

NATIONAL QUALITY FORUM

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PERSON AND FAMILY CENTERED CARE PHASE 3

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MONDAY

JUNE 6, 2016

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

PRESENT:

LEE PARTRIDGE, Co-Chair  
 CHRISTOPHER STILLE, MD, MPH, FAAP, Co-Chair  
 BETH AVERBECK, MD, HealthPartners, Inc.  
 KATHERINE BEVANS, PhD, Children's Hospital of Philadelphia  
 SAMUEL BIERNER, MD, University of Nebraska Medical Center  
 REBECCA BRADLEY, LCSW, HealthSouth Corporation  
 JENNIFER BRIGHT, MPA, Momentum Health Strategies  
 DAVID CELLA, Northwestern University Feinberg School of Medicine\*  
 SHARON CROSS, LISW, Ohio State University Wexner Medical Center  
 DAWN DOWDING, PhD, RN, Visiting Nurse Service of New York\*  
 NICOLE FRIEDMAN, Kaiser Permanente  
 STEPHEN HOY, Patient Family Centered Care Partners  
 SHERRIE KAPLAN, PhD, MPH, University of California Irvine School of Medicine

LINDA MELILLO, MS, MA, CPHRM, CPXP, Spaulding  
Rehabilitation Network, Partners  
Healthcare System

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

ELIZABETH MORT, MD, MPH, Massachusetts General  
Hospital/Massachusetts General Physicians  
Organization\*

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

DEBRA SALIBA, MD, MPH, UCLA/JH Borun Center for  
Gerontological Research, VA GRECC, RAND  
Health\*

LISA GALE SUTER, MD, Yale School of Medicine,  
Yale Center for Outcomes Research &  
Evaluation (CORE)

PETER THOMAS, JD, Powers, Pyles, Sutter &  
Verville, P.C.

CARIN VAN ZYL, MD, FACEP, Keck School of  
Medicine of University of Southern  
California

#### NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer

ANN HAMMERSMITH, JD, General Counsel

ELISA MUNTHALI, MPH, Vice President, Quality  
Measurement

ALEXANDRA OGUNGBEMI, Project Analyst

DESMIRRA QUINNONEZ, Project Analyst

KIRSTEN REED, Project Manager

SARAH SAMPSEL, MPH, Senior Director

SUZANNE THEBERGE, MPH, Senior Project Manager

ALSO PRESENT:

SVEN BERG, MD, MPH, CPE, West Virginia Medical  
Institute/Quality Insights

NICHOLAS CASTLE, PhD, University of Pittsburgh  
Graduate School of Public Health\*

DEXANNE CLOHAN, MD, Retained Consultant

KATHLEEN DANN, UDSMR

MAGGIE DIVITA, UDSMR\*

DAVID GIFFORD, MD, MPH, American Health Care  
Association

DANIEL GREEN, MD, FACOG, Centers for Medicare &  
Medicaid Services\*

DEANNA HAYES, PT, DPT, MS, Focus on Therapeutic  
Outcomes\*

BETH JACKSON, PhD, Truven Health Analytics

KERRY LIDA, PhD, Centers for Medicare & Medicaid  
Services

JANE LUCAS, Quality Insights of Pennsylvania

CORETTA MALLERY, PhD, American Institutes for  
Research

JAMES MULLER, American Health Care Association

PAULETTE NIEWCZYK, PhD, MPH, UDSMR

GARY REZEK, West Virginia Medical Institute\*

ANITA SOMPLASKY, RN, West Virginia Medical

Institute/Quality Insights of Pennsylvania

\* present by teleconference

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

2 8:39 a.m.

3 CO-CHAIR PARTRIDGE: Welcome again to  
4 Washington, D.C., on a typical June day,  
5 temperature nearly 90.

6 So just because I suspect you, like  
7 me, wondered what all the construction is across  
8 the way, that was for many, many years, as long  
9 as I lived here, the site of the Washington Post.  
10 But its new owners decided to sell it, and the  
11 property is now being developed, I understand,  
12 into a mega-complex of residential and  
13 commercial.

14 MS. HAMMERSMITH: Fannie Mae.

15 CO-CHAIR PARTRIDGE: Oh, Fannie Mae is  
16 the principal tenant? Okay, so the new home of  
17 Fannie Mae. It seems very strange because for  
18 years we've been looking at those sort of  
19 yellowish brick buildings and watching Post  
20 reporting.

21 It's Chris and my pleasure to welcome  
22 you here today, and Sarah is going to start us

1 off with some of the ground rules, et cetera.

2 Right?

3 MS. SAMPSEL: Yes. So, good morning,  
4 and thank you all. I know a number of us had  
5 problems making it across the country yesterday,  
6 and we'll have a couple of people joining us a  
7 little bit late, but we do have a couple of folks  
8 on the phone, as well, so just want to remind  
9 folks that we will have some Committee members on  
10 the phone.

11 But I'm Sarah Sampsel, I'm the Senior  
12 Director for this project. And how we're going to  
13 start this morning is by doing introductions and  
14 disclosures of interest. So we'll have staff do  
15 introductions first, and then we'll turn things  
16 over to our General Counsel, Ann Hammersmith, who  
17 will go around and give you the instructions for  
18 disclosures of interest.

19 But again, just want to welcome you  
20 all and do hope that you will get a lot out of  
21 this meeting. We are very much looking forward  
22 to all of your feedback, and we'll talk about

1 some of the logistics and other things after we  
2 do our introductions. So why don't we go ahead  
3 and start. Desi, do you want to go ahead and  
4 start, please?

5 MS. QUINNONEZ: Good morning,  
6 everyone. I'm over in the corner. I'm Desmirra  
7 Quinnonez. You'll see me often as Desi on my  
8 emails, and I'm the Project Analyst on this  
9 project.

10 MS. REED: Good morning, everyone. I am  
11 Kirsten Reed. I am a Project Manager here at NQF.  
12 Today actually marks week seven for me, so I am  
13 very excited to really jump right in and get  
14 started with everyone today.

15 MS. THEBERGE: Good morning, everyone.  
16 I'm Suzanne Theberge. I'm the Senior Project  
17 Manager on the team, and enjoying working with  
18 you all again.

19 MS. OGUNGBEMI: Good morning. My name  
20 is Alexandra Ogungbemi, and I am a Project  
21 Analyst at NQF. I just work on the quality  
22 measurement department.

1 MS. MUNTHALI: Good morning. I'm Elisa  
2 Munthali. I'm Vice President for Quality  
3 Measurement; just wanted to welcome everyone and  
4 thank you for serving on the Committee.

5 MS. HAMMERSMITH: Hi, everyone. I'm Ann  
6 Hammersmith. I'm NQF's General Counsel. Many of  
7 you have heard the little talk I'm going to do  
8 before, and I'll do it again just to remind  
9 everyone.

10 If you recall -- I'm sure you do, it's  
11 a rather long form -- we sent you a conflict of  
12 interest disclosure form a while ago in which we  
13 asked you some detailed information about your  
14 professional activities. So what we're going to  
15 do this morning is go through an oral disclosure,  
16 the purpose of which is transparency so that each  
17 of you and the public who are present or  
18 listening know where you're coming from.

19 I'll remind you that you sit on the  
20 Committee as an individual. You're here because  
21 you're an expert in this area. You don't  
22 represent your employer, you don't represent



1 anyone who may have nominated you to serve on  
2 this Committee.

3 Some guidelines for what you should  
4 disclose. You should only disclose things that  
5 are relevant to your service on Committee. In  
6 other words, that are relevant to the subject  
7 matter of the Committee. We are particularly  
8 interested in speaking engagements, consulting,  
9 grants, research. But again, only if it's  
10 relevant to the subject matter that's before the  
11 Committee.

12 Just a reminder that just because you  
13 disclose doesn't mean that you have a conflict of  
14 interest. As I mentioned before, the idea behind  
15 this is transparency. So you might be involved  
16 in something that's relevant to the subject  
17 matter but it's not a conflict of interest, but  
18 you may wish to disclose it because it is  
19 relevant to the subject matter.

20 So with that, I'll start with the Co-  
21 Chairs. We'll go around the table. If you're on  
22 the phone, I will call on you at the end of the

1 in-person disclosures.

2 CO-CHAIR PARTRIDGE: I'm Lee Partridge.

3 I retired on the 1st of April from many years of  
4 volunteer service with the National Partnership  
5 for Women and Families, here in Washington. And  
6 I picked up a new part-time assignment in my new  
7 home, which is now New York City, with the United  
8 Hospital Fund, a 125-year old nonprofit  
9 foundation in the city where I am working happily  
10 on pediatric care, which is my first love. And I  
11 have no conflicts or other issues to disclose.

12 I do want to say, however, as we go  
13 around the room, particularly since we have seven  
14 new members, not all of whom are here, but most  
15 of whom are here, just if you would add a  
16 sentence or two about where you're from just so  
17 that we have a better -- just a little bit better  
18 acquaintance.

19 CO-CHAIR STILLE: Good morning,  
20 everyone. My name is Chris Stille. I'm a  
21 professor and section head at General Academic  
22 Pediatrics at the University of Colorado School

1 of Medicine and Children's Hospital Colorado.  
2 It's an honor and a pleasure to be working with  
3 all of you. My academic interests are in  
4 improving systems of care for children and  
5 families with special care needs. I have no  
6 disclosures or conflicts to note today.

7 MEMBER THOMAS: My name is Peter  
8 Thomas. I think this is the third time I've been  
9 here. I'm happy to be here. I'm a consumer. I  
10 have two artificial legs that I kind of wear on  
11 my sleeve because it's given me a tremendous  
12 front row seat to the healthcare system  
13 throughout my life, and kind of went into that  
14 field, I'm a lawyer and a lobbyist and do a lot  
15 of healthcare work from a disability and  
16 rehabilitation perspective.

17 So I represent a lot of different  
18 clients in the rehabilitation space. I don't  
19 represent UDSMR, which is one of the measure  
20 developers. I don't believe I have any conflicts  
21 to disclose. I will be speaking to the UDSMR in  
22 August, but it's not really about -- it may touch

1 on quality issues but it's really about  
2 rehabilitation issues overall. And I've never  
3 worked with anyone on measure development, so I  
4 don't think I've got any conflicts.

5 My office is two blocks away and I'm  
6 from Washington, D.C., and Chevy Chase, Maryland.

7 MEMBER MELILLO: Hi, I'm Linda Melillo.  
8 I am the director of quality and compliance at  
9 Spaulding Rehabilitation Hospital Cape Cod, and  
10 I'm also the Director of Patient Experience for  
11 the Spaulding Network, which is part of the  
12 Partners Healthcare System out of Boston.

13 I suppose I don't -- I don't know if  
14 you'd call this a conflict or not, but Spaulding  
15 Rehabilitation Network includes inpatient  
16 rehabilitation facilities, long-term acute care,  
17 skilled nursing facilities, and home care. So I  
18 just wanted to get that out there.

19 I'm thrilled to be here. I'm also a  
20 consumer. I had a traumatic brain injury years  
21 ago, so lots of use of the healthcare system. So  
22 great to be here, thank you.

1                   MEMBER BRIGHT: Hi, everyone. I'm  
2   Jennifer Bright. I have my own consulting  
3   company, Momentum Health Strategies, and I'm  
4   based here in Alexandria, Virginia. I'd like to  
5   think I have a place at this table today because  
6   I grew up on patient advocacy working in the  
7   mental health community and started a coalition  
8   about 12 years ago, back when it was not  
9   fashionable to talk about patient engagement.

10                  So I started to coalesce a whole bunch  
11   of patient groups, from kidney to diabetes, to  
12   get involved and to educate their members about  
13   why patients' rights was important and  
14   comparative effectiveness and policy development.  
15   And currently, my clients are mostly non-profits,  
16   but I also some advisory to -- not currently, but  
17   in the past with some healthcare companies on  
18   topics related to policy development, patient  
19   engagement, which is my passion, as well as care  
20   integration for behavioral health and primary  
21   care. So thanks.

22                  MEMBER MORRISE: I'm Lisa Morrise, and

1 I'm from Salt Lake City, Utah. I am a patient  
2 advocate. My daughter, Kirsten, who's now 23 and  
3 a student at Utah State studying social work, was  
4 born unable to breathe or swallow. And her  
5 medically intense journey that included a  
6 tracheotomy, NG tube, and 45 surgeries to-date  
7 has helped me understand the needs that we have  
8 for improvement in patient engagement and patient  
9 and family centered care in the medical system.

10 And while we feel like we've been  
11 extremely fortunate with the providers who have  
12 worked with Kirsten, especially as I work with  
13 other parents whose children have the same birth  
14 defect but are not getting the kind of care that  
15 they need. We found that in general the system  
16 really needs patient input. So now I work as a  
17 subcontractor to a subcontractor for CMS and work  
18 in patient and family engagement on projects like  
19 Partnership for Patients and TCPI, and also help  
20 hospitals around the country develop patient and  
21 family advisory councils, and just in general  
22 consult in other areas of patient and family

1 engagement. And I don't believe I have anything  
2 to disclose. Thanks so much.

3 MEMBER BEVANS: Good morning, everyone.  
4 I'm Katherine Bevans, I'm an associate professor  
5 at the University of Pennsylvania School of  
6 Medicine and the Children's Hospital of  
7 Philadelphia. I'm a researcher who develops  
8 patient-reported outcome measures, especially for  
9 use with children and parents. And I also do work  
10 on the development of methods for enhancing  
11 patient, family, other stakeholder engagement in  
12 research. I don't believe I have any conflicts of  
13 interest.

14 MEMBER VAN ZYL: Hi, everyone. I'm  
15 Carin Van Zyl. I am Assistant Professor of  
16 Medicine at the Keck School of Medicine. And I  
17 run the programs for palliative care at LA County  
18 Hospital and the Keck School. I have no conflicts  
19 to disclose.

20 MEMBER HOY: I'm Stephen Hoy. I'm a new  
21 member here. I work in a place called Mammoth  
22 Lakes, California. I'm the director of strategy

1 and programs for a small consulting company  
2 called PFCC Partners that partner with healthcare  
3 organizations to advance PFCC practices in their  
4 organizations. And I don't think I have any  
5 disclosures, conflicts of interest to disclose.  
6 Thanks.

7 MEMBER CROSS: Good morning. My name is  
8 Sharon Cross. I am currently the Program Director  
9 for patients care at the Ohio State University  
10 Wexner Medical Center. And within my role I am  
11 the person that manages all of our patient and  
12 family advisors and advisory councils, and work  
13 with researchers who are engaging patients and  
14 families in their research design. I have  
15 participated in some different projects with  
16 PCORI but I don't believe I have any conflicts of  
17 interest to disclose. Thank you.

18 MEMBER AVERBECK: Good morning. I'm  
19 Beth Averbeck from Minneapolis-St. Paul,  
20 Minnesota with Health Partners. We're an  
21 integrated care delivery and financing  
22 organizations. My administrative



1 responsibilities, I lead primary care, which is  
2 about 400 physicians. And my clinical practice is  
3 in long-term care, TCU, assisted living. And I've  
4 also worked with Minnesota Community Measurement  
5 on some patient-reported outcomes and electronic  
6 health record measure submissions. Thank you. Oh,  
7 I have nothing to declare.

8 MEMBER PARISI: Good morning. My name  
9 is Len Parisi. I am out of New York City, vice  
10 president of quality management for MJHS. I'm a  
11 post-acute care provider, home care hospice,  
12 skilled nursing facility. I have no conflicts of  
13 interest but I do sit on the Joint Commission  
14 Standards and Survey Methods Committee, as well  
15 as the Home Care Advisory Committee.

16 MEMBER BRADLEY: Good morning. My name  
17 is Becky Bradley. I'm a social worker by  
18 training. I'm currently the National Director for  
19 Case Management for HealthSouth Corporation which  
20 is a post-acute provider. We are users of many  
21 instruments in our settings, and I have nothing  
22 to disclose.

1                   MEMBER KAPLAN: I'm Sherrie Kaplan. I'm  
2                   a Professor of Medicine and Assistant Vice  
3                   Chancellor for Healthcare Measurement and  
4                   Valuation at University of California Irvine  
5                   School of Medicine. I have currently a grant from  
6                   PCORI to further the development of the  
7                   children's measure of self-reported functional  
8                   status. It's animated touchscreen-based. The  
9                   functional status measurement was developed about  
10                  1996 and is being developed now for anesthesia  
11                  and perioperative anxiety, post-operative pain  
12                  management.

13                 And I also developed a number of  
14                 measures in patient-reported outcomes, and  
15                 participatory decisionmaking style that's  
16                 relevant. Those two things are relevant but  
17                 they're not -- for me don't constitute a conflict  
18                 of interest.

19                 MEMBER BIERNER: Good morning. I'm Sam  
20                 Bierner, Professor and Chair of the Department of  
21                 Physical Medicine and Rehabilitation, University  
22                 of Nebraska Medical Center. And I'm medical

1 director of the Madonna Rehabilitation Hospital  
2 in Nebraska. And I have no conflicts of interest.

3 MEMBER FRIEDMAN: My name is Nicole  
4 Friedman, and I am the medical anthropologist in  
5 my background, and currently I am the Regional  
6 Manager for Patient Navigation and Community  
7 Health Work for Kaiser Permanente in the  
8 Northwest. I am from Portland, Oregon. I'm new,  
9 and I have no conflicts of interest.

10 MS. HAMMERSMITH: I'm now going to call  
11 on the people who are on the phone. Dawn Dowding.  
12 Is Dawn Dowding on the phone?

13 MEMBER DOWDING: Yes, hi. Sorry, I was  
14 on mute. I'm Dawn Dowding. I'm a professor at the  
15 School of Nursing at Columbia University, and I  
16 have a joint appointment with the Visiting Nurse  
17 Service of New York, and I have no conflicts.

18 MS. HAMMERSMITH: Thank you. David  
19 Cella.

20 MEMBER CELLA: Good morning. This is  
21 David Cella. I'm Professor of Medical Social  
22 Sciences at Northwestern Medical School. This is

1 my second time on the Committee. I don't have any  
2 conflicts that are directly related to any of the  
3 submissions for this meeting, but I do have a  
4 grant from NIH to curate and distribute PROMIS  
5 and Toolbox and Neuro-Qol measures for use around  
6 the country. And some of those at some point may  
7 be used as performance measures.

8 And I'm co-investigator on a PCORI  
9 grant to the Rehabilitation Institute of Chicago  
10 to develop performance measures for post-acute --  
11 patient-oriented performance measures for post-  
12 acute care, none of which are in front of the  
13 Committee at this meeting.

14 MS. HAMMERSMITH: Okay, thank you.  
15 Debra Saliba.

16 MEMBER SALIBA: Hi, I'm Deb Saliba. I  
17 am a geriatrician and health services researcher,  
18 Professor of Medicine at UCLA, the VA, and the  
19 RAND Corporation. I don't have any conflicts of  
20 interest. I am, as a researcher, funded by  
21 multiple federal agencies and federal  
22 foundations, but none of my current work is

1 developing quality metrics.

2 MS. HAMMERSMITH: Okay, thank you.

3 MEMBER SALIBA: And I look forward -- I  
4 apologize that I can't be there today and look  
5 forward to participating.

6 MS. HAMMERSMITH: Okay, thank you. Liz  
7 Mort.

8 MEMBER MORT: Good morning. This is Liz  
9 Mort from Mass General. I'm the Senior Vice  
10 President of Quality and Safety here. I have a  
11 background in health services research and  
12 quality measurement.

13 My apologies that I'm not there in  
14 person and that I can only participate partially  
15 today. My clinical and administrative  
16 responsibilities changed dramatically and  
17 unexpectedly.

18 I have no conflict of interest other  
19 than the fact that I am from Mass General, and  
20 tomorrow you will be considering a measure from  
21 MGH. Should there be decisions that need to be  
22 made post the in-person meeting, I will recuse

1 myself from those decisions. And happy to be  
2 participating again.

3 MS. HAMMERSMITH: Okay, thank you. Is  
4 anyone else on the phone who I've missed?

5 All right. Thank you, everyone, for  
6 those disclosures. You have very interesting  
7 backgrounds. This is one of the most interesting  
8 committees I've done disclosures for.

9 Anyway, do you have any questions of  
10 each other or anything you want to discuss, or  
11 any questions for me?

12 Okay, before I leave you, I just want  
13 to remind you of one thing, which is if at any  
14 point in the meeting you think you may have a  
15 conflict, or if you think someone else has a  
16 conflict that they haven't declared, or if you  
17 think someone is going beyond stating their  
18 opinion and heading into bias, we ask you to  
19 speak up.

