonization.

Step number five, take the measure down to what are the measures that are – they would both be same target area, same measure focus, you consider them competing and you think there may be opportunities to harmonize, or you want to make a determination that they're best in class.

The final determination of, do you agree that this is a competing measure and will these measures be harmonized, or if the measures can be harmonized or if you want to choose best in class, will be conducted in the vote offline.

But, just kind of wanted to walk you through that, we'll walk through it again and talk a little bit more about your choices on the voting as we go through each of the measures.

Now, if we could move down to the set of measures.

Sherrie Kaplan: This is Sherrie …

Lee Partridge: Sarah …

Sarah Sampsel: Sherrie, OK, go ahead.

Lee Partridge: Yes, go ahead.

Sherrie Kaplan: About data source. I didn't notice in the algorithm anything about two measures have the same target population and the same whatever, but they come from two different data sources. For example, symptoms reporting from the patient and symptom reporting from a claims database or something like that.

So data source is not one of those conditions on which you would then establish some conversation about competing or needing to be harmonized, et cetera.

Sarah Sampsel: So it's not the actual criteria, however, it could be part of the discussion in your recommendations of saying you – you know, this measure – so let's say – and I'm just pulling out of the hat, I don't want anybody to be defensive about this. But let's say we're talking about a, you know, a self-care measure that one data source is provider report and the other data source is patient report and therefore, the same – you have the same type of facility, so let's say, they're for home health. You know, then those measures would be competing and what you might want to do in the harmonization discussion is say that we really feel, you know, the measure that's best in class is the one that comes out of patient report, because we feel patients are the best source for this information.

The same degree you could say, you know, our – you know, we would recommend that the measure that is physician reports consider will lead to a self-patient report measure.

Sherrie Kaplan: Thanks.

Sarah Sampsel: Suzanne, did you have anything to add to that?

OK, good. Lee, go ahead.

Lee Partridge: I just want to …

Female: Sorry …

Lee Partridge: … see if there are no other questions.

Peter Thomas: I have a question.

Sarah Sampsel: OK.

Lee Partridge: Go ahead.

Peter Thomas: This is Peter Thomas. Some of these measures have a long-standing history are embedded in certain provider settings, data has been collected for years, people benchmark off that data, and other data sets that are being compared to that or measures that are being compared to that are much newer, they have relative strengths or weaknesses compared to that existing data set, but they're not nearly as in trench and such.

These are pretty important decisions we're making here. To what extent do we take into consideration the reality on the ground of how these measures are being used today and what that might mean for a particular field or setting of care?

Sarah Sampsel: You know, I think that's really important and you're right, that's a strong consideration and especially when we get to the competing measures, you know, and that would be something that we would have to reflect into the overall report and it could be something that you choose when you vote to say, "You know, we agree these measures are competing but we choose not to choose the best in class and therefore, stop one measure from moving forward as endorsed."

And I think that would be, you know, and I don't think you'll get to that conversation based on how some of these measures are, you know, kind of aligned here.

You know, I think the other thing – and this is where, you know, Suzanne, I don't know if, you know, you can talk more about this than I can as there's this – there's a concept called the reserve status, where a measure is chosen as extremely important to continue their endorsement or continue the NQF endorsement and stay in the overall measure portfolio but is not really the best in class measure in the current realm.

Suzanne Theberge: Yes, I think reserve status also really focuses on measures that are topped out, you know, things that we think are important to continue reporting on, but there's not a lot of room for improvement in those areas.

It's rare that we actually get to that because I think, you know, there's …

Male: Right.

Suzanne Theberge: … it's rare.

Male: The stuff is now complete, please close your browser when …

Peter Thomas: Thank you.

Lee Partridge: Any further questions? OK.

Sarah Sampsel: OK. So, what we will do now is I will go ahead and introduce each set of measures that has been identified as potentially related or competing and the rationale for why the staff found them as such.

We will then give each developer, again, very brief amount of time, two to three minutes to respond, especially for those measures that were found competing, there are also written comments from each developer. And that follows each of the tables that summarize and compare the measures side by side.

It is possible for the committee during your discussion to say, "Hey, we don't agree that these are competing." And then that – and, you know, even on the phone, we could figure that out by listening to you. However, you know, if we don't get strong indication of that, we would go ahead and go through the full vote on those measures offline.

But we do want you to discuss, you know, are things different enough or the same enough that they are what they considered competing measures and then as, you know, I think Peter just brought up, you know, if there are some of these measures that are in trench in the community and you want to make those notes as well, you know, I would suggest the committee to do that so we have that documentation.

So the first two measures that we have identified as potentially competing, the measure focus is functional status change. And then the target population is knee. And so, 0422 is functional status change for patients with knee impairments that focus on – that's a FOTO measure focus on therapeutic

outcome. It a self-reported measure of change in functional status for patients 18 years plus, so 18 years and older with knee impairments.

I should note on this, if you recall at the in-person meeting, FOTO had originally suggested dropping their age range to 14. And they've changed that so some of the documentation that they provided talks about the 14 and older, where that decision is now off the table, it is 18 and older and that's how you should be considering it.

This is a patient-reported outcome that would be reported at multiple levels, facility, clinician, and then it could be a clinician group or clinician individual. And then, mainly, ambulatory care.

The other measure would be 2653, which is the average change in functional status following total knee replacement surgery. This is a Minnesota Community Measurement measure. Again, the population is 18 years and older. This is – goes a little bit beyond the impairments to knee surgery and knee replacement surgery but it is looking at that functional status change. This is also a function – a patient-reported outcome and would be reported at the clinician and group and practice.

So, as staff, we saw enough similarity too that we want to do to discuss competing. Again, you have the option of saying, you know, these are really enough difference that it makes sense to keep two separate measures, and you would want to consider them as related and we could reclassify as related. But before we do that, I don't know if (Ben) or who's on the phone from FOTO.

Is someone on the phone from FOTO?

Linda Resnik: Yes, this is Linda Resnik representing FOTO.

Sarah Sampsel: Hey, Linda, if you want to go ahead and make some brief comments.

Linda Resnik: OK. First, I wanted to say that the FOTO measure really has a different focus and content even though you're saying they're both functional status measures. The FOTO measure assess the functional status only, whereas measure 2653

is based on the Oxford Knee Scale, which actually is 12 items, four of which assess pain (and eight are) about function. So the content of the measures are just similar.

And the FOTO measures are applicable to a much broader patient pool which is the patients of all types of impairments of the knee, whereas, measure 2653 is only applicable to patients who've had knee replacement. So, I think it's – the FOTO measure is much broader and they are related and that there's overlap of appropriate patients in the case of those patients that knee replacements to whom either measure would be appropriate.

And, in terms of our care settings, it looks like 2653 was intended for ambulatory care only, whereas, 422 is specified for a broader array of care settings.

Sarah Sampsel: Great, thanks …

Linda Resnik: The one other thing I would say is the FOTO measure is a patient-reported outcome performance measure, and the time window for measure in a provider performance is 12 months. And – but the PROM itself can be used to measure change and functional status for the patient level from intake to discharge from an orthopedic care.

Sarah Sampsel: Great. Thank you, Linda.

And then, could we have Minnesota Community Measurement?

(Collette): Sure. Hi, this is (Collette) from Minnesota Community Measurement. I just have a small correction on the response that was created right after the table. Our measure 2653 is also a PROM-PM, a performance-based measure. So, that isn't the major difference between the two of these.

I appreciate all the comments from Linda and FOTO. We agree. I – we believe that the target population of these two measures is very different, the FOTO measure is broad and is concerning with any kind of knee impairment. Our measure is really focused on patients undergoing knee replacement,

looking at their preoperative functional status compared to their postoperative functional status at one year.

Measure calculations are different and the provider types and clinical settings in which these measures are applied are also different as well.