20 What we don't want is to have you pop  
21 up three months later and go, "you know, I think  
22 I may have had a conflict" and you didn't tell us

1 at the time of the meeting. So if any of the  
2 things I've described occur, in your opinion,  
3 you're always free to bring it up in realtime in  
4 the meeting. If you don't want to do that, you  
5 could approach your Chairs who will work with NQF  
6 staff, or you can approach staff directly. So  
7 with that, I will let you get on with your  
8 meeting. Thank you.

9 MS. SAMPSEL: Thanks, Ann. And thanks,  
10 everyone. A couple of housekeeping issues. First  
11 of all, we do have breaks put into the agenda.  
12 However, if at any point you still feel you need  
13 to stand up, do whatever, the restrooms are out  
14 through the lobby and to the right, but we do  
15 have breaks at 10:45, and then lunch, and the one  
16 in the afternoon, as well.

17 You should have all hopefully been  
18 able to log into our guest network, but if not,  
19 the information is on the screen right now. We  
20 ask you to mute your cell phone during the  
21 meeting. We definitely understand if folks need  
22 to get up, but if you have to have a

1 conversation, if you could leave this area. We do  
2 tape these conversations in these meetings, and  
3 then we also have a transcriber in the back  
4 corner of the room who is documenting everything.  
5 So, microphones.

6 MS. THEBERGE: Yes, there's somebody on  
7 the phone, I think, who also has the webinar  
8 streaming. If you could mute your computer if  
9 you're dialed into the open phone line, we would  
10 appreciate it. Thank you.

11 MS. SAMPSEL: Suzanne can fix echos; I  
12 can't. So with that -- and, again, somebody on  
13 line does have their computer streaming audio.  
14 The microphones, when they're lit it means that  
15 they're active. Only two can be active at one  
16 time, so we ask that as you speak, once you're  
17 done if you'll turn your microphone off, and all  
18 of us need reminders about that typically.

19 And then the way we do it, if somebody  
20 wants to speak, if you have a question or a point  
21 to make, or whatever, if you will raise your card  
22 like this, that way Chris and Lee can identify



1 who wants to speak next.

2 So with that, we want to do just a  
3 very brief overview, again, of what we're trying  
4 to accomplish today and do some reminders. But  
5 also recognize the fact that we've had a couple  
6 of calls already. I think we've had a lot of  
7 discussions about the criteria. But just a  
8 reminder, in this meeting we have one maintenance  
9 measure for review and then we have 12 -- some  
10 with multiple submissions on one form -- but 12  
11 additional new measures.

12 So the bulk of our work are new  
13 measures. But as a reminder on the maintenance  
14 process, these are all measures that are  
15 currently endorsed, so they've already been  
16 evaluated to meet the criteria in the past.  
17 However, you know, NQF criteria have changed over  
18 time, so we ask you to look at the measures in  
19 light of the criteria that have changed, and the  
20 fact that you all have been actually brought up  
21 in this process with the new criteria, so you may  
22 have additional questions.

1           For some of the criteria, such as  
2       evidence and testing, if there is no new evidence  
3       or data, you're able to accept the past  
4       evaluation without further discussion and voting.  
5       However, the measure that we're looking at today,  
6       there's been some updates to specifications, et  
7       cetera, and therefore, we are going to have those  
8       conversations about evidence and testing.

9           And we want greater focus placed on  
10      the current performance and opportunity for  
11      improvement. Obviously, you know, one of the  
12      goals of measurement is to improve over time and  
13      to really show that it's making a difference. And  
14      so that's why we want some focus on the  
15      performance and if there continues to be growth  
16      in the measure. And then usability and use, how  
17      well is the measure being used, who is it being  
18      used by, et cetera. Next slide.

19           These are just reminders. And, again,  
20      we went through these on the conference call. The  
21      SDS, or the sociodemographic trial, we convened  
22      an expert panel on demographic factors. And prior

1 to this panel, NQF was not asking folks -- and,  
2 in fact, suggested against including SDS factors  
3 in performance measures.

4 There are two perspectives on SDS. One  
5 is that when you adjust it will mask disparities.  
6 And the other is that you have to adjust because  
7 it's necessary to avoid making incorrect  
8 inferences about the context.

9 So this expert panel came together and  
10 said, yes, we acknowledge that, but we still feel  
11 there is a need to understand more about what is  
12 going on. You know, for each individual measure  
13 perhaps there needs to be more consideration on  
14 how the SDS factors are impacting that measure.

15 So the SDS panel recommended, the NQF  
16 Board approved: a two-year trial period with  
17 adjustment of measures for SDS factors is now no  
18 longer prohibited.

19 So, basically, this started in April  
20 of 2015. Even though this group has been active  
21 since then, this is the first group of measures  
22 that has been under this trial period even though

1 we're a year in. So we just want you to be aware  
2 that these are things that we asked for from the  
3 developers. The developers have been educated on  
4 this. And they are part of these measure  
5 submissions. And we've added questions into those  
6 preliminary analyses, as well.

7 So what are these SDS factors? They're  
8 patient characteristics that are present prior to  
9 treatment. And they are known or suspected to be  
10 a confounder of the treatment. So these are SES  
11 in one group. Socioeconomic status: income,  
12 education, occupation and employment. And then  
13 the SDS are sociodemographic factors: we're  
14 talking about language, insurance, homelessness,  
15 marital state, literacy, health literacy.

16 You know, I think it's important, and  
17 as staff went through all of the forms and all of  
18 the submissions, we were looking to see if these  
19 were noted in the submission forms. And we would  
20 either adjust the questions that you're asked to  
21 consider as part of that preliminary analyses.  
22 Next slide.

1           So during your evaluation, and this is  
2       where something has changed from your past  
3       review, you are asked to consider this list of  
4       questions. And, again, we've talked about these  
5       on the phone. And where they were applicable we  
6       left all of these questions in the forms, so none  
7       of them should be new. You should have seen them  
8       in looking at any of your forms.

9           But, basically, we're looking for  
10      conceptual relationships, we're looking for at  
11      least some kind of testing and analysis that was  
12      done, if someone says there was a relationship or  
13      not a relationship. And, hopefully, we would have  
14      identified where we felt something was missing,  
15      or you should consider if something is missing.  
16      Next slide.

17           Also, as we've talked about, and we're  
18      obviously going to be getting into this, for  
19      those of you who have made it through all of the  
20      forms, we just wanted to give you some reminders  
21      about tool-based measures.

22           In the past, and certainly in Phase 1

1 and Phase 2, we've had a lot of discussions on  
2 are there differences in the measure evaluation  
3 criteria, with specifically PRO-PMs, or the  
4 Patient-Reported Outcome Performance Measures. As  
5 staff have taken back really a lot of the  
6 information shared during these meetings, a lot  
7 of the pushback from these meetings, a lot of the  
8 discussions about interpretation of criteria from  
9 this Committee specifically, we've really been  
10 looking at the NQF criteria and how they're  
11 applicable, and are they working for different  
12 kinds of measures? Because we're seeing more PRO-  
13 PMs coming forward, we're seeing more tool-based  
14 measures.

15 And just for clarification, when I'm  
16 talking about tool-based measures, these are  
17 surveys, whether they're patient experience --  
18 so, therefore, might be a PRO-PM -- or as we did  
19 last time, we had 28 functional status tools, 28  
20 functional status measures based on various tools  
21 or instruments. Those were not PRO-PMs, some of  
22 them were clinician-based assessments, but we

1 really felt the rule should be the same, that we  
2 should be looking at the same type of data, the  
3 same type of analysis, the same understanding of  
4 the psychometric properties of the instruments.

5 So we've been having back and forth  
6 conversations internally, and then we had a  
7 conversation with the CSAC. And we're still in  
8 the process in rolling some of this out, in  
9 educating developers. So we're still dealing with  
10 criteria, but these are some notes that we want  
11 you to know that we have tried, and have been  
12 pushing the developers to provide in their  
13 submissions for this phase of work.

14 MEMBER KAPLAN: I don't mean to  
15 interrupt your flow there, but can you clarify  
16 that what you're -- for me a survey is a data  
17 collection method.

18 MS. SAMPSEL: Yes.

19 MEMBER KAPLAN: It's not -- so what  
20 you're talking about, really, it's like the  
21 medical record abstraction form.

22 MS. SAMPSEL: Yes.

1                   MEMBER KAPLAN: You wouldn't go through  
2                   the exercise for the form, you'd just go through  
3                   the exercise for the measure that's represented  
4                   on the form.

5                   MS. SAMPSEL: Correct. Yeah, and I  
6                   think I have a slide coming up on that. It's a  
7                   really good question, because in all honesty  
8                   that's one of the issues and part of the  
9                   confusion that was internal to NQF as well as  
10                  what are we talking about, and why is it such a  
11                  big deal?

12                  So the first reminder is we do not  
13                  currently endorse surveys, tools, or instruments,  
14                  that even though we have a set of measures coming  
15                  in on a measure submission that might be about  
16                  nursing home CAHPS, or may be about the FIM, or  
17                  may be about the CARE tool, we have not endorsed  
18                  that tool. Those are the data elements that feed  
19                  into the actual PRO-PM.

20                  That being said, it's really important  
21                  to consider the fact that by the time something  
22                  becomes a performance measure, whether it's a



1 PRO-PM or a tool-based measure, that tool should  
2 have been -- its reliability and validity should  
3 have been established before coming to this, and  
4 that is an NQF policy. So some of those questions  
5 are fair game but we just want to make sure the  
6 interpretation is clear: we do not endorse those  
7 tools per se. Next slide.

8           Again, you know, and I think folks who  
9 were here in Phase 2 will remember, there have --  
10 we had been interpreting the NQF criteria with a  
11 higher standard for the PRO-PMs. And this  
12 especially happened in Phase 1, when Karen Pace  
13 was here, where we were constantly reminding  
14 folks -- and if you remember, a lot of data came  
15 in after the in-person meeting because folks were  
16 providing all of their data on their actual tool  
17 and no data on the performance measure.

18           And I think Sherrie, you brought that  
19 up repeatedly during Phase 2, and we really  
20 struggled with that as a Committee. So this is  
21 really -- and we took this to the CSAC, as well,  
22 just a reminder. You all are evaluating the

1 measures, and so it is fair game to say "we want  
2 the data on the performance measure." And during  
3 the algorithm where it used to almost give you an  
4 out if you had the data element or tool-based  
5 testing, then we, you know, had let measures go  
6 through before. We are evaluating the performance  
7 measures, so we want that performance measure  
8 data.

9 Staff went through all of these forms,  
10 we've worked with all of the developers to make  
11 sure that the performance measure data was there.  
12 Is it the right data? That's something we still  
13 have to work on. But to the same degree, we did  
14 look for it and, hopefully, every single  
15 submission should have that performance measure  
16 data in it for this go-around. Next slide.

17 So this is what I was talking about  
18 before. Approximately three years ago, four years  
19 ago, NQF convened a panel talking about patient-  
20 reported outcomes and what happens when you get  
21 to PRO-PM. And there are steps. And so, first of  
22 all, you have the patient-reported outcome, and,

1 obviously, that should be your first step or a  
2 developer's first step: what are we trying to get  
3 to?

4 And then you might have the PRO-M, or  
5 the patient-reported outcome measure, that's  
6 typically the tool in this process. So that's  
7 where we're talking the FIM is a PROM, the CARE  
8 is a PROM, the PHQ-9 itself is a PROM. We expect,  
9 NQF expects, that before you ever get to that  
10 PRO-PM level, that that PROM has already been  
11 tested for validity and reliability, and that it  
12 is a usable tool or instrument, so that, frankly,  
13 by the time they get to these panels we shouldn't  
14 have to be evaluating the reliability and  
15 validity of the tool. There should be some  
16 assumptions made.

17 At the same time, that also assumes,  
18 well, then aren't we endorsing the tool? Right  
19 now, nomenclaturally, no, we're not, but that's  
20 something that obviously -- and something we want  
21 to talk about tomorrow after we make it through  
22 everything today, and then the final measures

1 tomorrow, that we still think there needs to be  
2 some work done there for understanding the  
3 criteria and how they apply.

4 But really what you're looking at, and  
5 what we've pushed the developers for, are this  
6 last box, to make sure that the outcome  
7 performance measure, whatever it is, average  
8 change, percentage proved, et cetera, that that  
9 is what has been tested for reliability,  
10 validity, threats to validity, et cetera. And so  
11 we've been pushing really hard on that and doing  
12 a lot of education on it. Next slide.

13 This is just a reminder on related and  
14 competing measures. We will not look at related  
15 and competing unless the measure has been  
16 recommended for endorsement. We have, I think, a  
17 couple of measures in this portfolio that have  
18 been identified as related to other measures. And  
19 then we have the FIM measures that we'll talk  
20 about this afternoon are competing with some  
21 measures that were submitted during our last  
22 phase of work. Only if those FIM measures are

1 recommended for endorsement will we have those  
2 related and competing discussions. And we'll talk  
3 about that more, and there are additional  
4 materials. Next slide. Suzanne?

5 MS. THEBERGE: Next slide.

6 MEMBER THOMAS: Still a little fuzzy on  
7 the SES -- SDS did you say? Right, either. And  
8 the interplay between that and risk adjustment.  
9 Probably not an easy answer, but I think you said  
10 that by taking those into account you mask the  
11 effects of risk adjustment, or you mask risk --  
12 I'm just not clear of the interplay between the  
13 two.

14 MS. SAMPSEL: So there are two kind of  
15 schools of thought when it comes to including the  
16 SES or the SDS in a risk adjustment methodology.  
17 The one school of thought is that if you include  
18 them, that you're masking the fact that there  
19 might be disparities.

20 MEMBER THOMAS: Okay.

21 MS. SAMPSEL: And then the other is  
22 that unless you risk adjust, unless you include

1       those, you won't know if there are disparities,  
2       or that they really are impacting the measure.  
3       And I can tell you even within NQF that are two  
4       different schools of thought. Those of us who  
5       are trained from NCQA say, no, you don't risk  
6       adjust, you don't include SDS, you stratify. And  
7       then others have a different belief.

8               But what we're looking for is not  
9       necessarily that there's a right or a wrong, but  
10      if somebody has included the SDS factors, if they  
11      have included a risk adjustment strategy, there's  
12      a rationale and analysis to support what they've  
13      done.

14             MEMBER THOMAS: Okay, thank you.

15             CO-CHAIR PARTRIDGE: Peter, this is --  
16      for folks on the phone this is Lee Partridge.  
17      CSAC, during my tenure there, which ends actually  
18      this month, spent a lot of time on this issue.  
19      And it came up mostly in the context of the  
20      equity of the hospital related measures and the  
21      safety net hospitals, and was there a possibility  
22      that we were unintentionally causing harm to the

1 safety net network?

2 And the way some of us tended to think  
3 about that was the clinical adjustments for  
4 things like race, or genetic background, or  
5 whatever, are embedded in the measure already.

6 Those risk adjustments have been done. What we're  
7 looking at is kind of should the measure itself  
8 be somehow structured differently or risk

9 adjusted to take account of things like -- I

10 think you'll see it here. There's one measure I  
11 remember in particular where people said --

12 acknowledge there was an impact if there was a  
13 different educational background on the part of  
14 the patients, but, in fact, they had tested and  
15 it didn't make any difference with respect to  
16 this measure. So, you'll see it come up.

17 MS. THEBERGE: Okay. So, as you folks  
18 are very familiar with our portfolio, we have  
19 about 60 endorsed measures in this person and  
20 family centered care portfolio. We had a call for  
21 measures for this project through last winter,  
22 from October to March. And we'll be looking at a

1 series of measures on health-related quality of  
2 life, functional status, shared decisionmaking,  
3 symptom and symptom burden, and experience of  
4 care. Next slide.

5 Our maintenance measure, which Sarah  
6 was just discussing, is Measure 420, the Pain  
7 Assessment Follow-Up. Next slide. The rest of the  
8 measures are new measures for endorsement in  
9 these areas.

10 We had a few measures that we've  
11 rescheduled maintenance review, meaning that they  
12 just were not ready for review in this phase and  
13 we will look at them at a later date. But you may  
14 have seen them in our portfolio and have wondered  
15 about them, and that's the series of CCAT  
16 measures and a health-related quality of life for  
17 COPD patients. Next slide.

18 We also had a number of measures that  
19 we'll be losing endorsement for several reasons.  
20 Developers have decided not to resubmit these  
21 particular measures and so they will lose  
22 endorsement and no longer be a part of the



1 portfolio. And we'll be having a longer  
2 discussion tomorrow, but your charge in relation  
3 to the portfolio of measures is to look for gaps,  
4 areas where we need more measures and make  
5 recommendations on where measures should be  
6 developed. We will also ask you to make  
7 recommendations on harmonization, provide input  
8 to the measure's application partnership, and  
9 make recommendations on measure concepts for  
10 harmonization. Next slide.

11           So just to talk briefly about the role  
12 of the Standing Committee in the measure  
13 discussion process, we ask you all to stand in  
14 as a proxy for our multi-stakeholder membership.  
15 And you work with the staff to achieve the goals  
16 of the project and evaluate measures against the  
17 criteria, respond to the comments that we will  
18 receive on this project in the next step of the  
19 work, respond to directions from the CSAC, and  
20 oversee the PFCC portfolio of measures. Next  
21 slide.

22           As we talked about during the

1 orientation call, this is the process for the  
2 evaluation that will be happening today. We've  
3 asked our developers to provide a very brief  
4 overview, two to three minutes, of their measure  
5 or set of measures, and they'll be sitting right  
6 up here at the table with us when it's their turn  
7 to have their measures discussed.

8 And then we'll ask the lead  
9 discussant, you've each been assigned as a lead  
10 discussant to a couple of measures, and then  
11 we'll ask you to kick off that discussion by  
12 providing a summary of the comments that were  
13 submitted beforehand and any issues that you  
14 discovered in your in-depth review on the  
15 measures. And we'd really like you to focus on  
16 areas of concern or places where there was a  
17 difference of opinion.

18 We'll have time for the developers to  
19 answer questions should you wish to ask them, so  
20 if you have any questions or anything you want  
21 clarified you can just ask our developer  
22 colleagues.

1                   And as Sarah mentioned, we ask you to  
2                   put up your cards when you wish to speak, and  
3                   then we'll call on you. And for the folks on the  
4                   phone, please do just jump in when you wish to  
5                   say something and we'll put you in the queue,  
6                   just let us know that you'd like to speak. And  
7                   we did have a request from one of our  
8                   participants on the webinar for folks to make  
9                   sure to lean close to your mic so that they can  
10                  hear everybody clearly.

11                  And then we'll have the Committee  
12                  discuss all the measures, then they will vote on  
13                  the criteria. Next slide will get into that  
14                  here.

15                  So voting is in the order that it's  
16                  presented on the measure worksheet. First,  
17                  evidence, then performance gap, then reliability,  
18                  then validity. Those four criteria are all must  
19                  pass, so if a measure does not pass any of those  
20                  criteria, it stops. Assuming it passes each of  
21                  these criteria, then we'll get into usability and  
22                  use, then feasibility, and then overall

1       suitability for endorsement.

2                   And we know that folks often have  
3       suggestions on how measures could be improved or  
4       things they would like to see, but we do ask that  
5       you evaluate and vote on the measure  
6       specifications as they are presented to you  
7       today. Any recommendations the developer can take  
8       back and work on for future presentation, but we  
9       need to look at what's been submitted today.

10      Next slide.

11                   So let's talk for a moment about the  
12      voting process. You all have a clicker. It's  
13      very important that you keep track of your  
14      clicker because it's assigned to you. We will be  
15      collecting your votes via Desi over there with  
16      the laptop, so when it's time to vote you'll have  
17      to point your clicker at Desi, the computer will  
18      count up how many votes we received so we'll know  
19      if we've gotten everybody, and the computer will  
20      calculate. When you're voting the remote will  
21      briefly display your vote choice so that you can  
22      see, and you can change your vote without

1 duplicating, so whatever the last thing you press  
2 will be your registered vote. The folks on the  
3 phone and webinar will be submitting their votes  
4 via chat, and Staff will be submitting their --  
5 we have special clickers for them and we'll be  
6 submitting their votes. Next slide.

7           So talking a little bit about what  
8 consensus actually is, a quorum is considered 66  
9 percent of the Committee that is serving in a  
10 particular phase so we have achieved quorum. And  
11 so to be recommended, measures must have greater  
12 than 60 percent of the Committee voting yes or  
13 high plus moderate, so that means 60.001 or, you  
14 know, anything in between 40 and 60, so inclusive  
15 of both 40 and 60 is considered consensus not  
16 reached. You may also hear Staff call it the  
17 gray zone. What this means is that the Committee  
18 has not achieved consensus. There's really no  
19 decision either way, so at that point the measure  
20 continues forward. Discussion continues if it's  
21 on one of the must pass criteria, and if it's on  
22 the final recommendation the measure will go

1 forward to public comment, and NQF will  
2 specifically seek comments on that measure and  
3 its consensus not reached status. Anything less  
4 than 40 percent is not recommended and so it will  
5 either stop, depending on if it's one of the  
6 criteria, or it will go forward as not  
7 recommended to public comment.

8 I will pause here and see if there are  
9 any questions on the consensus not reached status  
10 and achieving consensus in general. No, okay.  
11 Next slide.

12 So just some quick ground rules. We  
13 have asked you all to have reviewed the measures  
14 beforehand, and we do hope that you will all  
15 engage in the discussion for every measure  
16 unless, of course, you are recused. And because  
17 we ask you to serve as a proxy for the NQF  
18 membership we really want input from all of our  
19 stakeholders and everyone around the table, and  
20 we do expect that there will be differences of  
21 opinion, and that's something that we look for  
22 and we want to encourage those discussions.

1           So as you know, we have quite a full  
2 agenda and so we ask that you try to help us keep  
3 on time; that is Staff and Co-Chairs' job to  
4 really keep us to the time but, you know, we ask  
5 everybody to help with that. And we will also do  
6 our best not to cut off any discussion that needs  
7 to happen, but just keeping in mind that we have  
8 folks coming in and dialing in. We have several  
9 developers that will be participating by phone,  
10 as well as in person.

11           And so with that said, I think we can  
12 actually kick off the discussion ahead of  
13 schedule, speaking of staying on time, unless  
14 anybody has any questions before we begin the  
15 measure discussion.

16           CO-CHAIR PARTRIDGE: Sherrie.

17           MEMBER KAPLAN: Just two quick things,  
18 if you could comment on the attribution issue and  
19 the purpose of measurement, and what the  
20 Committee's responsibilities are with respect to  
21 how the measure is being used, and does that  
22 change the psychometric standards that you would

1 use in applying the measure? And the second  
2 thing is to clarify the multi-item measures --  
3 the items that are supposed to represent a  
4 single construct to make it clear that you're  
5 endorsing the composite of those multi-item  
6 measures, not individual items within the  
7 composite that's supposed to measure, for  
8 example, quality of shared decision making.

9 MS. SAMPSEL: Sherrie, it's so early.  
10 So kind of regarding attribution, and I just want  
11 to make sure I'm using it the same way that you  
12 are. You're not talking about the concept of how  
13 measures are being used with quality improvement  
14 versus accountability.

15 MEMBER KAPLAN: That's what I was  
16 talking about, if there's no difference in the  
17 standard, you're not -- you're supposed to be  
18 agnostic to the purpose of measurement for the  
19 purposes of this Committee versus ---

20 MS. SAMPSEL: Correct.

21 MEMBER KAPLAN: You're supposed to be  
22 thinking, for example, about what proportion of



1 the variation is attributable ---

2 MS. SAMPSEL: Correct.

3 MEMBER KAPLAN: -- to what you do to  
4 the patient, not who you attract in the case of  
5 the SDS adjustment, so the attribution of that --  
6 -it is supposed to represent quality of  
7 performance of the unit that's being compared.

8 MS. SAMPSEL: Correct.

9 MEMBER KAPLAN: And you're not  
10 supposed to consider how it's being used, i.e.,  
11 in the penalty phase of the CMS, you know, re-  
12 admissions thing, for example, or to incent  
13 physicians. We're supposed to be agnostic --

14 MS. SAMPSEL: That is correct.

15 MEMBER KAPLAN: Okay.

16 MS. SAMPSEL: You should be agnostic  
17 to that.

18 MEMBER KAPLAN: And then the multi-  
19 item thing, just to clarify what you were --  
20 because I'm -- it's still resonating as a little  
21 bit of a confusion, the term survey versus a  
22 multi-item measure of a construct. You don't want

1 people looking at individual items within that  
2 multi-item composite's intended use ---

3 MS. SAMPSEL: That's correct. Where  
4 there's a little bit of difference for that is,  
5 for example, the second measure we're looking at  
6 today, 2967, which are 19 measures within a  
7 submission, and there's a difference between the  
8 measures that were submitted, those 19 measures,  
9 and the items that were collected on that survey.  
10 So we're not asking you to dive into each  
11 individual item on the survey, but how those are  
12 then being combined into the measure.

13 CO-CHAIR PARTRIDGE: Sarah, I know  
14 it's early in the morning, but I think it will  
15 probably come up fairly often. I wonder if we  
16 could just talk a tiny bit more about your  
17 statement that the -- whatever the data  
18 collection tool is, whether we're talking a  
19 survey, or as I think Sherrie said a chart  
20 abstraction, whatever, we should be comfortable  
21 that that tool has been tested. If we're not  
22 comfortable that it's been tested, we should be

1 raising that in the validity, reliability part of  
2 our discussion, yes?

3 MS. SAMPSEL: Yes, so that would be  
4 under -- I mean, technically it's under both  
5 reliability and validity because if you think  
6 about it they both have to -- they both have  
7 questions about the specifications. And so one  
8 analogy we are talking about internally is how  
9 this kind of translate -- if you have a claims-  
10 based measure, your data elements are typically  
11 some demographic data, age, gender sometimes,  
12 things like that, and then you have claims.  
13 Those are your data elements, those exact claim  
14 numbers. When you're talking about a survey or a  
15 tool, your data elements are technically the  
16 items on the survey so there is some level of  
17 having to have some comfort that the reliability  
18 and the validity of that survey, you know, is  
19 accurately performing into the measure. It's  
20 kind of hard to discern that but that is the data  
21 -- the survey and those instrument items are our  
22 data elements for these measures. So yes, those

1 are valid questions. But you guys have  
2 procrastinated long enough, you have to start  
3 reviewing measures now.

4 CO-CHAIR PARTRIDGE: Chris and I are  
5 going to tag team throughout these two days.  
6 When he's been involved particularly in working  
7 on a measure as a lead discussant, I'll take  
8 over, and vice versa. In some cases neither of  
9 us was, we'll just take turns.

10 I want to start by saying thank you so  
11 very much to all of the NQF Staff. Those of us  
12 for whom this is the third time around for these  
13 measures recognize the tremendous amount of work  
14 that has gone into the material that we received  
15 in preparation for this face-to-face meeting in  
16 comparison to what was available the time that we  
17 began in Phase 1. And I know it's been a lot of  
18 work for you and for all the developers and their  
19 representatives sitting behind me and sitting up  
20 here at the table, now we've pestered you with a  
21 lot of questions for additional information. You  
22 probably thought we were nuts but, particularly,

1 I think that the measurement -- what do we call  
2 it, the sheet that we all get to read which  
3 records through the process the comments that  
4 have come in from the public prior to our  
5 considering these measures, the questions that  
6 were raised by the Standing Committee Members,  
7 the responses from the developers. They're there  
8 and they're now all in one place that we can read  
9 in preparation for this meeting, so I hope it's  
10 going to help everything go a little more  
11 smoothly.

12 With that, I am going to turn to our  
13 first measure, 0420: Pain Assessment and Follow-  
14 Up. And this measure steward is CMS. The  
15 representatives here are --

16 DR. BERG: Yes, I'm Sven Berg. I'm  
17 the Chief Medical Officer at Quality Insights,  
18 and with me is Jane Lucas. I'll have her  
19 introduce herself, as well.

20 MS. LUCAS: Hi, I'm Jane Lucas. I'm  
21 the Project Manager for this project.

22 CO-CHAIR PARTRIDGE: Thank you. And

1 our lead discussants are David Cella, Linda  
2 Melillo, Rebecca Bradley, and Carin Van, I'm  
3 going to pronounce it wrong, Van Zyl. And I  
4 apologize if you all on the phone are getting a  
5 little bit of the sound of mechanics out there.  
6 There's a construction site on the other side of  
7 the street.

8 DR. BERG: All right. Well, thank you  
9 for the opportunity to come here this morning.  
10 It really has been beneficial to us to get many  
11 of the comments prior to this meeting, and so we  
12 appreciate the new process. Having been here a  
13 number of times before myself, I recognize that  
14 usually the first presenter gets hit with lots of  
15 questions, and so it's with a little bit of  
16 trepidation this morning that we begin the list  
17 of measures today. However, on behalf of CMS,  
18 and as the measures developer for this measure,  
19 Quality Insights is pleased to have the  
20 opportunity to discuss the maintenance of NQF  
21 0420: Pain Assessment and Follow-Up.

22 This measure received initial

1 endorsement in 2008. It was originally developed  
2 under a contract with CMS to allow non-physician  
3 providers to report quality measures through  
4 their reporting programs which have evolved over  
5 the years. And it was first implemented in the  
6 Physician Quality Reporting Initiative, and most  
7 recently in the Physician Quality Reporting  
8 System program.

9 PQRs uses G-codes for the eligible  
10 professionals to document whether the quality  
11 action has been performed. The level of detail  
12 in defining the G-codes to describe the clinical  
13 actions indicates there is a relationship between  
14 the assessment of the patient on the date of  
15 encounter using a standardized tool and a care  
16 plan based on that assessment when the screening  
17 is positive.

18 Pain assessment is the critical first  
19 step in determining interventions, establishing  
20 goals within a care plan, and measuring the  
21 effectiveness of the care plan or treatment  
22 interventions. For example, the specification

1 provides the numerator quality data coding  
2 options for reporting satisfactorily. G8730,  
3 which is then a G-code is that the pain  
4 assessment documented as positive using a  
5 standardized tool and a follow-up plan is  
6 documented.

7           The measure specifications for NQF  
8 0420 provide clear definition for each of six G-  
9 codes used for reporting, as well as definitions  
10 of what constitutes a follow-up plan. Measure  
11 testing by Quality Insights includes chart review  
12 to determine that the correct G-code was selected  
13 by the eligible professional, a standardized tool  
14 was utilized, and document of a follow-up plan  
15 was done when indicated.

16           The intent of this process measure is  
17 for an eligible professional to document that an  
18 assessment of pain has been performed using a  
19 standardized tool and that a follow-up plan,  
20 i.e., a treatment plan has been documented in the  
21 medical record. The measure focuses on the adult  
22 population, those 18 years and older, and the



1 denominator includes all visits occurring during  
2 the 12 months reporting period.

3           Since implementation the number of  
4 eligible professionals reporting the measure has  
5 increased each year, as well as the scope or the  
6 type of professionals that have reported. What I  
7 would like to point out is that although noting  
8 that the evidence surrounding the effect of pain  
9 screening on treatment prescriptions for the  
10 level of pain is of low quality at this point,  
11 the Institute for Clinical Systems Improvement  
12 included pain assessment in their most recent  
13 opioid prescribing protocol and in their  
14 guidelines for the assessment and management of  
15 chronic pain. In addition, the recently published  
16 CDC Opioid Prescribing Guidelines also include an  
17 assessment of the characteristics of pain. It  
18 notes that an assessment of pain perception over  
19 time can be a valuable measurement of pain  
20 improvement over time. Failure to assess,  
21 address, and treat pain may negatively impact the  
22 quality of life, resource use, and productivity.

1                   A report by the Institute of Medicine  
2                   entitled, "A Blueprint for Transforming  
3                   Prevention, Care, Education, and Research,"  
4                   suggests that chronic pain rates will continue to  
5                   increase as a result of Americans experiencing  
6                   disease in which chronic pain is associated like  
7                   diabetes, cardiovascular disease, et cetera, the  
8                   increase in obesity which is associated with  
9                   chronic conditions that have painful symptoms,  
10                  progress in lifesaving techniques for  
11                  catastrophic illnesses and injuries for people  
12                  who would have previously died, surgical patients  
13                  that are at risk for acute and chronic pain, and  
14                  that the public itself has a better understanding  
15                  of chronic pain syndromes and the new treatments  
16                  associated with that. Therefore, as a result of  
17                  all of these things we believe that this measure  
18                  is still important to improve the quality of  
19                  life, reduce unnecessary medical treatment, and  
20                  undue financial burden.

21                         We thank you for your consideration of  
22                         the endorsement, and we look forward to your

1 questions and the discussion that is surely going  
2 to follow. Thank you.

3 CO-CHAIR PARTRIDGE: Thank you. David,  
4 do you want to -- David Cella, do you want to  
5 lead off?

6 MEMBER CELLA: Yes, hi. Can you hear me  
7 okay?

8 CO-CHAIR PARTRIDGE: We can hear you  
9 just fine.

10 MEMBER CELLA: Okay. Yes, you know,  
11 maybe I could just say a little bit up front and  
12 then have somebody in the room that was a primary  
13 reviewer like Linda or Rebecca go through the  
14 criteria. But I just -- maybe we'll start by  
15 saying this is a maintenance measure. It's the  
16 only maintenance measure we'll be reviewing, and  
17 so some of the criteria don't have to be  
18 discussed, but evidence does have to be  
19 discussed, and it's the first criterion.

20 The Staff review was that the data  
21 were insufficient. I actually, if we're talking  
22 about evidence, I think that there is evidence in

1 the literature, not specific to this measure, but  
2 in support of this measure that most of the time  
3 people study the impact of pain, you know, with  
4 monitoring and setting up a treatment plan for  
5 symptoms that are monitored, not just pain, that  
6 there is a benefit to a patient's experience of  
7 care fairly consistently. The data on benefit to  
8 actual outcomes on that symptom or general  
9 quality of life are a little more mixed but my  
10 personal view is based upon you knowing more  
11 about this than chronic disease management like  
12 cancer is that there is evidence for this  
13 practice being good for patients.

14 CO-CHAIR PARTRIDGE: Linda. I'm sorry,  
15 David. I don't want to cut you off.

16 MEMBER CELLA: Yes. Well, I really  
17 thought I should just start with a quick  
18 introduction. And we are just focusing for now on  
19 evidence. Correct?

20 CO-CHAIR PARTRIDGE: Correct. So which  
21 of your colleagues here in the room wants to  
22 continue? Linda? Carin.

1                   MEMBER VAN ZYL: Yes, as a palliative  
2     care provider, pain is the number one thing that  
3     I assess, and I also had the interesting  
4     experience of trying to develop this measure for  
5     our cancer program.

6                   In the 10 years that I've been doing  
7     this, I understand that there is a -- there's  
8     sort of a necessary but not sufficient component  
9     here; meaning you can't make pain better unless  
10    you ask about it. So the assessment is crucial,  
11    but my clinical experiences, and I think the  
12    experience -- the reason that there's so little  
13    in literature that supports assessing means  
14    better outcomes is because I don't think that  
15    there's a very good relationship between them.  
16    And, you know, the rating scales are such a poor  
17    substitute for the total experience of pain. The  
18    new medical rating scale is the most commonly  
19    used measure but at this point is relegated  
20    almost to a joke because it seems to have so  
21    little relationship to how a patient functions in  
22    the world.

1 I thought the evidence was  
2 insufficient here, and not on the fault of the  
3 developers. I think we really grapple with  
4 anybody studying pain trying to figure out how  
5 you put a number to it, and what that really  
6 means for somebody, and more importantly what you  
7 can do about a number that's really high,  
8 especially in chronic pain. And when we were  
9 trying to go through developing an easier way of  
10 documenting a pain assessment and a pain plan, it  
11 was a year's worth of work, the physicians were  
12 furious that they had to document this. They  
13 believed that they already were; they weren't.  
14 And the only way to go through and make sure that  
15 a physician had really sort of ended the sentence  
16 with an assessment and a plan was a manual data  
17 abstraction. So we tried to come up with a  
18 standardized note that made it easier for  
19 physicians to document, and after a year's worth  
20 of work we couldn't figure out whether there was  
21 any way of insuring that this extra step had  
22 actually meant a single thing to a patient.

1 I don't -- my comments are not meant  
2 as a criticism of the idea, but more a comment on  
3 the practicality as a clinician and as somebody  
4 who tried to implement this measure in the real  
5 world.

6 MEMBER MELILLO: So thank you for those  
7 comments. I would agree that pain is a huge  
8 issue. I would also agree it's very difficult to  
9 measure. One of my concerns is that patients  
10 frequently will gain the number scale. You know,  
11 the find out very quickly that the higher the  
12 number they give it, it changes the medication  
13 they receive. So also the FACES pain scale was  
14 designed for children, and much of the evidence  
15 was on low back issues. So I really would like  
16 more clarification on the patient populations you  
17 would use this with. Is this just for patients  
18 diagnosed with chronic pain, or if this is  
19 broader, is there any evidence of its use, any  
20 broader context that where it's been beneficial?

21 CO-CHAIR PARTRIDGE: We just clarify  
22 for Linda the age range. I think it's 18 and up.

1 DR. BERG: 18 and up, yes.

2 CO-CHAIR PARTRIDGE: Yes, so it  
3 wouldn't apply to children.

4 MEMBER BRADLEY: I love going last  
5 because -- I have --

6 CO-CHAIR PARTRIDGE: Just a reminder  
7 everybody down at that end of the table, we can't  
8 see you.

9 MEMBER BRADLEY: Yes. I had the same  
10 concerns about -- that my colleagues previously  
11 mentioned about the validity and the evidence.

12 I guess I was also, as I read it --  
13 you mentioned that the number of provider --  
14 eligible providers have increased since 2008,  
15 but participation, this is a voluntary reported  
16 measure, and participation has decreased during  
17 that time. And I was wondering if you could  
18 address that, and since it is a measure that has  
19 been out there a while, what do you attribute the  
20 decrease of participation to?

21 MS. SAMPSEL: Actually, I'm going to --  
22 we have a new member who joined, so I'm going



1 to, Jane, give you a second to come up with an  
2 answer. And, Lisa, if you will introduce  
3 yourself, kind of a brief background, but also we  
4 need you to make any comments and disclosures of  
5 interest or conflicts of interest with any of the  
6 measures we are being reviewed.

7 MEMBER SUTER: Can you hear me? Okay.  
8 I'm Lisa Suter. I apologize for being late. Can  
9 you hear me? Okay. I'm an Associate Professor of  
10 Medicine and Rheumatology at Yale School of  
11 Medicine. I also work for the Center for Outcomes  
12 Research and Evaluation as a measure developer on  
13 some outcome measures under contract for CMS,  
14 none of which are under consideration by this  
15 Committee. But that's my main disclosure as a  
16 measure developer. I'm also a health services  
17 researcher. Again, I apologize for the  
18 disruption.

19 CO-CHAIR PARTRIDGE: I'm going to  
20 remind everybody again we are having to talk over  
21 the sound of digging machines next door. Try to  
22 remember to bring the mic a little closer to you

1 and that way we'll all hear throughout the room.  
2 Jane.

3 MS. LUCAS: I'm showing on the form  
4 that we submitted the number of eligible  
5 providers reporting the measure is about 10.7  
6 percent, which is an increase of 3.6 percent in  
7 2010, and then it went up to 7.4 in 2013, and  
8 10.7 in 2014.

9 CO-CHAIR PARTRIDGE: Peter, you're up  
10 next.

11 MEMBER THOMAS: I guess I'm just having  
12 a little trouble understanding when you would  
13 apply -- two questions; when you would apply this  
14 -- does this apply to anyone who walks in for an  
15 office visit to a physician, that the intent is  
16 to do a pain assessment, and if there is pain  
17 follow-up, or is this only after a patient  
18 reports pain or chronic pain?

19 DR. BERG: So the measure is not  
20 specific to diagnosis, so the measure was  
21 originally developed for individuals like  
22 physical therapists, occupational therapists, et

1 cetera. So it was an important part of their  
2 practice, and an everyday condition for most of  
3 the patients.

4 It is a voluntary measure so it's a  
5 measure that a physician can select to perform. I  
6 would anticipate it would be used in practices  
7 where there is a significant amount of pain in  
8 their patients.

9 With regards to the other question  
10 about decreasing performance rates, I think was  
11 the question that you had. You know, when it was  
12 initially adopted then it was very specific  
13 towards the type of eligible professionals that  
14 were using it. I don't have specific information  
15 in front of me, but my -- I would suspect that  
16 the performance rates have decreased because  
17 there is a broader range of professionals who are  
18 using the measure over time, as well. But I don't  
19 have any evidence to support that.