Sarah Sampsel: Great.

(Collette): So we would agree they're related, but not necessarily competing. Thank you.

Sarah Sampsel: Thank you both. And Lee, I'll turn it back over to you for committee discussion and any additional questions the committee may have.

Lee Partridge: OK, thank you, Sarah.

I'll open it up to my colleagues for discussion and questions.

Samuel Bierner: Yes, I have a comment.

Lee Partridge: Go ahead.

Samuel Bierner: This is Sam Bierner. And I also see these as different measures with different target audiences.

Sarah Sampsel: OK.

Lee Partridge: OK. I have a clarifying question for Linda. Am I correct that your measure doesn't necessarily address just clinician – just physicians?

Linda Resnik: No, our measure is used with the change and functional status after an episode of rehabilitation care. So, it's used to assess typically therapist, physical therapist or occupational therapist, so it's not targeted to physicians.

And one other comment I just wanted to make in terms of a correction or response to the comments is that, all those measures, both the patient inquiry software for the (CAT) version of the measures that a lot of the short-terms are publicly available on the FOTO (web share) site as well as all of the information to all the risk adjustment modeling.

Sherrie Kaplan: This is Sherrie Kaplan. Can I ask a quick question about risk adjustment?

Lee Partridge: Sure.

Sherrie Kaplan: Are the risk adjustment models parallel, or they're very different? And I don't have enough data in front of me, I'm sorry, to look deeply into that question.

Linda Resnik: In terms of the variables that we have (inaudible) each of the models in all model as compared to the Oxford Knee model?

Sherrie Kaplan: Yes.

Linda Resnik: I can tell you what in the FOTO risk adjustment model, I don't know about the Oxford model or the Minnesota model. But the FOTO model has age, gender, acuity, baseline, functional status of intake, number of comorbidity (inaudible) category, and so on things like that. I'm not sure within the other model.

(Collette): This is (Collette). I can answer for our measure. Again, very different data source for the – for where the information is coming from.

Our risk adjustment for patients undergoing for knee replacement includes variables such as age and gender, insurance product type as a proxy for socioeconomic status, smoking status, the presence of diabetes, and BMI.

Thank you.

Female: All right.

Peter Thomas: This is Peter Thomas. Can I ask a question please?

Female: Go ahead, Peter.

Peter Thomas: So, because this is the first one that we're really looking at and I'm new to this whole thing, I guess I'm wondering if I could ask a question that is much more representative of what we're actually doing here and the implications of it rather than these two particular measures.

So, anyone – because the 2653 really is only relevant following knee replacement surgery, anyone with knee impairment that does not undergo a total knee replacement, you know, that measure would really not be relevant to them. So, let's just say that we said, well – first off, I do think that they're related, I don't think that they're in conflict or duplicative, but let me just say, you know, we chose to adapt the FOTO measure and that because it was broader and applicable to more people.

What would that actually mean – and we said that there was a conflict here, what would that actually mean for 2653? What's the implication of that decision?

Sarah Sampsel: Right, so in the event that we've decided that the measure was – the measures were competing, you would then be asked if you want to designate one measure as superior over the other. And so, in your scenario where you say that – you know, where you said that, so let's say, we chose 0422 as the superior measure, it means the Minnesota Community measure would not be endorsed.

However, you can also – you can say, "Yes, they're – you know, in this case, you know, kind of bad scenario or bad example, but if they're just related, they're just related. Both measures can be endorsed.

You could also say, you know, let's say, you know, further down in the path as we have two measures that really appear to be competing, you know, very similar target population, same focus area, really measuring the same concept and the same population, you would then have a choice of, do you want to vote one measure as superior over another. And if you do, you would choose which one is superior and the one not superior would not be – would not move forward.

You could also have two competing measures where the committee just can't come to, you know, you decided you don't want to choose superior measure, you'd like them – you'd like both developers to continue to monitor and look at harmonizing in the future. But both measures could be endorsed.

Peter Thomas: Very helpful. Thank you.

Lee Partridge: OK, further questions.

Sarah Sampsel: So what I – so, if I may here, what I've heard so far from committee members is when it comes to 0422 and 2653, you don't find them competing that, you know, it seems like overall, folks are finding them or would consider them related. And therefore, you know, I'd like that to take this off the vote as competing unless there are objections and there are, you know, if people who do not agree that these are not, you know, that these are related and not competed – competing, if you could voice your concerns now.

Lee Partridge: Any objections?

Peter Thomas: My only question is public comment, is the public get an opportunity to comment now, or at some later time, or later in the call, or when?

Lee Partridge: Later in the call.

Sarah Sampsel: Later in the call.

Peter Thomas: Got it, thanks.

Christopher Stille: Hi, this is Chris Stille. I just joined and I agree with what I've heard in the last minute and a half, I think they're related but not competing.

Sarah Sampsel: OK, any – OK.

Peter Thomas: No objection.

Lee Partridge: No objections being heard, I think you – we will not say this one on the follow-up vote.

Sarah Sampsel: Correct.

Lee Partridge: OK.

Sarah Sampsel: OK. So then the next two measures, these were identified as potentially related, because the measure focuses were motor skills of – you know, so they were – there's a broader list, then they're compared side by side in the table.

The target populations, though, differ 2287 being inpatient rehab and then 0167 and 0175 being home care.

0167 is a CMS measure. It's the improvement and ambulation locomotion, and I apologize, we group a lot of these measures. So 0167 is improvement and ambulation locomotion, 0174 improvement in bathing, 0175, improvement in bed transferring. And these are home health measures. They're considered outcome measures, and it is – they're collected electronically through reporting in OASIS.

2287 is functional change, change in motor score. This is UDSMR. This was submitted as – this is submitted as an inpatient rehabilitation facility measure, also an outcome measure but collected using the FIM.

What I – you know, when we get to the committee discussion, I think the consideration here are, you know, I think was brought up before, one of these measures is in trench, has been used for a long time, others are more new and more on the horizon. But we'd like to hear conversation about potential to harmonize or for a further alignment if there are significant differences in the measures.

But before we do that, we'll start with CMS and I believe this is (Anne) who's going to comment.

Female: No, this is actually home health.

Sarah Sampsel: Oh, I'm sorry.

So who – is somebody from CMS or RTI, or actually – or the Pennsylvania – or Quality Insights on the phone to discuss?

OK, so why don't we – UDSMR to go first, then if you have some comments about the related concepts of the measures.

Male: Is UDS on?

Male: Hello?

Male: And we didn't get any written responses from them on this measures – on these measures, right?

Sarah Sampsel: Correct.

Male: We're …

Lee Partridge: All right, if we don't have developer presentation, do we move onto discussion?

Male: I mean, is this a technical problem do you think or do you think they're just not on the phone?

Rebecca Bradley: This is Becky in our committee member. I had a little bit of trouble getting in myself on the call and there was a long wait so it may be a technical problem.

Suzanne Theberge: I see someone named Dale Strasser has a hand raised, I'm wondering if that is someone from one of our developers.

Male: No, that's just a listener.

Suzanne Theberge: OK.

Male: I do notice – I do see some UDS people on the attendees.

Operator: If you're currently in the call and you do not have an open line, please press star zero and the operator will open your line.

(Off-mike)

Sarah Sampsel: Then, you know, Mitra, Nadine and Suzanne, do we know who from CMS presented these at the in-person meeting that we know their names to vote for them?

Female: It does say here that we have a (Sharlene Dan) from CMS.

(Off-mike)

Suzanne Theberge: I think someone needs to mute their line.

Female: Oh …

Male: And I'm wondering if maybe we should skip this one and come back to a little later …

Female: OK.

Male: … and maybe some people could e-mail some folks in these places to see if they can get on the line because we don't have anything written up that kind of lays out their physicians, if you will.

Female: Suzanne, we do have some UDS attendees on the line and their lines are open.