20 CO-CHAIR STILLE: Any follow-up?

21 MEMBER THOMAS: So the materials, the  
22 Staff rated this insufficient for evidence and

1 the materials talk about the developer having the  
2 opportunity to provide additional information.  
3 Have you provided them additional information, or  
4 do you have something more to tell us?

5 DR. BERG: Well, we've provided the  
6 information that is available with regards to  
7 this. It's a fair criticism, and I recognize your  
8 comments, that it's been very difficult to take  
9 pain assessment and study whether or not there is  
10 a better outcome because the assessment has been  
11 made. And we -- after the comments were provided  
12 we did a literature research and we looked for  
13 other evidence along those lines, and really  
14 those studies have been difficult to do, and the  
15 evidence that is there is of fairly low quality  
16 on both sides. In other words, studies that have  
17 been done that look at the effectiveness of this  
18 and have found no effect have also been rated as  
19 having low quality, as well, so it's a very  
20 difficult topic to address.

21 We believe that because those that are  
22 continuing to develop protocols around the

1 management of pain continue to use pain  
2 assessment as part of those protocols, we believe  
3 that it's justified to continue to utilize this  
4 measure at this time, but we recognize the  
5 criticism that has been raised by the Committee.  
6 And our recommendation and take home back to CMS  
7 is, is that perhaps this is something that  
8 deserves additional study in the future so that  
9 we can be assured that utilization of a measure  
10 like this, which is a process measure, actually  
11 has benefit to patients in terms of outcomes. And  
12 we recognize that that is a weakness in the  
13 current science.

14 CO-CHAIR PARTRIDGE: Lisa.

15 MEMBER MORRISE: Thanks, Lee. I have a  
16 couple of questions or comments. As a mom of a  
17 kiddo who encounters pain on a really regular  
18 basis, and it's really bad, I really think this  
19 is important, because if you don't ask you don't  
20 know. And as far as the scale goes and using the  
21 FACES scale, while I agree that there's probably  
22 some issues around the scale, if I heard

1       correctly, Sarah, we're not looking at the scale.  
2       We just looking at the measure, so we kind of  
3       need to take our concerns around the scale and  
4       put them aside. I personally really like the  
5       Legos scale.   Anyway, Lego FACES, you know.  
6       Anyway, so that's one comment.

7               The comment that was made by the  
8       reviewer around the fact that certain ethnicities  
9       are under assessed, I think is one reason,  
10      glaring reason why we need this measure, why we  
11      should say that it is essential because there is  
12      an under-assessment, and as a consequence of  
13      that, under-treatment of pain specifically for  
14      the African American population. And that is true  
15      in the pediatric population, as well as the adult  
16      population. It significantly impacts our friends  
17      with sickle cell disease, and we really need to  
18      ask.

19             The outcome piece should be paired  
20      eventually, but I think that's a separate issue  
21      also; that first you have to determine if the  
22      pain exists, and then determine if appropriate

1 treatment is applied, two separate issues. But if  
2 you don't ask you don't know, so those are my  
3 thoughts. I think we should say yes, it's needed.

4 DR. BERG: I appreciate that type of  
5 endorsement. One of the things that I would like  
6 to point out is that we're not specifying which  
7 pain assessment tool to use, so although you  
8 might find fault with the FACE scale, et cetera,  
9 that's -- we're not really -- we're not assigning  
10 a particular protocol with this. We're just  
11 asking for the use of a pain assessment tool, and  
12 so we're allowing clinical judgment to be used  
13 within each practice on how to do that.

14 And the other thing that's difficult  
15 because most of the study that's been done on  
16 whether or not a pain assessment has been  
17 performed is looking at just that, and then  
18 whether there's an improved outcome. This measure  
19 also asks for the addition of a treatment plan  
20 after the pain assessment, so we recognize that  
21 it was not just the assessment of pain that was  
22 important but that an appropriate treatment plan

1 was then provided following that assessment tool.  
2 And because this measure is looked at for each  
3 visit that a patient encounters with that  
4 provider, then further assessments of pain should  
5 be happening, we should be tracking the patient's  
6 self-reported pain over time, and as a result of  
7 that the treatment and the treatment plan can be  
8 modified in response to that pain. That's the  
9 design of this measure so we're not looking just  
10 as the assessment, but that a treatment plan has  
11 been added, as well.

12 CO-CHAIR PARTRIDGE: Chris.

13 CO-CHAIR STILLE: I think Becky had --

14 MEMBER CELLA: This is Dave Cella,  
15 again. I might be repeating myself a little bit,  
16 but I -- you know, I think that there is -- we're  
17 really just focusing on evidence here, not the  
18 tool, and there's not even a specific tool  
19 recommended in this particular measure. I think  
20 it's a plus that the addition of a plan to  
21 address the assessment of pain is included. I  
22 think it moves this process measure on step



1 closer to outcome because having a plan to  
2 management pain is also associated with improved  
3 pain.

4 I mean, I go back to 30 years ago, you  
5 know, when people starting wearing -- providers  
6 starting wearing pain buttons saying "Ask Me  
7 About Pain," and the No Pain button. The reason  
8 we do that is because it helps encourage patients  
9 to tell us about their pain, and then we have --  
10 that's when you do something about it. And I'm  
11 concerned in this era of worrying about narcotics  
12 overuse and the Joint Commission pulling away  
13 from its recommendation of pain assessment that  
14 we're going to swing in the wrong direction  
15 saying hey, we've just come to realize there's no  
16 relationship between asking about pain and  
17 managing pain. And I don't think that's true. I  
18 think there is evidence. I'd like to see this  
19 measure go a step further and actually, you know,  
20 the pain outcome. And I guess I'm trusting that  
21 that's going to happen in time, but just focusing  
22 on the evidence criteria and the other issues to

1 discuss, I just repeat, I think the evidence is  
2 there.

3 CO-CHAIR PARTRIDGE: Becky, you're up.

4 MEMBER BRADLEY: Thank you. Several of  
5 the research articles that you cited talked about  
6 disparity, and also the -- one of the objectives  
7 is hopefully to reduce the cost and utilization  
8 of healthcare services. But as a -- a G-code is a  
9 billing code, I assume, and so this is a code  
10 that you abstract from claims. And it's kind of  
11 confusing how this would reduce cost and  
12 utilization. It seems like it might add to the  
13 cost and utilization where we have more providers  
14 assessing and documenting that they ask about  
15 pain, and then they developed a treatment plan  
16 because they can bill for those assessments now,  
17 where they could not in the past. So maybe they  
18 were asking but they weren't documenting.

19 I'm having a little bit of trouble  
20 getting from how it become a quality or an  
21 outcome measure and meet the goal of reducing  
22 costs versus increasing costs.

1 DR. BERG: And, again, this is not --  
2 it's not an outcome measure, and so although we  
3 would like our processes to be associated with  
4 good outcomes, it's not what the measure was  
5 designed to do. Our thought process here is that  
6 the appropriate assessment of pain and then  
7 appropriate treatment plan will result in less  
8 pain, and the treatment of those conditions then  
9 over time should then decrease healthcare  
10 utilization, and so that's the theory. Again,  
11 we're looking for that connection and that  
12 evidence. And that evidence of what the outcome  
13 is from this we agree needs to be stronger than  
14 it is right now.

15 CO-CHAIR STILLE: As a pediatrician, I  
16 just have to ask this question. Given that there  
17 are good tools for measuring pain in patients of  
18 all ages, what rationale do you have for  
19 excluding patients under 18?

20 DR. BERG: Can you say what that --

21 CO-CHAIR STILLE: Well, again, I think  
22 it -- the measure, when the measure was developed

1 was -- that was the population that was being  
2 used, and so it hasn't been updated from that  
3 time.

4 DR. BERG: So just had to get out  
5 there.

6 CO-CHAIR STILLE: Sure.

7 DR. BERG: I'm a pediatrician, as well,  
8 so I understand where you're coming from.

9 CO-CHAIR PARTRIDGE: Are there  
10 questions from any other Committee Members in the  
11 room? I'm sorry, Nicole, I'm just looking right  
12 past your card. Go ahead.

13 MEMBER FRIEDMAN: I have two quick  
14 questions. My first one is in terms of dropping  
15 the G-code or the code, is that something a non-  
16 licensed provider can do, like a community health  
17 worker? And is there evidence that increasing the  
18 care plan reduces non-pharmacological  
19 intervention to improve pain?

20 DR. BERG: We would hope that the care  
21 plan would be appropriate for the patient, and so  
22 if non-pharmacological intervention was the

1 intervention that should be used, then we would  
2 hope that that would be the care plan. Again,  
3 we're not specifying what the treatment is, we're  
4 allowing for the clinician to use their best  
5 judgment in determining what that treatment plan  
6 should be. So this is not pain assessed, provided  
7 opiates or other pain medication. That's not the  
8 purpose of this measure.

9 The first question, give me a little  
10 -- remind me again what that was?

11 MEMBER FRIEDMAN: In the documentation  
12 part of the --

13 DR. BERG: Sure, okay, whether or not  
14 non-physicians and community health workers can  
15 do that. I don't know the answer to that  
16 question. I don't know exactly who can -- who's  
17 allowed to build specific G-codes. I don't know  
18 if anyone else on our team knows that.

19 MS. LUCAS: It is -- CMS defines who  
20 the eligible providers are, so I don't have that  
21 list in front of me but it would include like  
22 nurse practitioners, chiropractic, social

1 workers, psychologists, et cetera. But there is a  
2 list that's out there.

3 DR. BERG: But you specifically  
4 addressed community health workers, and I don't  
5 know the answer to that question.

6 DR. GREEN: So this is -- can you guys  
7 hear me?

8 CO-CHAIR STILLE: Yes.

9 DR. GREEN: This is Dan Green from CMS.  
10 So the G-code just to be clear is only to add a  
11 quality data code, I believe, in this measure, to  
12 indicate that the quality action was performed or  
13 not performed. I don't know if that helps at all.

14 CO-CHAIR PARTRIDGE: Peter.

15 MEMBER THOMAS: In other words, it's  
16 not a billing code. You don't get paid under a G-  
17 code, it's just merely a data collection code?

18 DR. GREEN: Generally speaking, G-code  
19 -- yes, generally speaking, G-codes are not  
20 reimbursable. There are some G-codes for certain  
21 services, I want to say Pap smears, for example,  
22 that may be associated with reimbursement. But

1 generally speaking, the G-codes that we have in  
2 our program are for quality reporting, just  
3 quality data codes where there's not a CPT II  
4 code, you know, developed by the AMA, for  
5 example.

6 CO-CHAIR PARTRIDGE: Peter.

7 MEMBER THOMAS: So given the importance  
8 of pain management and the opioid epidemic, I  
9 mean, this is a very important area, so I'm  
10 really tossing and turning on this issue of  
11 insufficient evidence. And I guess what I'm  
12 wondering is -- I'm trying to establish a --  
13 what's the threshold for this? So in the real  
14 practical scenario where a patient comes in to a  
15 physician and the physician asks kind of oh --  
16 even just kind of routine questioning are you --  
17 you know, do you have pain? And the patient says  
18 well, I've got a little low back pain but I'm  
19 fine, and they move on in the conversation. Is  
20 that an assessment? Does that qualify to the  
21 level of an assessment, or is that not really  
22 what you're talking about? You're talking a more

1 formal thing.

2 DR. BERG: When we do the chart review  
3 we are looking to confirm that the G-code  
4 actually matched what happened. That's part of  
5 the validation that we'll talk about later. We  
6 are looking for a specific pain assessment tool.

7 MEMBER THOMAS: Okay.

8 DR. BERG: Not just a --

9 MEMBER THOMAS: Not just a random --

10 DR. BERG: Not just a question about  
11 pain.

12 MEMBER THOMAS: It's higher level than  
13 that. Thanks.

14 DR. BERG: Yes.

15 CO-CHAIR PARTRIDGE: Are there more  
16 questions from the room? Jennifer.

17 MEMBER BRIGHT: Sorry, I didn't do my  
18 tent thing first. Okay, I'm a novice at this, so  
19 bear with me while I ask what might be an obvious  
20 question. But listening to all this, I certainly  
21 agree with Lisa that there is huge value in  
22 assessing, asking patients, especially those that



1 are under-represented what their level of pain  
2 is. And I certainly agree with the marrying of  
3 assessment with a plan. Too often we -- those are  
4 disjoint. But I guess when I'm thinking about  
5 this, what we're talking about is this is a  
6 measure of quality, and what I'm hearing is that  
7 we don't have evidence that we can associate this  
8 process with actual quality of care. So we know  
9 through this process measure the data that you've  
10 collected for the last six years or so tells us  
11 that there are people doing this, and that it's  
12 happening the way it should be happening. But  
13 what we don't have evidence for is any indication  
14 that it's resulting in quality of care. We're  
15 interpreting that. So I guess where I come down  
16 on this is, why are doing the -- why is this  
17 measure valuable then? It's not to say that pain  
18 assessment is not valuable, it's not to say that  
19 we shouldn't be doing it better, but what I'm  
20 hearing is that we don't have evidence to tell us  
21 that this measure is making an impact, or we  
22 don't know yet, there needs to be more study.

1                   So in my job in this Committee as I  
2 understand it, I guess my question is why? Why  
3 re-endorse this measure if what we're really  
4 saying is we need a better measure?

5                   DR. BERG: Again, I think it's a fair  
6 question. Is that Dr. Green? You can -- I'll  
7 start then.

8                   In many situations when research  
9 studies are designed and you're going to do a  
10 controlled study between one arm or another arm,  
11 you have to determine whether harm is going to  
12 happen to your patients and what the risk of each  
13 of those study arms are. This is a very difficult  
14 topic around which to develop a controlled study  
15 because obtaining a patient history, and  
16 developing then a treatment plan around a history  
17 is the standard of care. And to design a study  
18 that would exclude that so that you can prove  
19 that this is associated with a good outcome might  
20 be an unethical study, so this is a very  
21 difficult study to develop. About the best you  
22 could do is do some type of retrospective review

1 comparing practices that utilize this tool with  
2 practices that don't utilize this tool. Those  
3 studies have not been done, but ethically this is  
4 a very difficult study that you're asking in  
5 order to obtain the evidence that you're asking  
6 for.

7 MEMBER CELLA: This is Dave Cella,  
8 again. I might be guilty of not understanding the  
9 evidence criteria. I may be being too broad in my  
10 interpretation of it, but although I accept that  
11 this particular specific process measure does not  
12 have an evidence base in the literature, there is  
13 a good size evidence base in support of the  
14 practice of monitoring symptoms and altering  
15 practice based upon that monitoring and the  
16 effect that has upon patients. I mean, there have  
17 been enough studies now where there have been  
18 reviews of the study that I'm just talking about  
19 in oncology and palliative care where, as I  
20 mentioned earlier, fairly consistently  
21 satisfaction with care has improved by this  
22 practice, and less consistently but with a small

1 effect overall symptoms are improved with this  
2 practice in well controlled randomized clinical  
3 trials. So that's -- but not with this particular  
4 performance measure, so if the evidence we're  
5 supposed to review is only on this measure or on  
6 the practice of monitoring symptoms and making  
7 treatment plans based upon that monitoring  
8 practice, I'm suggesting that the evidence is  
9 there. And what's not clear to me is whether that  
10 is part of what we should be considering as  
11 evidence.

12 CO-CHAIR PARTRIDGE: Jennifer, does  
13 that help you?

14 MEMBER BRIGHT: It helps me, but it  
15 doesn't convince me.

16 CO-CHAIR PARTRIDGE: Fair enough.

17 MEMBER BRIGHT: I guess my take on this  
18 is -- a follow-up question is would this practice  
19 continue? It's a voluntary measure, number one,  
20 so it's not required, but is your sense that the  
21 measure is required to keep the focus on this  
22 becoming standard of care, because to me that's

1 the purpose of a quality measure, is to both  
2 incentivize and insure that there's a consensus  
3 understanding of what to do to lead to quality.  
4 But if this is (a) a voluntary measure and (b)  
5 not really demonstrating correlation with quality  
6 outcomes, how are we accomplishing that?

7 DR. BERG: So, again, it's -- further  
8 in the discussion, if we get past the initial  
9 vote. But, again, speaking to the gap that  
10 exists, there is a practice gap. And it was noted  
11 that the performance as more providers have been  
12 utilizing the measure, the actual performance has  
13 been diminished, and so based on that performance  
14 gap we believe that there's still a place for  
15 this measure because it's not being utilized by  
16 all of the eligible providers that are actually  
17 reporting the measure.

18 CO-CHAIR PARTRIDGE: Sherrie.

19 DR. GREEN: So this is Dan Green, also.  
20 I mean, I know we're not talking program-  
21 specific, but for parts of Medicare, I mean, we  
22 have over 300 measures in our Ambulatory Quality

1 Reporting Program. We don't require really any  
2 specific measures. We do require some specific  
3 types of measures in the program. Obviously, I'm  
4 sure there are other quality reporting programs  
5 around, but I think we're probably the biggest.  
6 So I understand your point about it not being a  
7 mandatory measure, but just for context, none of  
8 our measures specifically are mandatory because  
9 we can't tell a provider, you know, a particular  
10 measure is or is not inherent to the care that  
11 they give.

12 CO-CHAIR PARTRIDGE: I'm going to go  
13 next to Lisa on the phone because she's been  
14 waiting. Liz, excuse me. Too many L's, aren't  
15 there?

16 MEMBER MORT: Thank you, Lee. I just  
17 wanted to add into the conversation about the  
18 evidence. And I feel that in addition to not  
19 knowing whether assessment of pain and an action  
20 plan leads to outcome, it's worth noting that --  
21 and when I read over the detail that the  
22 specifications for what the action plan are are

1 very broad. It really just means you're looking  
2 for the provider to document that they either  
3 gave medication or made a referral. And I think  
4 that we're really in the throes of trying to  
5 understand how to manage pain better, you know,  
6 in light of the opioid epidemic, Fentanyl, et  
7 cetera. We're all getting lots and lots of  
8 direction, not all evidence-based but we're  
9 getting a lot of direction to back off on  
10 narcotic opioid prescriptions and use other non-  
11 pharmacologic or non-opioid prescriptions. So in  
12 light of the change in the Joint Commission, in  
13 light of what's going on nationally, I feel that  
14 there's too much uncertainty in the best approach  
15 to pain management to endorse the measure at this  
16 point in terms of the evidence.

17 CO-CHAIR PARTRIDGE: Sherrie.

18 MEMBER KAPLAN: I think we're getting  
19 a little bit confused between the two competing -  
20 - I'm hearing two competing kind of issues. One  
21 is the under-detection of pain and suffering, and  
22 the ability of an assessment. And the old wheez

1 is in public health terms if you monitor it,  
2 you'll detect more of it. So, you know, there's  
3 the sort of is pain really being under-evaluated  
4 and, therefore, under-detected and unnecessary  
5 suffering is going on versus the use and  
6 usability issue which is different from the  
7 evidence-base issue of are there going to be  
8 unintended consequences of implementing this  
9 measure in terms of elevating the prescribed --  
10 you know, the number of prescribed opioids, et  
11 cetera, et cetera?

12 So, Sarah, help. Are we drifting into  
13 use and usability here, or are we -- is there --  
14 what's being -- what evidence are we looking  
15 for?

16 MS. SAMPSEL: That's a great question.  
17 I mean, yes, I think there have been some other  
18 questions that have been trending down the use  
19 and usability side, and specifically we're going  
20 to talk about that in that section of the  
21 measure. But, you know, what I can talk about is  
22 the Staff review and the Staff analysis, and to



1 interpret why we gave it as insufficient. And  
2 that was because of the fact that we weren't  
3 able, and we were looking specifically for  
4 clinical guidelines, USPSTF recommendation, or  
5 the empirical evidence citing that the actual  
6 documentation of a pain assessment and actual  
7 documentation of a care plan led to, you know, a  
8 change in the intervention or improvement in the  
9 intervention which then impacted the outcomes,  
10 and we weren't able to find that. But that's not  
11 inconsistent with other pain measures, and other  
12 measures even, you know, kind of how David Cella  
13 has been talking about it, that there are some  
14 things that, you know, it's kind of if you don't  
15 measure it, how are you going to know if it's  
16 happening or not? And, actually, the Palliative  
17 Care Committee reviewed a very similar measure to  
18 this, as well, and they went down the line of  
19 evidence insufficient but how do you argue  
20 against the fact that assessing for pain and  
21 putting a treatment plan in place is not  
22 important? And, therefore, that's how they

1 passed, it was insufficient evidence with  
2 exception, which is available here. So, I do  
3 think it's been going down both paths, and what I  
4 would suggest you all think about is, you know,  
5 first of all the requirement for the process  
6 measure is some kind of guideline or empirical  
7 evidence saying it's a good thing. If not, you  
8 have the exception possibility, and really kind  
9 of -- you know, and I think Jennifer got to the  
10 question, as well, is then, you know, kind of  
11 what does this do with standard of care, and is  
12 there evidence that supports it? And is there the  
13 need for the quality measure, and that's what  
14 we're looking for under importance and evidence.