Paulette Niewczyk: Hello, this is Paulette Niewczyk with UDSMR. I was trying to speak but I think I was placed on – my line was placed on mute.

Sarah Sampsel: Yes. Paulette, can you hold on a quick second. Committee members – anybody actually on the phone, will you please make sure that your phone is on mute, we have a lot of background noise right now.

(Off-mike)

Paulette, go ahead.

Female: (Inaudible) that line privately.

Female: Yes, we are locating it now.

Paulette Niewczyk: Hello?

Sarah Sampsel: Yes, Paulette, go ahead.

Paulette Niewczyk: OK, sorry about that. I was speaking and then I heard all the commotion.

So, this is Paulette Niewczyk with UDSMR and I do want to respond to the change in motor score measure. When we originally submitted our measures for consideration, in the interest of harmonization according to the IMPACT Act, we intended for use in IRF and skilled nursing long-term care and home

health. Since that time, it appears that we're only considered for IRF only, so because of this, I don't feel that it is a competing measure as the target populations are very different.

(Nicole Kane): Hello, this is (Nicole Kane) from Abt Associates representing home health.

Sarah Sampsel: Thanks, go ahead.

(Nicole Kane): I'm sorry, I couldn't get on as well.

Piggybacking on what they had just said as well, this population is intended for certified home health patients 18 and above, and we do feel that it's a different population than the other measure that is being represented here.

Sarah Sampsel: OK. Then Lee and Chris, if you want to turn over to the committee for any questions they might have.

And I just want to clarify, you know, we have identified these as potentially related versus – we have not considered these as competing.

Male: So, they're principally related in terms of the almost that kind of the subject matter of what they're measuring, but they are quite different in terms of the setting. To what extent does the fact that they're administered in different settings mean that they're either non-related or related?

Sarah Sampsel: So, I mean, where are we drawing your attention there is really on the numerator and then, you know, and thinking about the fact that, you know, they are measuring, as you indicated, similar concepts of things as ambulation and locomotion, bathing, transferring, and then, you know, and they can just be related. And, you know, that could be the end of the conversation.

I think where the committee might want to discuss a little bit more is, you know, as measures advance in the future, you know, is there a better way to, you know, is one of these ways, and I'm not suggesting talking about competing here, but really talking about what are those concepts that you'd want to see in those type of measure, and are they sufficiently different that the way that they are being measured to the FIM or through OASIS, you

know, in the event, you know, that the measures could apply to other care settings, you know, in the future, would we be in a situation where the measures come back and they are competing, because they would be looking at the same concepts in those the same focus areas.

And I'm not sure that made sense other than the fact to say that we understand that there are different target populations, however, the focus areas in what is being measured is very similar. And so, you know, if you need to tease out anything more about how related they are and any comments you would want to make in the final report.

Lee Partridge: I have a question that – excuse me, go ahead. I'll save mine.

Samuel Bierner: I have a comment.

Lee Partridge: Sam, go ahead.

Samuel Bierner: And my comment is that, these are somewhat different in what you're actually measuring. As I recall from the in-person meeting, what you're measuring here is just change and improvements in the numerator, number of health care episodes where the value is less impaired. And that's not quite the same thing as what the FIM score is measuring or not – doesn't have the same level of accuracy or potential accuracy, you have to know what a clinically significant change is in the FIM score.

So, I don't even think they're – I don't think they are competing, I see them as related measures at this point in time.

Sarah Sampsel: OK.

Lee Partridge: Sam actually asked my question.

Sarah Sampsel: OK.

Lee Partridge: Or my comment.

Samuel Bierner: Yes.

Lee Partridge: Except, I think I would ask one further question on the home health measure. We talked a little bit in our earlier discussions about the potential for a patient being denied access to care because he or she is not likely to improve significantly.

Could you remind me again, are there exclusions or other ways that the home health measures address that issue?

(Nicole Kane): The only exclusions for the measure are patients under 18, OASIS wasn't completed for those patients, maternal child health.

Other than that, those – go ahead.

Lee Partridge: So from a patient's perspective, if you look at the score, this home health agency has a great track record, everybody they care for improves.

The other home health agency who may have a number of people for whom the prognosis is not to improve but just not to get worse, will come out with a worse score?

(Nicole Kane): I hear the committee's consideration around stabilization measures. But we do report out, I believe, I'm not the actual metrics analytics person, I'm the clinician, but we do, I believe, report out on stabilization for one of the measures. But I'm mindful of what you are saying.

Lee Partridge: Thank you.

Sherrie Kaplan: This is Sherrie Kaplan. I have a quick question, Lee.

Lee Partridge: Yes.

Sherrie Kaplan: It's probably not unique to this situation, but supposing both things travel in parallel and CMS decided that – or these measures, we're going to be using some kind of incentive program to improve quality of care. I know we're not supposed to consider use, you know, blah, blah, blah, that's the MAP's committee. So …

Lee Partridge: No, no, we consider use.

Sherrie Kaplan: So, what happens if both – would there be a situation which someone might be a double jeopardy for a penalty under the …

(Off-mike)

Lee Partridge: Hello?

Sherrie Kaplan: Hello.

Sarah Sampsel: Sherrie, I …

Female: We're accessing his line.

Sarah Sampsel: Sherrie, could you repeat the last part of your question?

Sherrie Kaplan: Sure. My concern was that if these are being used, for example, in an incentive program, the quality improvement incentive program for a penalty – you know, the flipside of penalty program, could a home health agency be a double jeopardy of both measures we're traveling to? Would there be a situation which have both are endorsed and both are in play or in use? An agency could be a double jeopardy if both are improved and go forward?

Sarah Sampsel: I think that's a question for CMS.

Lee Partridge: But I think it's an issue, perhaps, that we might mention at this point in the report, Sarah.

Sarah Sampsel: OK.

Lee Partridge: Because we have talked about – around that issue several different ways on context of a number of these measures.

Sarah Sampsel: Yes.

Lee Partridge: And Sherrie – and Mitra, you correct me here, the MAP's function is essentially to recommend measures to be used in the several Medicare program. We do consider and should consider usability in general regardless of what – which purchaser might want to use it. So it's not off the table for us.

Male: Right.

Sherrie Kaplan: Thanks.

Rebecca Bradley: This is Becky Bradley, I have a question.

In previous discussions, it was mentioned that one of the mandates or one of the primary concerns was to come up with measures under the IMPACT Act that would cost several settings. And so, it just seems that 0167 is unique to home health whereas, the UDS measure, 28 – 2287, does cost multiple settings. And I'm just curious as to why we would be continuing to present measures that are unique to one setting.

Lee Partridge: Sarah?

Sarah Sampsel: Yes, you know, and I think, Becky, that's a really good question. And I think we started talking about that a little bit in the meeting. And, you know, and I'm not sure at all times if, you know, we're at the point with the IMPACT Act that all the measures that have been developed that might be developed across settings.

But I do know there was discussion – I mean, multiple times that I think Tara McMullen from CMS made the comment, or another one of her colleagues should CMS made the comment that, you know, really that is what CMS is striving to do with have alignment on the focus area and then across settings.

And, I think which the UDSMR measure, you know, the way, and this was also talked about in the in-person meeting, is, you know, while we fully acknowledge and understand the way that the FIM is corrected, administered, et cetera is across settings, the measures that came before us was submitted for IRS only.

So, I mean, that's why there's that little differentiation, I just think it's going to take a little while to catch up to have all of the measures and alignment and truly, you know, be able to choose, you know, and ensure that all of the measures would have the same focus areas across settings.

Paulette Niewczyk: This is Paulette from UDSMR. I did want to just clarify for that, the submission application did indicate offsite and there was data analysis provided for data from the IRF facilities and from nursing facilities, and from long-term care facilities.

There was no home health data, however, we do feel that our measures had utility for a home health population as well.

Peter Thomas: But either way – this is Peter Thomas, either way, CMS is just simply isn't there yet in terms of, you know, having their – all their measure sets cut across all settings of care, I mean, that's …

Paulette Niewczyk: Oh, so it has to be a CMS measure, it can't be other measure to be considered? I thought in the IMPACT Act, there wasn't …

Lee Partridge: Hello …

Paulette Niewczyk: … a charge to consider all measures.

Lee Partridge: I'm getting – I'm – this is Lee. I'm looking at the clock.

Sarah Sampsel: Yes.

Lee Partridge: And …

Sarah Sampsel: And I …

Lee Partridge: … we have five more of pairs or triplets, in some cases, to go through, am I correct?

Sarah Sampsel: Correct. So I think you're right, Lee, I mean, I think the point has been made, in fact, Lee, hopefully I answered your question. Is, you know, I guess what I would ask if there are any other committee members that, you know, that oppose that these would move forward as related measures.

Ellen Blackwell: Hi, this is Ellen Blackwell at CMS. I'm sorry to interrupt, I was on a close line.

I just wanted to emphasize which – and I apologize because I'm in my car. I just wanted to emphasize what some of you have been discussing about, the IMPACT Act and the measures across settings, in fact, we just met with NQF yesterday to kick off on how many community-based services quality measurement, you know, efforts.

So, I do think that you're not being in exactly the right place now, but your discussion is right on point, that as we move forward, it is important to take the aspects of cross-setting measures into consideration.

Lee Partridge: Thank you.

Sarah Sampsel: Thank you.

And I heard nobody is opposing that these would be – these would move forward as related.

Male: No objection.

Sarah Sampsel: OK.

So let's move forward, and I – you know, we'll try to hurry this stuff a little bit. These next two measures again – or the next two sets have been identified as related. So, it's basically all of the FOTO measures that, as you know, have specific focus areas on different body parts and that 0422 to 0428, these are patient-reported measures and they are reported to the FOTO tools.

And then 2624, the CMS measure, the developer is Quality Insights of Pennsylvania, again, this is a more of a global functional outcome measure, 18 years and older and the photo should say 18 years and older, that wasn't (inaudible) to update. The differences, the 2624 measure is actually a process measure and not a PRO measure. And so, I, like, quickly, you know, Linda, if you have anything additional to add based on what you have said before of 0422, if you could go ahead and briefly comment.

Linda Resnik: I guess, as you pointed out, the 2624 is a process measure that's more generic and it doesn't specify a particular measurement instrument. And it measures

the percentage of patients that have both the functional outcome assessment with a standardized measure as well as a care plan that is based on the identified deficiencies.

And I could just want to point out that 2624 could use as a standardized measure, the FOTO (from) as one of the standardized measures, you know, as I mentioned there in the public domain. So I see that they could be harmonized in that way, but 2624 is a process measure and the FOTO measures are PROM-PM.

Sarah Sampsel: Thank you. And is there anybody on the line from Quality Insights of Pennsylvania who want to make a comment on 2624?

Sven Berg: Well, this is Sven Berg from Quality Insights of Pennsylvania. And, thank you for your recommendation for endorsement of our measure.

We agree with the folks from FOTO that there is a similar target population. And although our care setting is narrower than theirs, their care setting includes our care setting. However, it is a process measure, not a patient assessment or functional outcome. We're really looking at, you know, was an assessment done, and was the care plan developed.

And so, we don't see room for harmonization since they are two different types of measures.

Thank you for the opportunity to comment.

Sarah Sampsel: Great. And Lee and Chris, you know, I think the question to the committee is, you know, any additional considerations, any questions that you have regarding these two measures being related, you know, any recommendations you have for developers, et cetera.

Christopher Stille: Yes, this is Chris. I actually had my own question about, can measures be related if they're just basically different in terms of what kind of measure they are, like one is an outcome and one is a process measure. I mean, that to me just sort of on the surface as they're really not that related.

I mean, one could be nested in the other, for example, like if they could be harmonized and that – like someone just mentioned could be sort of nice. But I think the measures themselves are not necessarily related.

Sarah Sampsel: So, technically, where we see this, so the answer is yes, they could be – a lot of time where we see this as both measures, you know, even though one is a process and one is an outcome, or some other variation of that while they might be – they're typically submitted by this – when we see that they're typically submitted by the same steward and developer, and they're meant to be paired measures.

Christopher Stille: OK. OK. So they're related maybe in that way, but, yes.

Lee Partridge: Further comments?

Sven Berg: This is Dr. Berg from Quality Insights, but they weren't developed to be paired. And, you know, our use of functional assessments or potential functional assessments, it would be broader and not specified to just the federal assessments.

Christopher Stille: OK.

Lee Partridge: OK.

Sarah Sampsel: OK, then if are no objections, these will continue to be classified as, you know, potentially related. They are not paired measures. There are some similar characteristics, but they are different measures and there is – are no recommendations for harmonization or other considerations.

Male: OK.

Male: Comfortable with that.

Male: Yes.

Female: No objection.

Sarah Sampsel: OK. So, we will move to page 11 of the memo and the tables, and this next set of measures is actually three measures where we find the first measure.

All three measures are – the measure focuses self-care. The target population is inpatient rehab patient. 2635 is a CMS measure. It is a measure that's looking at the percentage of inpatient rehab facility patients who meet or exceed an expected discharge self-care score.

2633 is also a CMS measure. It is a – it estimates the risk-adjusted mean change in self-care score between admission and discharge for IRF Medicare patients.

And then, 2286 is the UDSMR measure functional change. Change in self-care score which is a change in (Rasch) derived values of self-care from admission and discharge among adult patients treated at an – and they may added additional information about timeframe for the measure.

Across the board, you know, we saw that these measures all had very similar measure focus and also target population of inpatient rehab and – but we did note that we really felt 2635 may be related to the other two measures, but it really is 2633 and 2286 that seem to be competing.

So, we can start with CMS or the developer for these measures with a comment.

Anne Deutsch: Sure. This is Anne Deutsch from RTI.

So, there are definitely some differences in terms of the measures specifications. Some of these issues were brought out during the in-person meeting. So, we have different items that are used across these two measures, so the measure that is the CMS measure uses the items that were tested as part of the Post-Acute Care Payment Reform Demonstration, the care items.

The measure that – our measure also uses raw scores rather than the (Rasch) measures. This is something that Dr. Cella talked about in terms of the – in the in-person meeting, he mentioned that the raw scores were probably a better approach. He was – expressed some concerns about the (Rasch)

measures and there's also some research to support that, looking at the relationship between the raw scores and minutes of assistance versus (Rasch) measures and minutes of assistance.

There are – in terms of risk adjustment, the CMS measure has 85 worth risk adjusters and so, we got a lot of public comment. We had expert panels review and we tested to ensure that we were as strong as possible in terms of risk adjustment for both these measure and the mobility measure.

The measures were developed with lots of inputs from technical experts and public comments, so we have three technical experts. We had individuals from different stakeholder perspective, including patients or former patient, patient advocates on our expert panel so we thought that was an important issue to bring up.

In terms of an issue that Peter mentioned and I think Lee mentioned about unintended consequences, we definitely thought about that as we were developing the measures.

So, for both self-care mobility measures, we agree that we did not want to include patients in these measures who may not be expected to make progress on those items that are currently included. And so, we do have exclusion criteria. For example, individuals with locked-in syndrome or tetraplegic complete would not be expected to gain function on this particular set of self-care items.

And so, those patients are excluded from the measure because we did not want to have any access problems for those patients.

In terms of the IMPACT Act, we've already talked about that a little bit. So, the items that are included in this measure are items that the committee has reviewed. Other measures for LTAC and SNF as well as the IRF settings and the MAP report in February 2015, specifically, ask that measure would be coordinate – there is a coordinated approach with standardized items across the different setting.