15 CO-CHAIR PARTRIDGE: I saw a card up  
16 down at the end of the table. Did it go down? No,  
17 all right.

18 MEMBER AVERBECK: A question. You've  
19 had about 10 percent it looks like of eligible  
20 providers submitting. If the goal is around a  
21 screening measure for pain assessment, I'm just  
22 curious because it does require a G-code. Are you

1 finding that the types of practices that are  
2 using it for the intended use is around sort of  
3 general practices, as opposed to practices that  
4 might be dealing more with oncology patients,  
5 palliative care? So just wondering if your field  
6 experience is reflective of what the goal is,  
7 which is to move it towards population screening.

8 CO-CHAIR PARTRIDGE: Jane, I'm not sure  
9 you have the data to answer that, but --

10 DR. BERG: She's furiously looking to  
11 see whether we can answer that question  
12 specifically.

13 MS. LUCAS: It looks like in 2014 we  
14 have the number of claims submitted by  
15 classification of eligible professionals, and it  
16 looks like about 50 percent were chiropractic,  
17 and about 12 percent were rehab and restorative  
18 providers. One of the issues that we have with  
19 trying to drill down into the types of providers  
20 is that there's a pretty large list of providers  
21 that we have, and so we're not always sure which  
22 bucket they will fit into, but pretty much it

1 looks like it's physical therapy and chiropractic  
2 in 2014. And that was the same year that we  
3 actually expanded some of the denominator codes  
4 for others to report.

5 CO-CHAIR PARTRIDGE: All right. If  
6 there are no further questions, I think -- am I  
7 right? I'm sorry, Linda and Lisa.

8 MEMBER MORRISE: I was just going to  
9 suggest that we -- because I'm hearing mixed  
10 responses, that we go ahead with the concept of  
11 no, but exception because I think what we're  
12 looking at here is that there may not be hard  
13 evidence, but we do know that if you don't ask  
14 you're never going to get -- I mean, it's the  
15 first step toward collecting that evidence, and  
16 so if you take that away then we're not going to  
17 get those interventions.

18 The other thing I point out, too, is  
19 kind of what was just brought up, is that this  
20 isn't just for physician practices, but was meant  
21 for expanded use across those who may be  
22 assessing pain, so physical therapists,

1       chiropractors, et cetera.

2                   CO-CHAIR PARTRIDGE: Linda?

3                   MEMBER MELILLO: Yes. It's my  
4       understanding that physical medicine and  
5       rehabilitation is one of the few specialties  
6       that's not required to submit quality data. Is --  
7       does anybody -- is CMS still on the phone? I  
8       believe that's the case, so how would you go  
9       about -- if -- I mean, you would want to include  
10      those folks, including the outpatient physical  
11      therapy, so how would you get data from those  
12      populations if they're not reporting quality  
13      measures?

14                  DR. GREEN: This is Dan Green, again,  
15      from CMS. PM&R are not excluded from PQRS, for  
16      example, and physicians practicing in physical  
17      medicine and rehab, at least as proposed under  
18      MACRA and the MIPS program will also not be  
19      excluded from participation. In fact, they have  
20      to participate or suffer reimbursement  
21      adjustment.

22                  CO-CHAIR PARTRIDGE: I am watching the

1 clock a little bit. We still have more work to do  
2 on this measure before we conclude, but I think  
3 it is time to take our first vote. And Sarah is  
4 going to tell me exactly what we're voting on so  
5 you all are clear.

6 MS. SAMPSEL: Yes, I will do that.  
7 Suzanne just took a drink of water. So the first  
8 thing we are going to vote on is the evidence,  
9 and should -- we'll see how these votes come out,  
10 but should the majority fall under insufficient  
11 is when we'll talk about the exception, and we'll  
12 let the voting tell us which way to go. So,  
13 basically, what you're voting on now will be  
14 evidence and, Desi, are you ready to take over?

15 MS. QUINNONEZ: Yes. So we are going to  
16 be voting on Measure 0420. For those who are on  
17 the phone the first option is high, second option  
18 is moderate, three is low, and four is  
19 insufficient. So option one is high, two is  
20 moderate, three is low, and four is insufficient.  
21 So voting is now open for evidence.

22 MS. THEBERGE: Just a reminder for our

1 Committee Members on the phone, please submit  
2 your votes via the chat. Thank you.

3 MS. QUINNONEZ: We're looking for 21  
4 votes so we're almost there. Okay, voting -- all  
5 votes are in and voting is now closed. So for  
6 option one we have zero percent who voted for  
7 high, 33 percent for moderate, 24 percent for  
8 low, and 43 percent for insufficient. So this  
9 measure fails for evidence.

10 MS. SAMPSEL: Sorry, we've never seen  
11 numbers like this before. Hold on a minute. So  
12 the measure did not fail. Basically, what we  
13 would do is take the moderate plus the  
14 insufficient and move forward, and we do think we  
15 should vote on the evidence with exception  
16 because of the high percentage under insufficient  
17 and continue the conversation, but the reality is  
18 consensus was not reached on this so we'll  
19 continue the discussion, move forward and  
20 there'll be an opportunity for reconsideration  
21 and revoting after public comment. But let's move  
22 forward to evidence with exception just so we

1 know what that result would be.

2 MS. QUINNONEZ: Okay. We will be voting  
3 for evidence with exception for Measure 0420.  
4 Option one is insufficient evidence with  
5 exception, and option two is no exception. You  
6 can submit your votes.

7 MEMBER SALIBA: This is Deb. Can you  
8 please explain what no exceptions means in this  
9 particular vote?

10 CO-CHAIR PARTRIDGE: It's no  
11 exceptions. It's with exception.

12 MEMBER SALIBA: I'm sorry. So the first  
13 option is -- it's not showing up on my screen  
14 what the options are.

15 MS. QUINNONEZ: Yes, I'll repeat. I'm  
16 sorry. Option one is insufficient evidence with  
17 exception, and option two is no exception.

18 MEMBER SALIBA: Yes, I was asking what  
19 -- if you could give me some definitions of what  
20 number two, no exception, means.

21 MS. SAMPSEL: It basically means that  
22 you do not feel that the measure should move



1 forward, so it would fail on evidence. So  
2 insufficient evidence with exception means that  
3 you -- you know, there may not be enough evidence  
4 available to support the exact measure construct  
5 but you feel it's an important enough measure  
6 despite the lack of evidence. The no exception  
7 means you don't agree that it doesn't matter what  
8 you do with providing more evidence, you still  
9 don't believe that the measure should be  
10 supported based on no evidence.

11 MEMBER SALIBA: Thank you very much,  
12 that's helpful. Thank you.

13 MS. THEBERGE: Deb, we still need a  
14 vote from you. Thank you.

15 MEMBER SALIBA: Did you get the vote?

16 MS. THEBERGE: Yes.

17 MEMBER SALIBA: Okay.

18 MS. THEBERGE: Can everyone vote one  
19 more time?

20 MS. QUINNONEZ: There we are, we have  
21 it now. Voting is now closed for evidence with  
22 exception for Measure 0420. The results are 90

1       percent voted yes for insufficient evidence with  
2       exception, and 10 percent voted for no exception.  
3       Voting is now closed for the evidence with  
4       exception for Measure 0420.

5               CO-CHAIR PARTRIDGE: Moving on, Sarah,  
6       you have to help me tee up the next part of our  
7       discussion.

8               MS. SAMPSEL: Sure, we'll just move to  
9       the next set of criteria and so that if -- and,  
10      Kirsten, if you want to scroll down on the  
11      measure information form now, going into the  
12      performance gap and opportunity for improvement,  
13      and starting with the lead discussants, if you  
14      had any comments about that. And we can start  
15      thinking about has it already been said, is there  
16      anything you want to -- because I think we  
17      crossed over into this a little bit, but are  
18      there any remaining comments about performance  
19      gap, because there have been some discussions  
20      about disparities and percentage of providers  
21      reporting, stuff like that.

22              MEMBER CELLA: This is Dave Cella, just

1 to say I agree with the review, and have nothing  
2 to add. There are disparities on this measure.

3 CO-CHAIR PARTRIDGE: Any of our other  
4 lead discussants want to add to David's comment?

5 MEMBER MELILLO: Yes, this is Linda.

6 CO-CHAIR PARTRIDGE: Linda.

7 MEMBER MELILLO: My only comment is  
8 that from a patient-centric perspective outcome  
9 would be really important, as well. So I know  
10 that there's a process when you have to reporting  
11 first, but just to keep that in mind.

12 CO-CHAIR PARTRIDGE: Any further  
13 comments? Okay, then we can proceed to vote.

14 MS. QUINNONEZ: Voting is now open for  
15 performance gap for Measure 0420. Option one is  
16 high, option two is moderate, option three is  
17 low, and option four is insufficient. All votes  
18 are in and voting is now closed for performance  
19 gap for Measure 0420. We have 43 percent high, 57  
20 percent moderate, zero percent low, and zero  
21 percent insufficient.

22 MS. SAMPSEL: So we'll go ahead and

1 move forward and back to the lead discussants to  
2 start talking about scientific acceptability,  
3 specifically reliability. And the first question  
4 there is about specifications.

5 MEMBER CELLA: This is Dave Cella. I  
6 think -- is this a category that doesn't require  
7 a vote necessarily, because it's a maintenance  
8 measure?

9 MS. SAMPSEL: So technically, Dave,  
10 yes, except for the specifications have changed  
11 considerably over time. The first --

12 MEMBER CELLA: Okay. Well, I was just  
13 -- I would just say, and to repeat the  
14 conversation earlier, with regard to the PRO-PM  
15 that is the performance measure, reliability is  
16 very high. This is not about whether pain is  
17 reliably measured itself but whether the pain  
18 performance measure -- the performance measure of  
19 pain assessment and treatment plan was  
20 documented. The reliability is quite high, so I  
21 would give it a pass.

22 CO-CHAIR PARTRIDGE: Any other

1       comments? All right, ready?

2               MS. SAMPSEL: Desi, are you ready to  
3       move forward?

4               MEMBER KAPLAN: Are we voting on the  
5       whole reliability issue or just the specs part?

6               MS. SAMPSEL: We vote on the whole  
7       reliability, so if there are any additional  
8       comments about the testing of the measure as it's  
9       been retested?

10              CO-CHAIR PARTRIDGE: Sherrie.

11              MEMBER KAPLAN: You have to help me  
12       with this because this may be one of those issues  
13       where the rules may be about to change and are  
14       not applicable in this circumstance. But the  
15       between provider variance doesn't look very big,  
16       and if you -- I don't know if you actually tested  
17       the reliability at the provider level because the  
18       unit being compared listed is the clinician or  
19       the group level, but the reliability data  
20       provided were kappa agreements and it looks like  
21       patient level. So can you help us understand what  
22       between -- is that a fair issue, or not?

1 MS. SAMPSEL: Yes. No, they should talk  
2 about their --

3 MEMBER KAPLAN: Okay. So if it's being  
4 used at the provider level, what did you do to  
5 test the reliability at the provider level like  
6 intraclass correlation coefficients? What  
7 proportion of the variance -- you provided  
8 something here that says that only 10 percent of  
9 the variation is attributable to the provider.

10 DR. BERG: Gary, can you answer that  
11 question?

12 MR. REZEK: Yes, I don't think that the  
13 percent of the variance attributable to the  
14 provider was not something we provided, I don't  
15 believe. The -- so the performance score  
16 reliability, the signal to noise data was based  
17 on all of the claims and registry data. We tested  
18 each separately reported. And, again, I'm not  
19 quite clear on what the question is, but we also  
20 did -- so the kappa results are basically a  
21 sample of that data where we extracted data from  
22 the medical record between two independent

1 reviewers to basically test repeatability of the  
2 measure spec. So the inter-rater reliability with  
3 the kappa is essentially a different analysis  
4 than the performance measure score reliability.

5 MEMBER KAPLAN: So on page 41 there's  
6 a column listed between provider variance, and it  
7 suggests that there's only like 10.5 percent of  
8 the variance is attributable to providers so I  
9 wasn't clear what that meant. Did you do the --  
10 did you test this at the provider level versus  
11 just the agreement between two data sources?

12 MR. REZEK: Yes, that is at -- that is  
13 variance at the provider level between providers  
14 defined by basically NPI.

15 MEMBER KAPLAN: So just to make sure I  
16 understand, 10.5 percent of the variance in the  
17 claims data, for example, was attributable to the  
18 between provider variance.

19 MR. REZEK: I think that that's a fair  
20 interpretation.

21 MEMBER MELILLO: So this is Linda. On  
22 one of the submission pages, I have the form,

1 page 3 where you note performance variation,  
2 showing that 90.6 percent are in the 25th  
3 percentile, and there is nobody lower than that.  
4 Just that there's a very high floor for this  
5 measure, and I was wondering how you interpret  
6 that?

7 MR. REZEK: Yes, I would say the  
8 performance scores are sort of highly skewed  
9 towards high performance. Again, I think where we  
10 sort of have difficulty making -- the problem is  
11 we have only 10 percent of eligible providers  
12 reporting so it's kind of difficult to generalize  
13 that, you know, that high performance across the  
14 entire population.

15 MEMBER MELILLO: Okay, so the majority  
16 of those who are reporting are doing well,  
17 obviously. Do you feel that the ones that are not  
18 reporting perhaps are not doing as well?

19 MR. REZEK: That is certainly not  
20 something that I would --

21 MEMBER MELILLO: Okay.

22 MR. REZEK: -- that I have information



1 to --

2 (Simultaneous speaking)

3 MEMBER MELILLO: It just struck me  
4 there was a very high --

5 CO-CHAIR PARTRIDGE: I think that's  
6 always an issue with a voluntary measure.

7 MEMBER MELILLO: Yes.

8 DR. GREEN: Well, that's exactly right.  
9 This is -- from our experience with PQRS we can't  
10 say with certainty that the folks that aren't  
11 reporting are not performing as well but,  
12 obviously, people tend to pick the measures that  
13 they do perform more highly on. When there's a  
14 small percentage of folks reporting, we can't  
15 conclude that the measure is tapped out because  
16 the argument is well, what about the other 80  
17 percent of folks who are not reporting, for  
18 example? So we can't say with certainty your  
19 assumption, but that's some of the general  
20 feeling behind them.

21 MEMBER MELILLO: Yes. Okay, thank you.

22 CO-CHAIR PARTRIDGE: Are we ready to

1 vote?

2 MS. QUINNONEZ: All right. Voting is  
3 now open for reliability. Oh, one comment?

4 MEMBER CELLA: No, okay, it's okay.

5 MS. QUINNONEZ: Voting is now open for  
6 reliability of Measure 0420. First option is  
7 high, second option is moderate, three is low,  
8 four is insufficient. First option high, second  
9 option moderate, third option low, and four for  
10 insufficient. Okay. All the votes are in and  
11 voting is now closed. For reliability of Measure  
12 0420, 24 percent voted high, 67 percent voted  
13 moderate, 5 percent voted low, and 5 percent  
14 voted insufficient. Measure 0420 for reliability  
15 passes the reliability criterion.

16 MEMBER CELLA: Okay, for validity?

17 CO-CHAIR PARTRIDGE: Yes, on to  
18 validity.

19 MEMBER CELLA: Lee, that was me that  
20 caused you to wonder if there was still someone  
21 just wanting to say something. This is Dave  
22 Cella, again. I think that the latter half of

1       that reliability conversation is actually a  
2       relevant validity conversation, and I think the  
3       validity is a little less than high, a little  
4       less than clear, also partly related to the  
5       original evidence conversation.

6               I want to just maybe clarify that in  
7       this case what we're talking about with regard to  
8       validity is the validity of that measure as a way  
9       of differentiating physicians with practices,  
10      clinicians with practices on equality and not  
11      necessarily our earlier conversation about the  
12      validity of the measure in terms of improving  
13      care. Is that right? I know that's -- that might  
14      sound like a non-distinction, but --

15              CO-CHAIR PARTRIDGE: Chris is nodding  
16      his head, David.

17              CO-CHAIR STILLE: Yes. David, I get  
18      what you're saying, and I think that's a very  
19      important point.

20              MEMBER CELLA: Okay. So, you know,  
21      along the lines of, I think, what Sherrie was  
22      pointing out and asking about in the

1 conversation, if you go to 2b5 on the meaningful  
2 difference, you'll notice that this 25th  
3 percentile even though the mean is 82 percent,  
4 the 25th percentile is 91 percent if you average  
5 up, round up, so there's a -- it's a voluntary  
6 program of a small percentage of eligible people.  
7 And, apparently, there's a small group of people  
8 that are probably doing really badly to pull that  
9 mean down from a median of 100 percent because  
10 there's some people that are participating and  
11 just making sure they do it all the time, in fact  
12 more than half. There's a group that's  
13 participating and maybe they don't realize  
14 they're participating and maybe not documenting  
15 at all. So I guess it's a matter in terms of the  
16 way I'm thinking of it is, you know, do you look  
17 at this glass as half full or half empty? Within  
18 this narrow band of voluntary participants  
19 there's a subgroup of something less than 25  
20 percent, maybe only 10 percent given the  
21 distribution statistics we have that are really  
22 not doing very well at all. And then the question

1 is, is that distribution which was probably  
2 contributing to the good reliability but low  
3 coefficient that Sherrie pointed out. Is that  
4 enough to be not considered a valid measure? And  
5 I think that may be part of why the Staff review  
6 came down moderate at its evaluation. That's  
7 probably where I land, too, although it's kind of  
8 moderate tipping to low in my mind. Welcome other  
9 discussion.

10 CO-CHAIR PARTRIDGE: Further  
11 discussion?

12 MEMBER CELLA: Oh, maybe just one other  
13 thing. I'm sorry, Lee. Another thing that I  
14 didn't mention that's factoring into that is that  
15 low response rate. You know, we don't know about  
16 89 percent of eligible people. I don't know how  
17 that plays out as a voluntary measure. That just  
18 means you do it if you're -- if you want to  
19 include it in your panel of performance measures.

20 CO-CHAIR PARTRIDGE: Chris.

21 CO-CHAIR STILLE: This is kind of a  
22 shot in the dark but apropos of David's question.

1 You don't have a visual representation of the  
2 distribution of responses at all?

3 DR. BERG: Do we? I don't believe that  
4 we've prepared one in that way. We could provide  
5 it for the Committee as a follow-on, but we don't  
6 have that right now.

7 MEMBER CELLA: But you do see -- I'm  
8 sorry to interrupt, but you do see that the 10th  
9 percentile is zero so, you know, if there's  
10 essentially not a lot of people between zero and  
11 -- between 1 and 90, so it's just a pretty good  
12 group of people that are just not doing it at  
13 all.

14 CO-CHAIR PARTRIDGE: Sherrie.

15 MEMBER KAPLAN: I guess to follow-up on  
16 David's issue, the issue -- if this is going to  
17 be used at the clinician level, then some  
18 demonstration that it actually discriminates  
19 practices or clinicians one from another would  
20 really be helpful. And if you've got a skewed  
21 distribution problem that's going to be an issue,  
22 and it's going to be tough in a voluntary

1       measure. So in fairness to the measures  
2       developers, that kind of skew in distribution  
3       you're really going to see meaningful -- you may  
4       be able to demonstrate meaningful differences but  
5       they're going to be -- or differences but they're  
6       going to be so small they wouldn't necessarily  
7       even be meaningful. So if this is only going to  
8       find those few outliers that really have, you  
9       know, the -- that really are providing crummy  
10      care, as mentioned by your current -- the way  
11      it's currently being developed, you know, I think  
12      we're kind of struggling with if only this had a  
13      better distribution, but what we're staring at is  
14      the discriminative, the discriminate validity  
15      isn't really optimal.