Also, I want to highlight that on Monday, CMS put out a proposed rule on the Federal Register that proposed these – actually, the four CMS self-care mobility items. And so, there is a version of the IRF-PAI that has been released that's proposed for October 2016 implementation. So, I want to be sure the committee was aware of that.

And just to address Peter's comments about, you know, the relative newness or not newness of measures, the CMS measures were developed more recently and take into account the most recent science of measurement, as well as risk adjustment and other aspects of quality measure.

So, I think it's important that measures that are new are considered for endorsement so that the latest science can be applied to measurement.

And on that issue, just want to highlight that the Institute of Medicine's definition of quality does end with the idea that quality should be measured consistent with current professional knowledge. So, even the definition of quality recognizes that things can change overtime and that quality needs to keep up with the science.

So, I think I'll stop there.

Sarah Sampsel: Thanks, Anne. Paulette.

Paulette Niewczyk: Yes.

Sarah Sampsel: Do you have any additional …

Paulette Niewczyk: I do. So, I want to back up with Anne that yes, I agree, we do have different items. But our tool does encompass all of the items there on the CMS self-care measures. And the additional items is (to) cognitive items, we believe. And we have over two decades worth of data that shows cognitive items do come into play in terms of predictability for discharge back home or back into a community setting.

Taking care of oneself is, you know, certainly, a motor or a physical component but also in cognitive element.

And just speak to the other point regarding continuous data versus ordinal data, it is well-established that continuous data specifically is more powerful than ordinal categories.

So, we have all of our measures have been converted into (Rasch) units to allow for some of the refinements between both facilities as well as the patients.

Additionally, by adding this – the cognitive items that also allows for better planning within a patient's care planning goal setting, we do use the (Rasch) derived value so we could provide the facilities and the clinicians with both observed as well as the expected value.

So, when trying to plan for a patient's potential discharge or setting goals upon admission, they're able to see what is a feasible realistic goal for that patient with taking into account their admission, functional scores, as well as the resource utilization, and so forth.

Our tool has demonstrated predicted validity for resource use, functional change, cost, readmission back to acute care, as well as program evaluation and quality improvement at the facility level.

We certainly do have a risk adjustment methodology that has been tested and sustained the test of time for over 15 years. And I did provide that within our measure submission to the committee.

Lee Partridge: Thanks …

Sarah Sampsel: So Lee and Chris.

Lee Partridge: Sarah, we need to go back to your first comment, the top of this group, which I believe you said is that 2635, perhaps, was related but not competing in the sense that it is – 2633 and 2286 are essentially measures of change. And 2635 is just the actual discharge score compared to the expected.

So I'm wondering, are we considering all three together, or should we consider whether or not 2635 is related or competing with either of the other two?

Sarah Sampsel: Yes. I mean, I think the first question would be, you know, does the group agree that 2635 is relate – you know, just related, and would hang up there as related. And then, continue the discussion on 2633 and 2286 being competing, and if the committee will want to vote on that. And we would take that vote offline.

Lee Partridge: OK. Reactions?

Samuel Bierner: I would agree that this is a different – that 2635 is different and should be considered as only related.

Brian Lindberg: This is Brian. I agree with that.

Male: As do I.

Lee Partridge: OK.

Christopher Stille: Yes. This is Chris. I agree with that. And …

Female: Agreed.

Christopher Stille: … just going a little further, I do feel like 2633 and 2286 are competing, based on what we were talking about.

Sarah Sampsel: OK. And then, so what we'll do with those is, you know, what I'd like the committee to do is, if there are any additional questions you all have for the developers to tease out or, you know, even just to talk among yourselves about the competing aspect. And then right after the call, we'll send out a survey where you'll all – the committee members will vote, you know, do you agree these are competing measures, and then do you want to chose a superior measure, and which one.

So what, you know, if the conversation here is, what additional …

Samuel Bierner: Can we ask a question?

Sarah Sampsel: Yes.

Lee Partridge: Sure.

Samuel Bierner: I wanted to ask the developer from CMS that the comment was made about the issue of cognitive score. What is the response to that that was made by UDS?

Anne Deutsch: Sure. This is Anne.

So, the items that are on the self-care measures do consider both motor and cognitive limitations.

So, for example, if somebody has difficulty with eating, because perhaps the person has had a brain injury, and they need to be reminded to slow down, or just need help to initiate, the score on the care item would be lower because of the cognitive limitation.

It's our position that self-care – the self-care items that we have selected do work well together to measure that one concept or construct. Certainly, research in the past has shown that the cognitive items on various functional assessment – functional assessment instruments should be measured separately because they're different constructs. So, that – we feel like there should be a separate cognition measure that goes through this process separately.

Sherrie Kaplan: This is Sherrie Kaplan. Is it legitimate to ask the question of each of the developers the magnitude of the measurement there associated with each, if we're going to have competing measures, what's the magnitude of measure minority to you that it's proposed to be used for associated with each of the measures that are being considered as competing?

Sarah Sampsel: So you can ask that.

Anne Deutsch: OK, this is Anne.

Let me – I'm not sure that I have an answer off the top of my head. We did submit the facility level analysis with the intra-class correlation for the previous call that was last Monday. So, that might be helpful, Sherrie.

I'm not sure that I have anything more that I could really comment on.

Paulette Niewczyk: This is Paulette with UDSMR. We do have – we've tested our measurement error with our measures, like I said, over 15 years worth of data. But certainly, we also provided the analysis by facilities. And you can see that they were right on. There was great consistency within raters by facility level. And we'd be happy to share additional data on the standard error of our measures.

Female: Thank you. Sorry, I missed Monday's call. I was running the Boston Marathon.

Male: OK.

Anne Deutsch: OK. So this is Anne. I'll just add, I mean, we did have high intra-class correlation and we also did (split-half), and certainly, our data looks strong in terms of the reliability of the measures at the provider level.

Peter Thomas: So this is Peter Thomas.

Anne, you mentioned the IRF proposed rule that just came out. My understanding is that CMS is requiring reporting of both sets of measures, FIM and care tool kinds of measures in its most recent rule.

A, is that correct? And B, I mean, is – to what extent is this really CMS's call as to what they do? I mean, if we decide to endorse one measure over another, what does that do for CMS? Does that mean that they must adapt that, or can they still choose to do whatever they wish?

Anne Deutsch: So (Stacey) from CMS, are you able to address that.

(Stacey): Yes, let me see if I can address. I think – this is (Stacey) from CMS. I think I heard two questions. One is, are we requiring the FIM measure, is that – I just want to clear – make sure I'm clear. Was that the first question?

Peter Thomas: Yes, the collection of data under both FIM and care tool.

(Stacey): OK. So, there is data that is already, you know, being submitted in the current IRF-PAI which includes the FIM for other purposes. And then for quality reporting purposes, we proposed a number of measures that use the function items that were – that came from the – excuse me – the care item set, the functional section, so not the care tool. I mean, not the care tool in its entirety. I just want to make sure we're clear on that for quality reporting purposes.

Peter Thomas: OK.

(Stacey): And the second question, I think, I heard you say is, would CMS just, you know, move forward with the measure whether it's endorsed or not. I want to be clear. Is that your second question?

Peter Thomas: Well, what I'm saying is, I can see that these measures have a lot of common elements and probably are competing. And I'm wondering if the decision is, by this committee, to go to endorse one over the other, does that mean that CMS must follow suit, or can CMS make whatever decision it wishes going forward in terms of adoption in the future of a particular measure set?

(Stacey): Right. So we have the discussion to finalize the use of a measure that's not endorsed. There's an exception both in the Affordable Care Act, Section 3004, as well as in the IMPACT Act. However, you know, I would defer to Anne, there is both information as far as – that in – on our posting, about the items and some of the nuance differences between what's currently in the IRF-PAI as opposed to the items. And it – sometimes, it does matter to dive into the details about the differences.

We want to be careful to make sure that we do convey that at the item level and in the scales and the coding requirements that there are differences.

Peter Thomas: Thanks.

Female: Yes.

Lee Partridge: I just have one quick question, I don't want to prolong it. But, do you – Anne or – do you envision that this measure could be used other than in the Medicare population? One of the differences between these two is that there's a broader applicability for the UDSMR.

Anne Deutsch: Yes. Yes, and …

Lee Partridge: (You expect it) for Medicare, but I assume it could be used – or could it be used, right, other than …

Anne Deutsch: Yes, yes. And (Stacey), do you want to address the Medicare issue population?

(Stacey): Sure, yes. So the – right now, in its current state, regulation has it such that the IRF-PAI is submitted to CMS for Medicare – for the Medicare population, certainly, that doesn't preclude providers collecting at the local level on any, you know, population they so choose.

But, regardless of the measure, the data submission right now through regulation is on the Medicare population. However, I think what I'm hearing is consider all populations and all payers, and that's very helpful information for us. Thank you.

Lee Partridge: I mean, couldn't – you wouldn't object if another payer use this measure? OK.

(Stacey): Not at all. It would – you know, it would exist in the public domain.

Peter Thomas: Well, this is …

Lee Partridge: Yes, I don't – go ahead, Peter.

Peter Thomas: Sorry. This is a primary example of what I was talking about earlier in the call with respect to kind of what's happening in the field and what's, you know, the implications of some of the decisions that we're making as a committee.

And I just – I'll be honest with you, I'm grappling with this one in a big way, because of the valid points that Anne made about the, you know, the science

and the newness, but, you know, based on a very robust, you know, packed PRD, you know, CMS has invested a lot in this care tool, it cuts across settings. And yet the kind of time honored, you know, FIM collection data instrument that's been used and is in use across the IRF setting, and people rely on and, you know, the significant change it would represent if we endorse, you know, one over the other.

And – so I just don't know really what to do in this instance. I don't even know if I have the proper tools to make the decision.

Paulette Niewczyk: This is Paulette with UDS. I just want to state that we would also be happy to provide our data in the reliability and validity of our Medicare population as well as our non-Medicare population.

I'm not sure if the other tool has been tested in that capacity.

Lee Partridge: Right.

Brian Lindberg: This is Brian Lindberg. To those comments, I'm making the assumption that both – having both tools out there will create a situation that isn't a true standardized comparison if some facilities are using one measure and other facilities are using another. Is that accurate?

Peter Thomas: Well, one is based on a seven-point scale. One is based on a six-point scale. I mean, there's various different elements that are being asked about. There's a lot of commonality, of course, but I would just offer those to issues alone in response.

Brian Lindberg: Yes, thank you.

Rebecca Bradley: And this is Becky Bradley. Just to clarify, it's my understanding that the proposal is that both scales would be used simultaneously, not one would be used over the other. And I think that's a point that would – needs to be considered because the scales are very similar, but not the same.

And so, for clinicians to be writing a patient on both scales at the same time, I think, could be confusing.

Peter Thomas: And duplicative and costly and, you know, inefficient, and all those things.

Brian Linberg: Yes, and you could be a health care provider working at a couple different facilities using a different scale one day, and another – the other scale the next.

Peter Thomas: So, I guess, I'm presuming that this discussion or the elements of this discussion will be reflected in the final report in some way?

Sarah Sampsel: Sorry, I was on mute this time, yes.

Peter Thomas: Thanks.

Sarah Sampsel: I mean, I think these are all really – you know, these are all very challenging questions and considerations. And, you know, we do need to reflect those in the report, and we'll do so. We're also thinking through, you know, what does this mean for both on competing and best in class. So, we're thinking about that at the same time that you guys are talking.

Lee Partridge: All right, we have three minutes left.

Sarah Sampsel: OK. So we might be able to hurry a little bit more through these. You know, I think the next set – this next set of measures starts on page 17. These are – this is 2613, which is measure based on the care tool and its improvement in self-care. Steward is American Health Care Association. This is a SNF-related measure, as well as 22 – again, 2286, which is functional change, change in self-care score collected through the FIM.

Staff found that this to be potentially related based on the differences in the measures and the differences currently in the setting as they're being evaluated.

And, I think what we should do here is just ask if, you know, anybody had any additional questions, or had any questions to the developers that would change this from related to any other way.

So hearing nothing, the interpretation of that is everybody's OK with these just being related, and you don't see any strong reason to discuss harmonization between the measures.

Male: Yes.

Peter Thomas: I'm comfortable with that.

Female: Yes, me too.

Female: OK.

Male: Yes.

Sarah Sampsel: OK. So then moving to slide number – or page number 20 of the document, this is, again, a similar issue. There are three, again, similar measures, all looking at mobility across different types of target populations between SNF inpatient rehab long-term care with ventilator support. They all are looking at mobility.

So the question to the committee would be, are there any additional questions you have of the developers, or are you in agreement that these are all related measures, they do not need to be considered as competing, and you have no recommendations for harmonization.

Samuel Bierner: Yes, the category of 2632, long-term care hospital, is a significantly different population than you get in the other care settings.

Sarah Sampsel: OK.

Christopher Stille: Yes. This is Chris. I agree with the – that jumped out at me.

Male: No objection in treating them as related or (alone).

Christopher Stille: Right.

Sarah Sampsel: OK. And then, see Lee, I can move things too very quickly.

The last set of measure is almost – is very similar to the discussion we just had on self-care. If you remember, there were a number of suites of measures, where one of the CMS measures was about the immediate patient who met or exceeded a discharge score, and that's 2636. The difference is, this is looking at mobility versus the last conversation was on self-care.

And so we have the one measure to the left that's way – that is talking of – that is considered related to the other two. And then the other two, I would assume, follows our last conversation regarding competing measures that 2321 is the UDSMR, change in mobility score. And then 2634 is the CMS using the care tool change in mobility score for medical rehab patients.

And so I think what we should do here is, as we did last time, look for agreement that 2636 is just related. And then the other two would be considered competing in any additional comments the committee or developers have.

Samuel Bierner: I would agree that 2636 is just related.

Female: Yes.

Male: Yes, pretty much everything that applied to the last conversation on – that we just had on this very similarly situated set of measures applies here.

Sarah Sampsel: OK. Well, I mean, were there any differences or, you know, anything else anybody wanted to bring up?

Samuel Bierner: The one thing I would want to comment on from the developers is that, the CMS measure has 15 mobility items, and the UDSMR uses a composite of four items.

Anne Deutsch: So, this is Anne. Do you want me to comment on that?

Sarah Sampsel: Sure, go ahead.

Anne Deutsch: Sure. OK.

So, yes, there are 15 mobility items on the CMS measure. And they reflect activities that are best done in terms of best practice facility.

So, as part of the Post-Acute Care Payment Reform Demonstration and part of our expert panel, we asked what are facilities doing in terms of best practices for assessing function ability.

And so, we did hear that car transfer was something important when people hopefully are going home after an inpatient rehab facility stay, walking on uneven surfaces. So those are both two items that are on the CMS measure.

Picking up an object was another area that was considered very important by the expert panels, because many patients are at risk for falling, given they may have new mobility limitations after an inpatient rehab facility stay.

And so, we really do feel that it's important to have those types of activities assessed at the time of discharge for patients in inpatient rehab facility.

And then, I guess, on the other end …

Samuel Bierner: So can I ask you …

Anne Deutsch: Go ahead.

Samuel Bierner: Anne, it would seem that your measure is more comprehensive and that it covers sort of the items that are not included in the UDSMR measure.