16               DR. BERG: And again, as it's been  
17      pointed out it is a voluntary measure, and so  
18      those who are reporting the measure are most  
19      likely going to be concentrating on that. I guess  
20      one could draw a certain sense of satisfaction  
21      from the idea that those who are measuring it are  
22      concentrated on using that measure, as well. But,

1 again, there are -- as has been pointed out  
2 there's a small portion that are not performing  
3 well that causes that, you know, overall -- the  
4 overall performance rate, you know, amongst all  
5 that are using it is still down around 82  
6 percent, and so there is room for improvement  
7 there.

8 MEMBER BRADLEY: I had a question, and  
9 I guess it relates to the performance and the  
10 voluntary participation because there are other  
11 measures of pain that other -- that clinicians  
12 are using and reporting in addition to this one.  
13 So is this one -- do you envision this being on  
14 top of or in place of, or -- and does that speak  
15 to why you have such low participation because  
16 perhaps they're using other measures to report --

17  
18 MS. SOMPLASKY: This is Nancy  
19 Somplasky, and I apologize, I was unable to get  
20 through on a speaking line until a few minutes  
21 ago. I'm the Director for this project, so I did  
22 want to offer up some background to help folks



1 understand both the history of this measure, but  
2 why the importance of it.

3 The PQRS program allows for non-  
4 physicians, physical therapists, occupational  
5 therapists, psychologists, social workers to  
6 report. This was originally intended as a non-  
7 MD/DO, non-physician type measure so that those  
8 physical therapists and occupational therapists  
9 would have a measure to be able to report. It was  
10 so -- it was well received and thought to be  
11 important enough that we did have a request from  
12 chiropractors to expand to include those MD/DO  
13 measures, but it is a claims and registry based  
14 measure only. So folks who -- which many folks  
15 now with the adoption of electronic health  
16 records are reporting electronic pain measures or  
17 using their EHR to report their PQRS, their  
18 voluntary PQRS reporting program. These measures  
19 are only claims or registry based, so what we  
20 find is that if a physical therapist is not  
21 linked to the Medicare reporting, they are not  
22 able to -- they may be measuring the pain but

1 they're not able to report that. And that's been  
2 an important distinction that we've heard that  
3 within certain health systems they may not be the  
4 ones who actually have the billing that  
5 submission go in because this is submitted via a  
6 claims form into CMS for the program. It's a  
7 little bit different than what you might see in a  
8 hospital for electronic reporting, and certainly  
9 from a physician practice where I think the mind  
10 set tends to be for a lot of the measures being  
11 reported.

12 CO-CHAIR PARTRIDGE: Thank you. I hope  
13 we're ready to proceed to vote on validity. Desi?

14 MS. QUINNONEZ: Yes. Voting is now open  
15 for validity of Measure 0420. Option one is high,  
16 option two is moderate, option three is low, and  
17 option four is insufficient.

18 MS. THEBERGE: Deb, we still need your  
19 vote.

20 MS. QUINNONEZ: Okay, voting is now  
21 closed for the validity of Measure 0420. We have  
22 10 percent voted high, 52 percent voted moderate,

1 29 percent voted low, and 10 percent voted  
2 insufficient. Measure 0420 for validity has  
3 entered the gray zone. Now it passes, this  
4 measure passes.

5 MEMBER CELLA: Feasibility. This is --  
6 feasibility is high. It's administrative data  
7 primarily. It's been in use.

8 CO-CHAIR PARTRIDGE: Looks to me as  
9 though there are no further comments so, Desi, I  
10 think you're up again.

11 MS. QUINNONEZ: All right. We are  
12 voting for feasibility for Measure 0420. Option  
13 one is high, option two is moderate, option three  
14 is low, and option four is insufficient. Okay,  
15 we're waiting for one more vote. Voting is now  
16 closed for feasibility of Measure 0420. Option  
17 one, 67 percent voted high, 29 percent voted  
18 moderate, 5 percent voted low, and zero percent  
19 voted insufficient. For feasibility Measure 0420,  
20 feasibility.

21 CO-CHAIR PARTRIDGE: Usability and use.  
22 David, any comments?

1                   MEMBER CELLA: Yes, it's also high,  
2                   although, I would add that we probably should at  
3                   least mention the potential unintended  
4                   consequence of narcotic overuse, although I think  
5                   the benefits of the measure outweigh the  
6                   potential. There's no data that that's the case,  
7                   but it's on everyone's mind so I thought I would  
8                   mention it. I think the benefits outweigh the  
9                   potential.

10                  CO-CHAIR PARTRIDGE: Sherrie.

11                  MEMBER KAPLAN: Sarah, can you -- is  
12                  there an opportunity to put some comment in from  
13                  the Committee about monitoring unintended --

14                  CO-CHAIR PARTRIDGE: Yes.

15                  MEMBER KAPLAN: -- consequences of the  
16                  use in case, you know --

17                  CO-CHAIR PARTRIDGE: Absolutely. I  
18                  think, actually, as the summary of this  
19                  discussion this morning is written up you will  
20                  clearly see that reflected because it came up  
21                  right in the very beginning. Any other -- yes,  
22                  I'm sorry. Lisa, right in front of me.

1                   MEMBER MORRISE: I'm just going to say  
2                   that while asking about pain is not the same and  
3                   developing the care plan is not the same as  
4                   overuse per se, I would point out that in the  
5                   case of many individuals I know with chronic  
6                   complex conditions, they actually tend to under-  
7                   report their pain because they are so used to it.  
8                   So while some people may game the system as Linda  
9                   suggested to overreport their pain because they  
10                  are seeking, there are others who don't want  
11                  intervention, who do the same thing going the  
12                  other direction, and that's a different study. So  
13                  I think in terms of the usability, it's easy to  
14                  use. You ask the question, you develop the plan.  
15                  So that's my insight.

16                 MEMBER CELLA: Agree.

17                 MS. QUINNONEZ: Voting is now open for  
18                 usability and use of Measure 0420. Option one is  
19                 high, option two is moderate, option three is  
20                 low, and option four is insufficient information.  
21                 We're looking for three more votes. Okay, all  
22                 votes are in and voting is now closed. For

1 usability and use of Measure 0420, 48 percent  
2 voted high, 52 percent voted moderate, zero  
3 percent voted low, and zero percent voted  
4 insufficient information. Usability and use  
5 passes for Measure 0420.

6 CO-CHAIR PARTRIDGE: Before we take the  
7 final vote on this measure are there any other  
8 comments either from David and company on the  
9 phone or here in the room? If not ---

10 MEMBER CELLA: None here.

11 CO-CHAIR PARTRIDGE: Okay. Sarah?

12 MS. QUINNONEZ: Okay. Voting is now  
13 open for the recommendation for overall  
14 suitability for endorsement for Measure 0420.  
15 Option one is yes, option two is no.

16 CO-CHAIR PARTRIDGE: I think I'm  
17 confused. Could we go back to the evidence  
18 insufficient with exception issue? If we didn't  
19 reach consensus on that point, but we passed  
20 everything else, we can now vote yes or no up or  
21 down for recommending to go forward. Is that  
22 correct?

1 MS. SAMPSEL: That's correct.

2 CO-CHAIR PARTRIDGE: Okay.

3 MS. QUINNONEZ: Okay, so we're still  
4 looking for votes for overall suitability for  
5 recommendation for endorsement for Measure 0420.

6 MS. THEBERGE: Liz, we need a yes or a  
7 no? Thank you.

8 MS. QUINNONEZ: All votes are in, and  
9 voting is now closed; 95 percent voted yes, 5  
10 percent voted no. For Measure 0420, this measure  
11 has passed the usability and use criterion.  
12 Excuse me, this measure has passed for  
13 recommendation for endorsement.

14 MS. SAMPSEL: So just a couple of  
15 comments here. So, first of all, you know, that  
16 first vote about, as Lee brought up about the  
17 evidence where consensus was not reached, but  
18 then there was the pass with exception. What  
19 we're going to do there is during -- accept  
20 public comment when this measure goes out for  
21 public comment, and should anything come up in  
22 public comment you'll have an opportunity to re-

1 discuss in your post-comment call and reconsider  
2 if anything is changed. In the same mechanism the  
3 developers have an opportunity if they want to  
4 pull together more evidence, provide that to you  
5 during that public comment section, as well, for  
6 re-discussion to see if that vote changes.

7 We've done this in the past where you  
8 all, you know, get all the information and you  
9 make the decision do you want to re-vote or no  
10 re-vote, but I think we have a clear indication,  
11 or a pretty clear indication that overall this  
12 measure is suitable for endorsement. There are  
13 some kind of open questions on how to translate  
14 that evidence piece.

15 The other thing we just wanted to  
16 mention here and kind of because that area was so  
17 questionable, we would typically have a related  
18 or competing conversation, but I think -- and we  
19 would draw your attention to the related and  
20 competing section of the measure evaluation form  
21 where -- and the original measure information  
22 form that Quality Insights presented. There are a



1 number of measures that are identified as  
2 related, but Quality Insights also provided a lot  
3 of information on why those measures are  
4 different, and so would technically be related  
5 measures.

6 If you have any comments now about  
7 opportunities for harmonization, the overall need  
8 for measurement on pain, the overall need for  
9 measure developers to be working together to be  
10 measuring pain and documenting correctly, I think  
11 we've pulled out a lot of those in the  
12 discussion, the overuse issues, potential under-  
13 use issues, and how to translate those, but this  
14 would be the time where if you have any final  
15 comments about what the developers should think  
16 about related to pain measures, this is where we  
17 would have them.

18 MEMBER CELLA: Can I make a comment  
19 there?

20 CO-CHAIR PARTRIDGE: Yes, David, go  
21 ahead.

22 MEMBER CELLA: This is Dave. It's

1 really an encouraging or maybe even a pressuring  
2 to move to pain as an outcome, as a reported  
3 outcome measure. This is a process measure, and I  
4 think a few people, I being one of them, you  
5 know, have commented on that along the way but I  
6 don't think it came out as an explicit, I guess,  
7 position or perspective of the Committee. I don't  
8 know if others agree with that, but I'd like to  
9 see it move in that direction.

10 CO-CHAIR PARTRIDGE: Linda.

11 MEMBER MELILLO: Yes, just that a lot  
12 of the patient satisfaction surveys include  
13 questions on pain, and so that might be an  
14 opportunity to see if you can match those  
15 numbers, correlate. Thank you.

16 CO-CHAIR PARTRIDGE: Becky.

17 MEMBER BRADLEY: Just to clarify that  
18 last conversation from the person from CMS that  
19 gave us the history of this measure, so it's  
20 currently only being reported in the physician  
21 quality reporting as a voluntary measure but it  
22 was intended for other providers to be able to

1 report quality measures, so I'm a little confused  
2 now as to the sample that you selected to review.  
3 Is it from the Physician Quality Reporting  
4 Program only, or was it from the other providers  
5 that are submitting claims for this?

6 DR. BERG: So the PQRS Program has  
7 expanded to include a number of eligible  
8 professionals now.

9 MEMBER BRADLEY: Okay.

10 DR. BERG: So it includes those  
11 professionals for whom this measure was  
12 originally built.

13 MEMBER BRADLEY: Intended.

14 DR. BERG: And so as I indicated in our  
15 introduction, we built it specifically for the  
16 physical therapists, and then as was mentioned  
17 chiropractors were added. And then it became part  
18 of the PQRS Program after the original  
19 development of the measure.

20 MEMBER BRADLEY: Okay.

21 CO-CHAIR PARTRIDGE: I see a card up at  
22 the end of the table.

1                   MEMBER AVERBECK: Yes, one other  
2                   comment. As this measure concept matures to take  
3                   a look at both pain and function, because it  
4                   could be that either decrease in pain but may not  
5                   be completely pain-free, and that balance that  
6                   sometimes it's around improving your function and  
7                   balancing that with the level of pain. Thank you.

8                   CO-CHAIR PARTRIDGE: So it's been a  
9                   long discussion, and as you predicted when you're  
10                  the first measure up you've probably got a lot of  
11                  questions that will be abbreviated as we work on  
12                  some of the others, but frankly, I doubt it.

13                  We were scheduled to take a break, we  
14                  are going to take a break. I'm going to ask that  
15                  in order to keep us more or less close to our  
16                  agenda's time frame that we make it 10 minutes  
17                  rather than 15, so back at 11:10, if I'm seeing  
18                  the clock correctly, and same for our folks on  
19                  the phone. Thank you for staying with us.

20                  (Whereupon, the above-entitled matter  
21                  went off the record at 11:00 a.m. and resumed at  
22                  11:14 a.m.)

1 CO-CHAIR STILLE: Okay. Welcome back.  
2 We are going to begin discussion of Measure 2967,  
3 the package of Home and Community Based Services  
4 Experience of Care Measures, developed by CMS.

5 Lead discussants will be Lee and  
6 Nicole, and I think Len, right? And Liz Mort  
7 also on the phone. And we'll have a three minute  
8 introduction by the measure developers. So,  
9 welcome, and take it away.

10 DR. LIDA: Good morning. Can everyone  
11 hear me? Okay. I'm Kerry Lida with CMS. And  
12 I'm in the Division for Community Systems  
13 Transformation and the Disabled and Elderly  
14 Health Programs Group. Guess not. Okay. Let's  
15 try it again.

16 And I'd like to briefly introduce our  
17 team who's been participating in this, and  
18 working on this. The experience of care area of  
19 work is about five years in existence at this  
20 time.

21 And so, I'd like to introduce Dr. Beth  
22 Jackson with Truven Health, and also Dr. Coretta

1 Mallery, with American Institutes of Research,  
2 AIR.

3 On the line we should have other  
4 colleagues from CMS joining us, including Jean  
5 Close, who's our deputy director for this  
6 division. And in the room also we have Allison  
7 Weaver, who works with this area of work with us.

8 And I'd like to briefly introduce some  
9 of the background information. And this will be  
10 very short, again, two minutes. Why we developed  
11 this area of work.

12 There is no cross disability  
13 beneficiary reported measures of service quality  
14 or experience with Medicaid HCBS, Home and  
15 Community Based Services.

16 And again, this developed over five  
17 years, beginning with NQE, the National Quality  
18 Enterprise, a grant. And most recently with the  
19 TEFT demonstration, Testing Experience and  
20 Functional Tools.

21 The development testing of these  
22 measures is directly related to a measurement gap

1 that was recently pointed out in the 2015 report  
2 by NQF. Can everyone hear me?

3 CO-CHAIR STILLE: You're a little soft.

4 DR. LIDA: Okay. And the quality  
5 report notes that there is a lack of systematic  
6 measurement of quality of HCBS across payers and  
7 delivery systems.

8 A brief overview of who the population  
9 is that we're serving, home and community based  
10 services. Persons receiving supportive Medicaid  
11 services so they can live at home and participate  
12 in community life and employment.

13 I know a number of you are very  
14 familiar with the recent shift in spending that  
15 we identified also within the background for  
16 this. We are over the 50 percent mark of  
17 spending for home and community based services,  
18 as opposed to the institutional services at this  
19 time.

20 Again, as it was noted, we submitted  
21 a package, including 19 experience of care  
22 measures, including seven scale measures, global

1 rating measures and recommendations, and  
2 individual items measures.

3 The importance of measures on Home and  
4 Community Based Services Experience of Care, CMS,  
5 and state Medicaid agencies both -- we require  
6 information on performance of Home and Community  
7 Based Services, providers and programs.

8 And the focus on the experience of  
9 care is very consistent with the recent rule in  
10 the end of 2014, that CBS rule, with the focus on  
11 person centered care, and person centered  
12 planning.

13 And the use of the measures that we  
14 are intending, states can voluntarily use these  
15 results for quality improvement and public  
16 reporting. We are using these in current  
17 demonstrations.

18 I noted the TEFT demonstration of  
19 which we have eight states participating at this  
20 time. This was part, and it was also continued  
21 from the NQE, where we had the field test data.

22 Round 2 for TEFT is going to be



1 starting very soon. And those eight states will  
2 be testing, will be using it again there.  
3 There's a broader interest of experience of care  
4 measures.

5 We have five states who have indicated  
6 they would like to use these at this time,  
7 including Pennsylvania, Massachusetts, Oregon,  
8 Nevada, Louisiana. We've had additional requests  
9 for information from MACPAC, AARP, researchers  
10 and MCOs.

11 We do plan a roll out of the data  
12 source for the experience of care areas of work,  
13 after we receive the CAHPS trademark, which is  
14 pending at this time.

15 And also, we have integrated the  
16 experience of care areas of work with a close  
17 project with the Office of the National  
18 Coordinator for an electronic long term services  
19 and supports plan that we're developing as part  
20 of the TEFT demonstration also.

21 So, thank you for your consideration  
22 of these areas of work. We sincerely appreciate

1 the opportunity to share this information with  
2 you today.

3 And I will turn to the next, I'll turn  
4 it back to our leads for the next steps, and what  
5 I anticipate will be a robust discussion that  
6 will continue. So, thank you.

7 CO-CHAIR STILLE: Okay. Thank you.  
8 So this is a package of 19 different measures,  
9 measured, I believe the unit of measurement is at  
10 the state level, what you've done you analysis  
11 as?

12 DR. JACKSON: At the state program  
13 level.

14 CO-CHAIR STILLE: That state program  
15 level.

16 DR. JACKSON: The state program level.

17 CO-CHAIR STILLE: Okay.

18 DR. JACKSON: Yes.

19 CO-CHAIR STILLE: Okay. Combining  
20 different providers that you've worked with?

21 DR. JACKSON: Yes. And there --

22 CO-CHAIR STILLE: Okay.

1 DR. JACKSON: There are multiple  
2 programs typically, HCBS programs per state.

3 CO-CHAIR STILLE: Okay. Okay. Great.  
4 Good. During the break we had talked about how  
5 to ideally try to get all of these discussed  
6 within an hour. With some preliminary comments  
7 that we've received, it's obvious that a few of  
8 the measures may require some separate  
9 discussion.

10 And what we've decided is that there  
11 may be one or more that actually require a  
12 separate voting. That if one requires separate  
13 voting, then we'll have to do a separate vote for  
14 all of the different parameters for that  
15 particular measure.

16 But then there are many others that  
17 may be able to be considered in one lump. So  
18 that's kind of how we're going to run things. I  
19 will turn it over to the lead discussants now to  
20 get into some of these things. And who would  
21 like to start?

22 CO-CHAIR PARTRIDGE: I will.

1 CO-CHAIR STILLE: Lee would like to  
2 start.

3 CO-CHAIR PARTRIDGE: I don't know that  
4 I'd like to, Chris, but --

5 CO-CHAIR STILLE: Okay.

6 CO-CHAIR PARTRIDGE: I should just, in  
7 all fairness to our developers and to my  
8 colleagues, should point out here that I was a  
9 state Medicaid director for almost ten years.

10 And I -- in our particular  
11 jurisdiction it didn't have any HCBS programs,  
12 per se. Because we had an extremely broad  
13 benefit package. And most of the kinds of things  
14 that people were discussing at that point, that  
15 would be in a HCBS program, we were already  
16 approving as just standard care.

17 Since then the HCBS program I think  
18 has morphed into covering categories that most of  
19 us would consider marginally medical, a lot of  
20 physical adaptation, et cetera, all of which are  
21 good and critical to this program.

22 So, my first question, Chris actually

1 already asked, which is, we are not measuring at  
2 the state level, we are measuring at the state  
3 program level.

4 If you wanted to measure at the state  
5 level you would presumably take the average,  
6 let's say the state had ten programs, their  
7 average score. And that would be that state's  
8 score. And then we would look across the state.  
9 But we are talking at program level.

10 We have a 95 question survey? Am I  
11 reading that correctly?

12 DR. JACKSON: You are. You're correct.  
13 However, there are many skip patterns within the  
14 instrument.

15 CO-CHAIR PARTRIDGE: I know.

16 DR. JACKSON: So not all items are  
17 asked of the beneficiary, the program  
18 participant.

19 CO-CHAIR PARTRIDGE: Right. But for  
20 those of you who work with other CAHPS tools, and  
21 this one I know is up for endorsement, but maybe  
22 not there yet. Ninety-five questions overall is

1 a pretty big gulp, and can take a fair amount of  
2 time to administer.

3 And I think we'll get into those  
4 questions when we get to usability and  
5 feasibility. But, you know, right now when I  
6 looked at this initially, I thought, this is  
7 expensive. Particularly since we're still  
8 talking mail or telephone follow-up. And, Sam.

9 MEMBER BIERNER: I just, I'm still  
10 trying to understand the state program. Can you  
11 give me a feel for how many -- how big is the  
12 denominator? How many potential, are these each  
13 individual, you know, provider surveys, like a  
14 home base provider? Like, is there 100 in a  
15 state?

16 CO-CHAIR PARTRIDGE: No.

17 MEMBER BIERNER: How many are you  
18 talking?

19 CO-CHAIR PARTRIDGE: You're typically  
20 talking -- I'm out of date. I haven't been a  
21 director for a good many years. But I keep up.  
22 And I would guess that in a lot of states you're

1 talking of three, four.

2 It depends in part on the size of your  
3 state. VNA is often one of your contractors.  
4 You may, I don't know. Linda, you live in  
5 Massachusetts. You have some idea, I know.

6 MEMBER MELILLO: I'm not sure what  
7 level --

8 CO-CHAIR PARTRIDGE: Mic.

9 MEMBER MELILLO: -- it would be.

10 CO-CHAIR PARTRIDGE: Well, this --

11 CO-CHAIR STILLE: Linda, use your mic.

12 MEMBER MELILLO: Oh, I'm sorry. No.  
13 I'm not sure which groups within the state you  
14 would be referring to. Do you --

15 DR. JACKSON: May I answer that?

16 CO-CHAIR PARTRIDGE: Please.

17 DR. JACKSON: Yes. Frail elderly,  
18 working age disabled, for the most part. Okay.  
19 Physically disabled. People with intellectual  
20 disabilities --

21 CO-CHAIR PARTRIDGE: Okay.

22 DR. JACKSON: -- and developmental

1 disabilities. People with brain injuries. It  
2 encompasses those groups of individuals. And I  
3 think the working age disabled could include  
4 other, you know, other sub-groupings of people  
5 with physical and/or cognitive disabilities.

6 MEMBER MELILLO: Okay. But at the  
7 state program level.

8 DR. JACKSON: State program level.  
9 And they're -- some states may have four or five.  
10 There are some who, up to 11 of these separate  
11 programs.

12 MEMBER MELILLO: Okay. So, like the  
13 Massachusetts Brain Injury Association?

14 DR. JACKSON: It's brain injury waiver  
15 typically, the 1915(c) waiver programs.

16 MEMBER MELILLO: Yes.

17 DR. JACKSON: Yes.

18 CO-CHAIR PARTRIDGE: Okay. Great.  
19 Thank you.

20 DR. JACKSON: Although there are other  
21 authorities as well.

22 CO-CHAIR PARTRIDGE: We are going to



1 talk about these as a group. So, as we think  
2 about the different measures, we've got five  
3 sets, I think. The data source is the same.  
4 It's this survey tool.

5 Okay. I guess, at what point do we  
6 talk about which ones we might want to pull out?  
7 Maybe I'll just stop and ask my fellow  
8 discussants for comments that they might have.  
9 Most --

10 CO-CHAIR STILLE: Okay. What, yes.  
11 Why don't we have general comments from the lead  
12 discussants, and then the discussants can  
13 recommend any that they really feel should be  
14 pulled out for separate voting. And then we'll  
15 open it up to everyone. So, Len.

16 MEMBER PARISI: Thank you. So, I  
17 guess I still need some clarification on the  
18 population. Are these beneficiaries that are  
19 enrolled in a managed long term care program?  
20 Or, I'm still not clear on who these are.

21 DR. JACKSON: It is both. Both fee-  
22 for-service as well as Managed Long Term Services

1 and Supports. There are well over 300 of these  
2 waiver programs, non MLTSS fee-for-service in the  
3 country, nationwide.

4 There are also Managed Long Term  
5 Services and Supports programs that were part of  
6 the testing, and for which these measures would  
7 be applicable as well.

8 MEMBER PARISI: So, in a -- I'm  
9 already at the point where I'm trying to  
10 understand what we're really evaluating. So, at  
11 the end of the day the goal is to evaluate a  
12 Medicaid program?

13 DR. JACKSON: Yes.

14 MEMBER PARISI: For each state?

15 DR. JACKSON: Medicaid programs  
16 typically --

17 MEMBER PARISI: Not, okay.

18 DR. JACKSON: In a state where you  
19 have a unified Managed Long Term Services and  
20 Supports program it may be one program that  
21 you're evaluating.

22 However, the measures could be applied

1 and used across MCOs to compare the experience of  
2 beneficiaries in those different managed care  
3 organizations that are part of the Medicaid MLTSS  
4 program.

5 MEMBER PARISI: So, that's how I was  
6 looking at it. But it seems like it's more than  
7 that.

8 DR. JACKSON: It's both and.

9 MEMBER PARISI: Okay. And these are  
10 not certified home health agency patients?  
11 They're not on a short episode of care? These  
12 are long term?

13 DR. JACKSON: Yes. This is long term  
14 home and community based services to people who  
15 would typically otherwise be being served in an  
16 institution. So, it is long term services and  
17 supports.

18 MEMBER PARISI: So, there would be no  
19 overlap. What if they were on an episode of care  
20 in a certified agency while they were still on  
21 this program? Would they be excluded in any way?

22 DR. JACKSON: It's -- they may be in,

1 may be receiving those post-acute care services.  
2 But in general they're enrolled in this program.  
3 They met the eligibility criteria.

4 Say there is an episode, they go to  
5 the hospital, and they need to go to rehab. And  
6 then they would go back home.

7 MEMBER PARISI: Thank you.

8 CO-CHAIR PARTRIDGE: I'm now getting  
9 totally confused. I thought the entity we were  
10 evaluating was typically a subcontractor, an  
11 entity with whom the state can, Medicaid agency  
12 contracts to run an HCBS program for X, whether  
13 it's your DD population or your physically  
14 handicapped, or --

15 But if this is somebody who's enrolled  
16 in a Medicaid managed care program, like a dual,  
17 well, forget it's a dual, just Medicaid managed  
18 care program, the entity you would be measuring  
19 would be the MCO's performance, with respect to  
20 that segment of their population?

21 DR. JACKSON: I want to distinguish  
22 between managed care for the Medicaid population

1 in general, and Managed Long Term Services and  
2 Supports programs, which may include both long  
3 term services and supports, as well as  
4 healthcare.

5 And some states roll the two into one  
6 program. Some separate out the MLTSS. But we're  
7 talking about the MLTSS portion. If they're  
8 being served. If their healthcare is being  
9 provided as well as long term services and  
10 supports. So, we're parsing out the HCBS  
11 portion.

12 CO-CHAIR PARTRIDGE: But, you're then,  
13 if the -- okay. I just, I tend to go back to  
14 thinking, who's the provider in front of me? And  
15 what's the score for that provider? And --

16 DR. JACKSON: And this is a score for  
17 all homemakers that are serving that program,  
18 that HCBS, say waiver program. For people who  
19 are being served, a waiver that's serving --

20 CO-CHAIR PARTRIDGE: But those  
21 homemakers are being hired and paid by some  
22 entity.

1 DR. JACKSON: Typically, right. But  
2 they're typically --

3 CO-CHAIR PARTRIDGE: It could be the  
4 state itself. I understand that.

5 DR. JACKSON: It could be. It could  
6 be.

7 CO-CHAIR PARTRIDGE: But, okay.

8 CO-CHAIR STILLE: Okay. Len, did you  
9 have some other questions before we --

10 MEMBER PARISI: I guess, I guess --  
11 and that's a really important point. Because, I  
12 mean, the goal of measurement is to have that be  
13 actionable so there can be some improvement.

14 And when it's -- in the case that you  
15 just described if you have multiple agencies that  
16 are providing various homemakers or staff to  
17 beneficiaries, it's hard to make that, those  
18 measures actionable to improve. Because you  
19 don't where to go with that.

20 So that was one of the things. As I  
21 was reading this it wasn't clear how you can  
22 actually do something with this information.

1 DR. JACKSON: The accountable entity?

2 (Simultaneous speaking.)

3 MEMBER SALIBA: This is Deb Saliba.

4 Can I slip in for a second, to say that, you  
5 know, from California's perspective, I'm actually  
6 working with the state right now. And sort of  
7 trying to come up with a more unified approach to  
8 home and community based services.

9 The, I think you want to have some  
10 sense of how the state is doing and organizing,  
11 and setting up its programs for Home and  
12 community based services Based Services.

13 So you're right. It's often a  
14 hodgepodge of a lot of different programs. But  
15 from the consumer's perspective what matters is  
16 whether their needs are being met. Not so much  
17 which programs.

18 And if we're seeing variations that,  
19 you know, in some states that have a more --  
20 let's just say is systematically organized, the  
21 systems tend to have better performance than in  
22 regions where there's less systematic

1 organization. Or vice versa, where there is sort  
2 of the more hodgepodge approach, might actually  
3 have higher levels of satisfaction.

4 I think that would be the way I would,  
5 you know, I think that would be very useful and  
6 helpful information from an HCBS, the Home and  
7 community based services perspective.

8 Though I think we -- I agree with you  
9 that it would also be nice to be able to look at  
10 it at the provider level. But, for example, the  
11 largest program in California is a program where  
12 the consumer gets to hire their own -- basically  
13 select their own person to do their in home care.

14 And so, you know, we're really not  
15 looking at a specific provider of care. I mean,  
16 the state directly pays those people. But it's  
17 the consumer that's selecting them and  
18 supervising them.

19 So, I think there's a lot of  
20 variability. But we really need some way of  
21 understanding what's going on in that space.

22 CO-CHAIR STILLE: Great. Deb, thanks.



1 That's an important thought. And please hold  
2 that thought. Because I think we can talk about  
3 that during the usability and use section.

4 I'd like to get Len, and then Nicole  
5 to kind of do their -- sort of finish their lead  
6 discussant stuff. And then we'll move forward.  
7 Anything else?

8 MEMBER PARISI: The other, I'm focused  
9 on the population. Because it wasn't clear who  
10 we're actually trying to evaluate in terms of the  
11 services that they receive. But it was clear,  
12 based on the discussion, who that is now. So,  
13 thank you.

14 CO-CHAIR STILLE: Okay. Nicole.

15 MEMBER FRIEDMAN: And I don't know if  
16 these will be more appropriate to get into  
17 further in the usability. But also thinking  
18 about the population.

19 And if we're evaluating homemakers,  
20 and caregivers, and different entities, how does  
21 this measure? If there's different levels of  
22 care that the state deems, you know, a certain

1 amount of hours a person gets, or based on what  
2 their need is, how does this measure look at  
3 that?

4 And especially around the component  
5 around unmet needs. Knowing that it might be  
6 that, you know, the person doesn't qualify for a  
7 certain amount of hours. Or there's variability  
8 in the amount of care in home.

9 DR. JACKSON: It does not control for  
10 that. What the measures do is tell you whether  
11 or not the person's needs are being met, at  
12 whatever level of service provision has been  
13 authorized for them.

14 CO-CHAIR STILLE: Nicole, any other  
15 points as lead discussant that you wanted to  
16 make? Questions?

17 MEMBER FRIEDMAN: I think mine are  
18 more for the usability.

19 CO-CHAIR STILLE: Okay. Great. So  
20 we'll do that then. Good. Okay. Thank you.  
21 Sorry.

22 MEMBER MORRISSE: I want to point out

1 that my daughter was the recipient of a home and  
2 community based waiver. I'm very familiar with  
3 them. I actually worked in the managed care  
4 division of Utah Medicaid for awhile in the home  
5 and community based services area.

6 And while this does not apply to  
7 individuals under the age of 18, I have a number  
8 of friends who graduate into adult based waivers,  
9 based on disability services, traumatic brain  
10 injury, as you suggest.

11 Individuals in our state also are able  
12 to contract privately with providers. And then,  
13 based on who their managed care provider may be,  
14 they also go through agencies for services. It  
15 depends on how the specific waiver is written,  
16 and what services they are able to access under  
17 the waiver.

18 There is a real need, on an aggregate  
19 or composite, to determine if these services are  
20 efficacious. And so, I really liked this when  
21 looking through it.

22 I can see where a state could

1 potentially find out on an aggregate that needs  
2 were not being met. And then implement some kind  
3 of effort to mitigate that. But they wouldn't  
4 know, again, they won't know if they don't ask.

5 And these services are vital to being  
6 able to be in the community for so many of our  
7 disabled, but able to function individuals, with  
8 minimal support in the community.

9 And I'll tell you, these kids hate to  
10 still be living with their parents because  
11 they're the only ones who will take care of them.  
12 And these kinds of waivers get them out.

13 But unlike when my daughter was on the  
14 waiver, and I was managing the providers and  
15 making sure that the people coming into my home  
16 were doing what they were supposed to do, or then  
17 reporting them, the kids don't always have the  
18 same ability to follow-up unless they're asked.  
19 And I think it's really important.

20 And when I say kids, I'm sorry, I am  
21 getting seasoned. I'm talking about mostly young  
22 adults, 20s, 30s, who are able to be in the

1 community thanks to these waivers.

2 CO-CHAIR STILLE: Okay.

3 MEMBER FRIEDMAN: That's all.

4 CO-CHAIR STILLE: Great. Thanks.

5 Sherrie, and then Nicole. And then we'll start  
6 to talk about evidence.

7 MEMBER KAPLAN: I'm still confused  
8 about the attribution, where -- what's being  
9 evaluated, what's the unit being evaluated.  
10 Because it sounded like, it's clearly the state's  
11 program that's being evaluated.

12 On the other hand, if there are, as  
13 suggested, and maybe I heard this wrong, some  
14 states have one, and some states have multiple.  
15 And so, the sort of nesting, you're going to  
16 confound states with programs that only have one  
17 program.

18 And for states with multiple programs,  
19 how much of the variation within -- where is the  
20 attribution going? Is it to the -- because some  
21 components are going to attributable to the  
22 state.

1           But, and they're, if you've got  
2 multiple programs it's more easy to evaluate. Is  
3 there a lot of between state, within state  
4 variation over programs? And how much of this  
5 belongs to things that the, you know, the state's  
6 program initiatives, et cetera.

7           Are you going to be able to  
8 distinguish the state variation from the program  
9 variation? And is there going to be a lot of  
10 reliability issues when we come to those, in  
11 estimating the within versus the between program  
12 variation within a state, across states?

13           DR. MALLERY: So, I think that's  
14 important to point out right at the beginning is  
15 that these will be administered moving forward by  
16 the states. So they might be administered  
17 differently within each state.

18           So, I don't think there is a plan to  
19 look at, to compare states at this point. So,  
20 it's almost like we have to look at within each  
21 state what is the different state's plan.  
22 Because they are very different. So, there isn't

1 a current plan to compare states.

2 CO-CHAIR STILLE: Okay.

3 DR. MALLERY: Does that help clarify?

4 MEMBER KAPLAN: Yes. I mean, I was  
5 trying to sort of get a sense of where, what  
6 your, ultimately the intent is. But if it's  
7 still -- you're not going to quite escape the  
8 issue of the confounding of state with program --

9 DR. MALLERY: Right.

10 MEMBER KAPLAN: -- for states that  
11 don't have very many of these things versus  
12 states that have multiple of these things. And  
13 then you can really look at, you know, is there  
14 variation across the state.

15 So, if you're doing it within states,  
16 that's even kind of a more perplexing problem, or  
17 potentially perplexing problem.

18 DR. JACKSON: I'd just like to add  
19 too, that this is going to -- this would be  
20 voluntary.

21 CO-CHAIR STILLE: So, Nicole and then  
22 Beth. And then I think we kind of need to move

1 on to the different parts.

2 MEMBER FRIEDMAN: Sorry. For the  
3 population that you would be excluding getting  
4 the survey, it says that it's folks that cannot  
5 pass cognitive screening. And at least in my  
6 experience a lot of the frail elderly who are  
7 getting in home service do have cognitive  
8 impairment.

9 Would you consider including  
10 caregivers or family members? Or how are you  
11 going to include this, you know, in my opinion  
12 big population that we want to have a -- to be  
13 heard?

14 DR. JACKSON: For the testing, because  
15 we were going for a CAHPS trademark, and they  
16 historically have not allowed proxies, for the  
17 most part we excluded them.

18 It became clear as we were progressing  
19 in the field tests that proxies were popping up.  
20 And so, we did allow them from a certain point  
21 onward.

22 What we are doing in the



1 demonstration, in the TEFT demonstration for  
2 Round 2 of data collection is allowing the TEFT  
3 state grantees to experiment with that. So  
4 moving forward there's an acknowledgment that  
5 proxies may be necessary.

6 DR. MALLERY: Can I just clarify that?  
7 The proxy data are not in the results that are  
8 presented in this packet. So we would have had  
9 about 1,000 more responses if we would have  
10 included. But because it wasn't administered to  
11 proxies consistently throughout --

12 CO-CHAIR STILLE: Okay.

13 DR. MALLERY: -- we excluded those  
14 from these analyses that are reported here.

15 CO-CHAIR STILLE: Okay. So your data  
16 in which you're applying for is without proxy?

17 DR. MALLERY: That's right.

18 CO-CHAIR STILLE: But maybe that might  
19 change. And then what does TEFT mean? I'm  
20 sorry.

21 DR. JACKSON: Testing Experience and  
22 Functional Tools.

1 CO-CHAIR STILLE: Okay. And, Beth,  
2 you've been waiting patiently.

3 MEMBER AVERBECK: I think, Lee, you  
4 had mentioned earlier on whether or not we pull  
5 any of the questions out separately. And I don't  
6 if we're getting to that, or if you want any  
7 comments now. So, I should wait?

8 CO-CHAIR STILLE: Just wait 30  
9 seconds.

10 MEMBER AVERBECK: Okay, great.

11 CO-CHAIR STILLE: Okay, great. We'll  
12 start to discuss the evidence now. And I'd first  
13 ask if any of the lead discussants feel strongly  
14 that we need to pull one or more particular  
15 measures out of this package.

16 CO-CHAIR PARTRIDGE: I think I would,  
17 I'd be more comfortable if we pulled the physical  
18 safety question out as a separate one. Because  
19 it seems to me it gets close to the never events  
20 issues.

21 CO-CHAIR STILLE: Okay. And that, is  
22 that Number 19, I guess, in the list they have?

1       Okay.  Others?

2                   CO-CHAIR PARTRIDGE:  The other  
3       possibility I would maybe note, and I'm not sure.  
4       When you look at the performance gaps, as I read  
5       the data it wasn't significant on all but the  
6       questions relating to unmet needs.  And then I  
7       said the physical safety one.

8                   There are the five measures relating  
9       to unmet needs.  And I don't know whether that's  
10      appropriate to pull them out separately, or just  
11      raise it when we talk about the whole package.  
12      Sarah?

13                  CO-CHAIR STILLE:  Okay.  So --

14                  CO-CHAIR PARTRIDGE:  I don't want to  
15      see five separate ones.

16                  CO-CHAIR STILLE:  Right.  So  
17      potentially the unmet needs is a package.

18                  MEMBER PARISI:  So, I hate to ask the  
19      question.  But I'll bring it up.  So when Sarah  
20      had talked about the concept of approving, or I  
21      think maybe you did Chris, approving the tool  
22      versus approving the criteria.  So, we're looking

1 at this as 19 different measures, and not as a  
2 tool, right?

3 CO-CHAIR STILLE: Right.

4 MEMBER PARISI: And that's how it's  
5 going to be loaded? Okay.

6 MEMBER BEVANS: That almost got at my  
7 question I think. But, just so I understand as a  
8 point of process. If we were to approve this  
9 measure set, would that be like NQF saying that  
10 use of this measure must, is recommended to be  
11 used as a full measure set? Or does that mean  
12 that it could be used piecemeal?

13 MS. SAMPSEL: Yes. So this is similar  
14 to, in Phase 1 with the CAHPS measures. And what  
15 we would see is different programs report  
16 different measures. So, we would be, you know,  
17 potentially endorsing 19 measures.

18 But that's what we're trying to get at  
19 now. Are there any you would like to pull out  
20 that make you very uncomfortable on making an  
21 endorsement decision on? Or do you feel that  
22 there needs to be a discussion?

1                   What happened in pediatric project, I  
2 believe, Suzanne. And maybe, Suzanne, why don't  
3 you talk about how it was handled in pediatrics.

4                   MS. THEBERGE: Sure. We had a  
5 measure. It was similar to this. And we ended  
6 up, the committee requested that the developer  
7 split it into 19 separate, or sorry, it wasn't  
8 19. It was ten in that case. Ten separate  
9 measures.