Anne Deutsch: That is correct. And at the lower end, we have some bed mobility items, like rolling left to right, which are targeted to patients who are, perhaps, at a lower level of function at that point in time.

Peter Thomas: So Anne, let me ask you. So, I'm looking at the page 24 where safety walking, 10 feet, 50 feet, 150 feet, walking 10 feet on uneven surfaces. Maybe this question is more directed toward UDSMR. But that, I would assume, is equivalent essentially to your third criterion which is locomotion, am I right, or …

Paulette Niewczyk: Yes, aside from the walking on uneven surfaces.

And what I would just like to state regarding that item and perhaps some of the others, is appropriateness upon the admission. So, when you're looking at an admission, you know, a change in score admission to discharge, safety may be a concern with some of the items.

And that – you know, just because the items can be assessed doesn't necessarily mean they would be assessed in the majority of the patient population. So, we would not include an item like that in terms of, you know, safety concerns within the facilities.

But, yes, those other refineries are encompassed in the locomotion item.

Peter Thomas: Same with steps, one step …

Paulette Niewczyk: Correct.

Peter Thomas: … four steps, 12 steps. There are some items here that don't look to be reflected in the four bullets. But, some of them at least are, I suppose as I'm going through this list.

Paulette Niewczyk: We also have found a lot of facilities do not have the – they're not able to have a car to be able to practice things like car transfers and so forth.

Anne Deutsch: Yes. So our feeling is …

(Off-mike)

Anne Deutsch: Yes, we want to promote best practices in getting in and out of the car as an important thing. If somebody's going home, patients can certainly be taken down to a parking lot, or whatever, and practice in a car.

Sherrie Kaplan: This is Sherrie Kaplan – oh, I'm sorry.

Samuel Bierner: I just want to say that there are two things that I see that are unique are the car transfers and walking on uneven surfaces.

Anne Deutsch: And pick up object, I think, is also somewhat unique.

Sherrie Kaplan: This is Sherrie. I was just going to add that some of these aren't – they almost – they're like a Guttman scale, because if you can walk 150 feet, you can walk 10 feet, for example. Or if you can climb 12 stairs, you can climb one stair.

So, some of them aren't actually unique items. They don't really represent 15 unique mobility items.

Samuel Bierner: Of course.

Peter Thomas: OK. So, what is the next step with respect to the voting? Let's assume that these two measures will be similarly viewed as competing. What happens from there? How does this document that we get and we vote, how is it going to handle the questions about competing, and best in class, and harmonization, and all those issues?

Sarah Sampsel: So, basically, the vote will be similar to what the vast majority of you did in Phase 1, where we – the measures and there's just the two sets now that are considered competing. You will be asked kind of a series of questions that goes through the algorithm.

You know, the first question is, do you consider the measures competing, yes or no. And then, the next question would be, do you feel there is a need, or is that your recommendation to choose a best in class measure, and if your answer is yes, which would you choose as best in class or superior to the other.

And staff, you know, just kind of taking into consideration, you know, there is not a black and white here. There's been a lot of discussion that, you know, there may be a need to run some of these measures parallel for a certain amount of time. Or there may be enough differences that the measures do need to be both recommended.

We're going to try – we're going to look at the survey when we get off the call, and just make sure that we're able to glean that out and give you those options to voice those opinions as well.

But, immediately after the call, staff are going to regroup. But you will receive an online survey that will – should be fairly simple right after this call. And we'd be looking for responses by Monday, I mean, actually by Monday morning, so Sunday night.

Rebecca Bradley: This is …

Male: OK.

Rebecca Bradley: … Bradley. Will we have – do we have any public callers that …

Sarah Sampsel: Yes. I mean, so we still have to do a public comment, and that's scheduled for actually right now. So, if we want to go ahead and do public and member comment right now, why don't we go to that? And then we'll talk about the next steps in more detail.

Operator: Thank you. At this time, if you have a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And you do have a comment from Brandi Damron.

Brandi Damron: Yes, my name is Brandi Damron. I'm calling from Norton Community Hospital in Norton, Virginia. And I just have a few comments to make or, I guess, questions.

In addition to the concerns raised in regards to changing for the IRF setting from the FIM to the care items for self-care mobility with all the expenses, time and resources to have that done, and the thousands and thousands of clinicians that would have to be retrained.

I guess the other thing to be raised with the amount of non-Medicare patients that are currently – that provide the non-Medicare patients insurance companies that are using the same tools to make decisions.

So currently, a lot of those plans are requiring us to submit the information in the FIM terms. And then we would have another tool to do for Medicare, which would make it extremely confusing.

Female: Thank you. Is that all …

(Crosstalk)

Operator: And your next comment comes from the line of James Gallant.

James Gallant: Hello.

Female: Go ahead.

James Gallant: OK, yes. My name is James Gallant from the Marquette County Suicide Prevention Coalition here in Marquette, Michigan. And I have two comments.

And, the first one, I'm not sure about your working definition of Person and Family-Centered Care.

So, one of the things I would like for consideration to be put on your list of future considerations list, you said you have a little list going there for – and for future measures to be looked into.

And one of them is, I was at the Home and Community-Based Services Committee meeting the other day, and they're talking about the definition of person and family-centeredness. And it talked about wants, needs and desires and goals, but it doesn't say legal rights.

So, two-thirds of (inaudible) nearly are children from single parent and no parent homes. So, we're trying to get a establish looking into the field to get people to consider how many of the people in their services have these legal rights and how are they handled in your care for – to, like, custody and parenting time to protect the interpersonal relationships between and the emotional stability of your patients. And to have that as a measure to say, does this person have specific legal rights, you know, other than your HIPAA and stuff like that, you have specific rights issued by a court like family court, personal protection orders and stuff like that.

But people aren't getting the enforcement, so they need to be referred back to the court to seek enforcement. And then everybody would kind of know they don't even know how many people have these legal rights in their care. So, if we started measuring that, we could get ahead of that.

And, the second thing is that seems to be a recurring subject here at this meeting and at the other meeting, the Home and Community-Based Service meetings, was on the procedure and the – how is it you're going to vote and how that's going to work. And I noticed in your report, your published report there, it says that the staff is still – is finalizing the voting procedure.

When, you know, people come to the meeting normally in America, like they have rules and procedure, there are like Robert's Rules of Order, you make a motion, I notice you have no motion pending today. And then you make a decision, well, there's unanimous consent and hearing no objections, that is making the decision by the chair. And then you don't – I didn't notice if you obtained the quorum today.

So now a draft is going to move forward without a quorum. There was no quorum here today and that you're deciding on behalf.

So, I'd ask you to consider a parliamentarian opinion on the rules or procedure because whoever – according to the general parliamentary rules in America, whoever appointed this committee, the rules of that board apply here. So it would appear that the board of directors of the National Quality Forum, their by-laws in their Articles of Incorporation apply at this meeting.

So the voting procedures and stuff like that are already set, but nobody seems to understand what they are, so if you could release to the public what are the rules or procedure and, you know, they shouldn't really be changed in the middle of the discussion. And now, we're going to change the voting procedures.

(Crosstalk)

Female: I think I – we're getting tangled up in semantics here. We really haven't changed our voting process of that as well, exactly.

James Gallant: Well, that's what I mean. They did the other day. And now, you got people that are going to be voting that weren't at this meeting. And …

Female: We …

James Gallant: … I'm just saying that …

Lee Partridge: I think we need to …

James Gallant: If I could just wrap up, I'll give a written comment but …

Lee Partridge: Thank you.

James Gallant: … you know, it's people need to understand what they're going to vote on and how it works before you get to the meeting and they're copying this at the state local levels. It's kind of like wing in it and, you know, plan as you go plan instead of a set procedure which people can understand and follow and – but I'll give a written comment and I'll just ask you to please consider that and that, you know, the court order (inaudible).

Thank you.

Lee Partridge: Thank you very much. We will.

Operator: And your next comment comes from …

(Crosstalk)

Female: If I could just respond to that comment, as a committee member, I feel that there has been continuity in the voting procedures. And that I'm sure others can share with you the process but there are measures in place to make sure that everybody has all of the information and the voting has (inaudible) from one step to the next.

So, I think that – I mean, that I feel comfortable with how the staff is going for.

Sarah Sampsel: Thank you. And I think (Nan), you are saying there's another comment?

Operator: Yes, we do have a comment from (Becksen Clowen).

(Becksen Clowen): Thank you very much. This is (Becksen Clowen). I'm a physician with the Specialty in Physical Medicine and Rehabilitation Service, Chief Medical Officer of (Inaudible) System of Rehabilitation Hospital.

And I really want to ask the committee members to step back a little bit because it's very exempting to try to get into the details of methodology on this, and I appreciate that all of you have great deal of expertise in that area.

I would never weigh in saying that one set of PhDs put together one methodology or significantly superior to another set of PhDs who put together another methodology. I've looked at it from the practical viewpoint.

In the field of physical medicine rehabilitation, where we take care these patients who have functional impairment, I have never actually heard someone say, "Wow, if only our quality measures were a little different on the area of measuring these functions of self-care mobility. Wow, if we only have a little different twist of data, we could be able to have better outcomes with our patients, we could do a better job. We could have one meaningful outcome." I've never heard that.

We're in the situation where we have a long-standing, well-respected measure in the field, functional independence measures that you've described to today. We have literally a decades worth of data, the research and the clinicians care and everything that's being (inaudible) in the field is based on that huge investment, intellectual effort of people to learn how to use the scale and use it accurately.

If we started fresh, if there had never been a scale, and these two scales will put up against each other, the functional measures, the care tool versus FIM, who knows, maybe it would a coin toss.

But I want the committee to consider very carefully to see existing rich benchmarks that we have, all of the research. It seems to me it would be the

ultimate irony if NQF body that was formed to promote quality measurement, would instead put the field in the situation where we're going to be tossing out decades of equality measurements, shifting over to a new tool, which invariably wipe out your benchmarks makes you start over.

In my view, it would actually put back quality measurement. By endorsing the two tools simultaneously, you're really promoting the idea of forcing clinicians to use two measures that are so close to each other, but they are – in my view, it's going to be very difficult to do simultaneously without being inaccurate. People will be looking for shortcuts, they'll be looking for ways to crosswalk, and there's not a mathematical crosswalk. It's not like converting Celsius to Fahrenheit.

(Each of) the six-point scale and the seven-point scale on very similar measures, there's not a way to do both of them accurately and simultaneously. Keep that all straight in clinicians' mind and come out with data that's accurate and reliable. I think the qualities of data will decline under both systems if we're required to use both systems.

So for those reasons, I would ask the committee to think very seriously about designating this kind of measures as being superior, and again, this is no intent to denigrate the tremendous work that's gone into creation of that functional element of the care tool. I have great respect for the clinicians.

But having served on one of those technical expert panels that Dr. (Deutsch) referred to and myself having been a member of this panel, I can tell you the starting get go position was that they would create a new tool. Not because of the new locked-in existing tool, the ability to measure out (inaudible) unless there's a quality improvement just because (itself), I think that that's where the legislation was leading them.

I think this committee can say, "No, that's not where the legislation required you to go." You can endorse the existing tool and keep our quality measurement tool intact.

So, thank you for taking public comment on this. I hope you will take this seriously from a larger perspective instead of trying to microanalyze whether

one specific measurement is (strikefully) superior on one tool than the other, but look at the purpose of quality measurement for the field of helping patient outcomes and better. Thank you very much.

Lee Partridge: Thank you, doctor.

Operator: And there are no further comments at this time.

Lee Partridge: All right.

(David Kiffin): Operator …

Lee Partridge: Sarah, back to you.

(David Kiffin): Hello?

Lee Partridge: Hello?

(David Kiffin): Yes, this is (David Kiffin), I've been hitting star one.

Sarah Sampsel: OK. If you have a very quick comment, we need to be wrapping up.

(David Kiffin): I just want to reiterate some of the earlier comments that are made by the members about cross-setting measures and the IMPACT Act.

I feel like this committee is making rush decisions and doing quick information on the phone without really thinking through the ramifications of the measures here and decisions are much greater than in the past, given the movement of IMPACT Act and the use of these measures and validates purchasing across settings.

And I think the questions that Sherrie was asking about, comparing things that there's going to be votes on measures of best in class and other measures, these – all anyone need to do is read the proposed rules for LTAC, IRF and SNF, that came out and realize that the votes of this committee are going to be – have a much greater impact on the day-to-day practice and the outcomes of residents than in the past.

And I would caution the committee to make sure they get adequately versed in those areas and understand the impacts rather than asking quick questions or getting quick answers from one or two people on the phone.

To the caller about Robert's Rules of Order, I don't think that's an appropriate way the vote should be done.

Female: OK.

Sarah Sampsel: Thank you. So with that, we appreciate all the public comments.

And I'm just going to – because we have pretty much zero time left, so, what will happen next is the committee will be provided a link to a survey to vote on the competing measures and we will also ensure that we leave some open text that you're able to make some additional comments should you want to on why you made your considerations so that we're able to reflect to all of that in the report.

We have established quorum on this call in addition for those members who are not on the call and those of you on the call who want to refresh your memory. The recording of this call will be available this afternoon. And then the full written transcripts will be available this evening and we will notify you when those are available as well.

As indicated previously, staff are going to meet immediately after this and make sure, you know, once again, that the questions, although they go through the algorithm, as the algorithm has been approved by NQF, we'll make sure that those are clear as well as have the ability to obtain any additional comments committee members have and also make ourselves available to those committee members who are not on the call today.

Currently, our timeline for voting on these measures is Sunday evening, so by Monday morning, and that is because we do have the full NQF member vote that has to start on May 12, meaning that we have to revise the report, get that through all of the editorial processes prior to being reposted.

Finally and very quickly, I do want to thank the committee as well as the developers, one, for being succinct in your conversations today. We have put you all to hard work. This is your second phase of working on Person and Family-Centered Care. And we do have another one coming up, more information to come on that and we'll keep you updated the best that we can.

I just also wanted to comment that we are in conversations with CMS regarding the potential of having almost the subgroup that talks about how we might be able to handle this Person and Family-Centered Care measures are more complicated a little bit differently in the future.

And so we'll talk to each of you about your interest in the subcommittee in helping NQF staff to think about the considerations of not only the functional status types of measures, experience of care measures, but then we have a number of patient activation and quality of life measure that need to be reviewed as well.

So with that, I'll ask Chris and Lee, any final comments, but I do want to thank the committee, the developers as well for being responsive to us and then, of course, the NQF staff because it really is a hard and a lot of work putting these calls together for you all.

Lee Partridge: Thank you, Sarah. I just want to say thank you also to our developer partners who have been patient making themselves available to us for numerous conference calls and follow-up memos.

To our fellow – my fellow members and particularly to Sarah, Mitra, Suzanne and Nadine for their tremendous support in helping us go through mountain of material and trying to understand a lot of differences between a group of measures in total overall are quite similar.

Chris and I will be defending the committee's recommendations to CSAC on June 9. And we will try very hard to do justice to all of the rich discussions we've had over these past four months.

Christopher Stille: And I couldn't have said it better myself. Thanks, Lee. This is Chris.

Sarah Sampsel: Great. Suzanne, Nadine, Mitra, anything that we missed or are we ready to end the call?

Suzanne Theberge: I think we're ready to adjourn today. Thank you.

Male: Thank you, everyone.

Male: Thank you.

Female: Thank you all.

Female: Thanks.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END