10                  And the committee voted on each one  
11 separately. Eight of them were endorsed. And in  
12 between the -- before the public comment period  
13 we went on the back end and split them out. So  
14 they became ten separate measures, with ten  
15 separate numbers. And the sub names of measures  
16 were the new title of the measure, et cetera.

17                  MS. SAMPSEL: But, and back to your  
18 question as well, Katherine, is, I mean, I think  
19 states in turn, and I think you guys should  
20 answer this.

21                  States in turn could say, we're only  
22 in our -- on our state dashboard for HCBS cert

1 programs we're only going to report the global  
2 ratings measures. Even though all are endorsed,  
3 states may choose to only report some of them.

4 CO-CHAIR STILLE: Okay.

5 DR. JACKSON: I think that's correct.

6 CO-CHAIR STILLE: Others that feel  
7 strongly about separating any particular -- Len,  
8 you have your hand up.

9 MEMBER PARISI: Well, question one and  
10 two, when you say staff, I don't even know who  
11 that's looking at. Is it the homemaker? Is it  
12 the case manager? Is it -- it's very unclear.  
13 So, I'm not sure that that would be something  
14 that you could even have a discussion about it,  
15 in terms of voting.

16 CO-CHAIR STILLE: So, yes. That might  
17 be more for the validity discussion.

18 CO-CHAIR PARTRIDGE: Well, I'm going  
19 to try to help you out, Len. I don't think you  
20 would be directly measuring the individual  
21 homemaker. I think you would be --

22 In the, and I'm talking really very

1 much from a common sense, I used to run this  
2 program kind of perspective, and not from the  
3 measurement set issue perhaps.

4 If I had, as you do in Utah, and I  
5 guess a couple of other states, a family in which  
6 you can choose your provider yourself from an  
7 approved list, supplied by the state.

8 I would say in that case the entity  
9 you're measuring is the state agency itself. How  
10 well does it select the people with whom it  
11 contracts, monitor them, and so on?

12 They're being -- in my state, for  
13 example, it was run by our Department of Social  
14 Services. So that would be, you would be  
15 evaluating the state.

16 But if you turned around and  
17 contracted with say the ABC Home Health Agency to  
18 contract with that group of homemakers, and  
19 supply them, and pay them, and monitor them, and  
20 vet them, and so on. You'd be evaluating the ABC  
21 Home Health Agency. Am I right? I mean, CMS, am  
22 I --

1 DR. JACKSON: What I'd like to do is  
2 just direct us to the actual items, or questions  
3 in the survey that --

4 CO-CHAIR PARTRIDGE: They do get  
5 there, right.

6 DR. JACKSON: -- identify who that  
7 worker is. And it can be a personal assistant, a  
8 behavioral health staff, or a homemaker for this  
9 particular scale. So it is identifying in  
10 general an individual.

11 CO-CHAIR STILLE: But it's not  
12 reported like that in the data? Or just  
13 aggregated at least one level above that, right?  
14 Okay.

15 DR. JACKSON: It's at the program  
16 level --

17 CO-CHAIR STILLE: Right.

18 DR. JACKSON: -- that it's reported.

19 CO-CHAIR STILLE: Right.

20 DR. JACKSON: Yes.

21 CO-CHAIR STILLE: Okay. Sherrie, you  
22 had a point?



1           MEMBER KAPLAN: Just one point about  
2 if states can cherry pick off from these things?  
3 The single item measures are notoriously  
4 unreliable.

5           So it does change the conversation  
6 about whether we want to include those as a group  
7 discussion and, you know, because the reliability  
8 issues do change when you have single item  
9 measures that could be potentially lifted out of  
10 this.

11           If you're going to, you know,  
12 attribute to the program, and it's got all this  
13 kind of variance that's attributable to the  
14 program from the kinds of people that are  
15 contracted with the providers of the program,  
16 yada, yada, single item measures really have that  
17 as a separate issue.

18           CO-CHAIR STILLE: And the single item  
19 measures would be 11 through 19, I guess, right?  
20 Yes. Okay. Nicole, you have a thing up?

21           MEMBER FRIEDMAN: I just had a  
22 question to clarify. So for the scale measure,

1 choosing services that matter to you. Aren't  
2 these services that are --

3 As mentioned, there's not a lot of  
4 choice. That there's kind of a bundled element  
5 of services that Medicaid will pay for. And so,  
6 I just don't see how, if there's, how the  
7 recipient, or the customer would be able to have  
8 choice of the services.

9 DR. JACKSON: There is typically a  
10 package of services per program that the  
11 individual can choose from. So for example,  
12 personal care. An individual may have a personal  
13 assistant come into the home. Or they may go to  
14 an adult daycare to receive those services. So  
15 it's that kind of choice we're talking about  
16 here.

17 CO-CHAIR STILLE: And then, Jennifer,  
18 did you have a question?

19 MEMBER BRIGHT: Yes. Just, first a  
20 point of clarification. We're still talking  
21 about how to approach these, as opposed to the  
22 evidence part, right?

1 CO-CHAIR STILLE: That's right.

2 MEMBER BRIGHT: I wanted to make sure  
3 I ask a germane question --

4 CO-CHAIR STILLE: Yes. That's right.

5 MEMBER BRIGHT: -- before I do  
6 anything. So, this is a question to the  
7 developer. Can you differentiate for me why  
8 we're talking about both a global ratings set of  
9 measures, and a recommendations measures?  
10 Because to me they kind of get at the same thing,  
11 but just at a different approach.

12 And given that one of the immediate  
13 concerns is the scope of the scale of this, why  
14 are you trying to lump so many things under one  
15 umbrella, is one question.

16 And the second is to reiterate the  
17 previous comment about individual items. I would  
18 say we should be talking about these as kind of  
19 buckets. I mean, there's, the scaled measures  
20 are really about specific measures of quality of  
21 the services, and types of services that are  
22 being provided.

1           The global ratings and recommendations  
2 measures are really patient satisfaction. How do  
3 you feel about what you're getting? And the  
4 unmet needs is trying to assess where there are  
5 gaps.

6           So, if we're trying to figure out a  
7 way to break this up, I would posit that we  
8 should be thinking about them in those buckets,  
9 as opposed to pulling them all apart into 19  
10 different painful discussions.

11           CO-CHAIR STILLE: And so we have five  
12 buckets with Number 19 in its own bucket. And,  
13 you know, that's interesting. So, considering  
14 these as five groups of measures, I think would  
15 answer everyone's concerns, from what I've gotten  
16 so far.

17           MS. REED: Chris, can I just follow-  
18 up?

19           CO-CHAIR STILLE: Yes.

20           MS. REED: Because this, I didn't want  
21 to be misleading. When, like the CAHPS measure,  
22 I was involved in the initial CAHPS measure, way,

1 way, way long ago.

2 When we did that you put, you sort of  
3 general overall ratings and recommendations  
4 that's what we call behavior intentions. The  
5 latter being behavioral intentions. And the  
6 global rating items are used as validation items  
7 for these subscales.

8 So, the scales for, you know, the  
9 staff are reliable and helpful, and the staff  
10 listen to me, and everything, those sort of  
11 overall ratings are usually used for validation  
12 internal to the instrument construct validation.

13 So, we want to make sure we're  
14 measuring where we -- so, you wouldn't sort of --  
15 that's why I freaked out. You wouldn't --

16 CO-CHAIR STILLE: Right.

17 MS. REED: -- separate those from the  
18 interior of the subscale structure that tells you  
19 where you need to focus the improvement. Because  
20 you want to use those measures to find the  
21 drivers of the overall ratings. For example.

22 CO-CHAIR STILLE: Right. So don't use

1 one without the other is kind of what you're  
2 saying. Yes.

3 MS. REED: I was just saying it  
4 wouldn't be really, I would feel uncomfortable  
5 breaking those out as a separate set when they're  
6 usually used in the context, especially HCAHPS  
7 and CG CAHPS, and so on.

8 They still put those, you wouldn't ever separate  
9 those out.

10 CO-CHAIR STILLE: Right. Linda.  
11 While we're catching our breath and figuring out  
12 what to do next.

13 MEMBER MELILLO: So, I'm going to  
14 muddy the water a little bit. Community services  
15 frequently offer employment services as well. I  
16 didn't see that anywhere.

17 DR. JACKSON: You didn't. It is in  
18 the instrument. There is what we're considering  
19 now a supplement to the instrument, an employment  
20 supplement.

21 And the reason that it really was not  
22 tested, because so few people who were surveyed

1 answered the question in a way that said, yes,  
2 I'm either interested in employment, or I am  
3 working. And you had to -- that was the trigger  
4 for those -- for that battery of questions.

5 And there were so few who said either,  
6 yes, I'm interested in working, not currently  
7 working, or I am currently working, to administer  
8 that supplement. So it is a supplement. But we  
9 did not test it. And I'll defer to my  
10 statistician here.

11 DR. MALLERY: So, those items will  
12 still be part of the instrument that we're not  
13 technically talking about here, but it will be  
14 part of the survey. So states will be able to  
15 still use those items. But we're not putting  
16 those up for endorsement, because we just had too  
17 few respondents to be able to sort of report  
18 reliability and validity --

19 MEMBER MELILLO: So, how many  
20 additional questions is that?

21 DR. MALLERY: I can tell you in a --  
22 give me a minute. But it -- yeah.

1 DR. JACKSON: Again there are a lot of  
2 skip, there are skip patterns. So.

3 CO-CHAIR STILLE: Okay. While you're  
4 looking, what we've decided to do -- this has  
5 been a great discussion, by the way, so, thank  
6 you. We're going to take any more general  
7 questions, including about, you know, splitting  
8 up discussion. We'll take public comment. And  
9 then we're going to break for lunch and discuss  
10 how we're going to vote on these while we're  
11 eating lunch.

12 We're going to take a 20 second time  
13 out, is really what we're going to do. So a  
14 little more than 20 seconds. 20 minutes? I  
15 don't know.

16 MEMBER THOMAS: I haven't said  
17 anything. Oh, I'm sorry.

18 CO-CHAIR STILLE: Okay. Jennifer, I  
19 think you were first.

20 MEMBER BRIGHT: I just wanted to go  
21 back to the first question I posed to the  
22 developers, which is, can you help us understand



1 the difference in the global ratings measures and  
2 the recommendations measures?

3 Because, again, I think they're trying  
4 to get at the same thing. And what's the value  
5 of having both? Because perhaps there should be  
6 some consideration of consolidating. I don't  
7 know.

8 DR. MALLERY: So, I would argue to  
9 keep both. I think they are used somewhat  
10 differently. And the global ratings items,  
11 again, are often used to correlate. I think that  
12 -- I mean, I guess they both could be used for  
13 that, for those purposes. But I do think they  
14 could be used slightly differently. But I do  
15 understand your point that they might be getting  
16 at the same concept.

17 CO-CHAIR STILLE: Okay. Becky, and  
18 then Nicole.

19 MEMBER BRADLEY: I just had a question  
20 about the intended use. Do you intend this data  
21 to be publicly reported in any way? Because,  
22 unlike some other providers, services, patients,

1 or communities, I mean, their only option would  
2 be to move to another state where there's a  
3 better program.

4 So, how do you intend to use the data  
5 from this? And I guess that gets to intended  
6 use. But I apologize for that.

7 DR. MALLERY: Yes, thank you for your  
8 question. And at this time we're just looking at  
9 states who are voluntarily using it. And so it  
10 would be their option for the TEFT states that we  
11 have. We have eight TEFT states who will be  
12 using this. TEFT again was Testing Experience  
13 and Functional Tools. It is their option if they  
14 would like to publicly report it.

15 The initial round 1 of the data, we  
16 did not publicly report it. It was available in  
17 individualized reports to the states. And then  
18 we shared information on -- aggregate  
19 information, but the states did not want that  
20 information reported. They wanted to keep it for  
21 their own purposes. And we respect that. But  
22 again, that was just for the TEFT demonstration.

1           We're doing the same thing for Round  
2       2. No plans have been made past that, beyond  
3       that. You know, we have five states who have  
4       expressed interest in using this. That would be  
5       their option. I don't know if Beth or Coretta  
6       have information to add to that.

7           CO-CHAIR STILLE: Okay. Peter.

8           MEMBER THOMAS: Just really quickly,  
9       as a general comment. I would think this --  
10      first off, this is an area that is just  
11      tremendously important for the disability  
12      community, the fact that the 50 percentile has  
13      been breached and we're now in a situation where  
14      we could provide care under Medicaid through home  
15      and community-based services more often than  
16      through institution-based services, especially  
17      for some of these populations, like brain injury  
18      and working age adults with disabilities, and the  
19      like.

20           So, this is a critical area that I'm  
21      really excited that we're kind of considering  
22      this. And I can most definitely see the states

1 taking a real stock of their different programs,  
2 their different waiver programs.

3 And there's so much variation in the  
4 states on how these programs are run that it can  
5 help the states determine whether the program,  
6 and the goals that they need to achieve with a  
7 particular program, are actually current, whether  
8 the end users feel that they're empowered to hire  
9 their own personal assistant. Or whether they've  
10 gotten too many restrictions in the program that  
11 it's not working the way they envisioned it.

12 And that's really valuable information  
13 that I think states can use to improve all of  
14 these different types of programs. So,  
15 tremendous variation across the states. But I  
16 can most definitely see these measures being very  
17 useful, not only for the states, but for the end  
18 users.

19 CO-CHAIR STILLE: So, good. So, where  
20 I would like us to be when we finish talking in  
21 the next couple of minutes is ready to come back  
22 from lunch to talk about evidence, validity,

1 reliability, usability, use, and that kind of  
2 thing, in whatever buckets we end up talking  
3 about.

4 So, other general questions before we  
5 open it up to public comment? So, should we?  
6 Okay. People on the phone?

7 MEMBER CELLA: None here, thanks.

8 CO-CHAIR STILLE: Okay.

9 MS. THEBERGE: So, public comment.  
10 Operator, can you open the lines for public  
11 comment? And if anyone in the room would like to  
12 make a comment, there's a microphone.

13 OPERATOR: Yes, ma'am. At this time  
14 if you'd like to make a public comment, please  
15 press star then the number 1.

16 MS. THEBERGE: Comments can also be  
17 submitted via the chat function on the webinar.

18 OPERATOR: And at this time there are  
19 no public comments from the phoneline.

20 MS. THEBERGE: Okay.

21 CO-CHAIR STILLE: Okay. So we shall  
22 break for lunch. And let's see, 30 minutes, 45

1 minutes? Okay. So if you could make it a  
2 relatively brief lunch. We have 27 minutes until  
3 12:30 p.m.

4 (Whereupon, the above-entitled matter  
5 went off the record at 12:04 p.m. and resumed at  
6 12:34 p.m.)

7 CO-CHAIR STILLE: All right, great.  
8 So, over lunch I was made aware of the  
9 possibility of deferring a vote on this package  
10 of measures. And it would be good to have a  
11 discussion of that. But we need someone to move  
12 that first.

13 So, Jennifer, would you like to kind  
14 of talk about kind of your thinking behind that?  
15 And then we can open it up to some discussion.

16 MEMBER BRIGHT: Yeah, so I'm guilty of  
17 raising this question. I just, as a new  
18 committee member, was asking procedurally, was  
19 there an opportunity to discuss the pros and cons  
20 of possibly deferring the consideration of this  
21 measure?

22 I think there are sufficient questions

1       about scale and about lack of data, being that  
2       this has just been field tested. And I think  
3       this is not a question of value. This is not a  
4       question of the value of doing this, of the  
5       considerable amount of work that's been put into  
6       this. But I feel that it's important to move to  
7       consider deferment because I think that this  
8       needs to be tested and teased out a little bit  
9       more.

10               And I do feel like the demonstration  
11       project that you mentioned in your introduction  
12       has a lot of value to answering some of the  
13       questions that I think have come up already and  
14       are likely to come up in further discussions.

15               So, for that reason, I'd like to  
16       suggest to the committee that we consider the  
17       pros and cons of deferring this at this time.

18               CO-CHAIR STILLE: So let's discuss  
19       this a little bit. I think I saw a couple of  
20       tents going up at some point. No? Yes? Lisa?

21               MEMBER SUTER: So, can I just clarify,  
22       what are the -- what's the downstream effect of

1       deferment? And what are we asking from the  
2       developer that would change our mind in the  
3       future?

4                   MS. SAMPSEL: So, basically, I mean,  
5       what we would do now that there's a motion to  
6       defer, there would be kind of a discussion. And  
7       it can be some back and forth continuing with the  
8       developer on, you know, what your global reasons  
9       are for suggesting the deferment and seeing if  
10      the developer has some information we're just not  
11      seeing here.

12                   And then there would be a formal vote.  
13      And it would be a hand vote of who supports  
14      deferment, who doesn't support deferment. And  
15      should that deferment move forward, then we would  
16      still want you to go through each of the criteria  
17      and talk about what additional information you  
18      would want to see that would make you more  
19      comfortable with a vote, so that the developers  
20      would know and be able to come up with a plan  
21      that would then come back on how they would  
22      address those issues.



1 CO-CHAIR PARTRIDGE: I'm sorry Sarah.  
2 Would we vote on the motion to consider to  
3 deferment? Is that it? Or do have to decide to  
4 defer first, and then, as we go through the  
5 criteria, we're giving them suggestions? Or do  
6 you assume the general discussion will surface  
7 the issues?

8 MS. SAMPSEL: I mean, I assumed that.  
9 How have they done it in other groups?

10 MS. MUNTHALI: Yeah, so you would vote  
11 on the motion to defer first, to even consider  
12 that. This measure could go forward if it passes  
13 all of the major criterion, but you're not sure.  
14 It sounds like you're saying you like the idea of  
15 this measure but there may be some weaknesses  
16 that the developer may be able to address within  
17 a time period.

18 And so when you're thinking about  
19 deferment, and when we're thinking about it as an  
20 option for committees, we would be working with  
21 the developer to come back with that additional  
22 information that Sarah mentioned within a

1 specified period, no more than a year.

2 So that's something to consider for  
3 the developers as well.

4 MS. SAMPSEL: And what I would just  
5 add there, too, I mean, the other option, of  
6 course, would be to continue and we vote through.  
7 And let's say some of these go down, they don't  
8 pass. Remember there's almost that cure period  
9 where the developers could come back and say, we  
10 want you to reconsider this, reconsider our  
11 request.

12 But there's only about two months for  
13 that. So it's during the writing period, it's  
14 during the public comment period that they could  
15 come back to us with a formal reconsideration and  
16 you would re-vote in about two months.

17 CO-CHAIR STILLE: Peter?

18 MEMBER THOMAS: I guess I would speak  
19 in opposition of the motion because I don't think  
20 we've really had the discussion to the point  
21 where I could say one way or the other that I  
22 think you need to develop more things. I've read

1 the materials. This is happening. These  
2 programs are in effect. Half the Medicaid  
3 population is undergoing some form of home and  
4 community-based services and there's very few  
5 measures out there.

6 So it's really important. And I don't  
7 know if a year delay is appropriate in light of  
8 the discussion we've had thus far. Maybe if we  
9 have more discussion I can get my arms around  
10 that. But I just don't know enough right now to  
11 say that. I'd prefer to move on with the  
12 discussion of the measures.

13 CO-CHAIR STILLE: Other thoughts?

14 CO-CHAIR PARTRIDGE: Sherrie's tent is  
15 up.

16 CO-CHAIR STILLE: Oh, Sherrie, sorry.

17 MEMBER KAPLAN: So can you go over,  
18 Sarah, the algorithm for our decisionmaking  
19 again? If we say deferral for a year, then what  
20 happens? If we move on and discuss these and  
21 decide, for example, to approve some and not  
22 others and do whatever it is we do after the

1 discussion, what happens? So that we can kind of  
2 clarify that. Because I think in one case,  
3 there's a short term and then other cases a more  
4 long term plan, it sounds like.

5 MS. SAMPSEL: So there would be a vote  
6 on the motion to defer. If it's decided that you  
7 all want to defer this measure, then we would  
8 still ask you to go through the criteria and  
9 provide recommendations to the developer on what  
10 you would want to see to make you more  
11 comfortable that this measure is ready for prime  
12 time, or measures are ready for prime time.

13 In that case, then the developers will  
14 be followed up by staff within 24 hours, 48  
15 hours, when we get out of this meeting. And the  
16 developers then have two weeks to provide us with  
17 their plan to address those issues and a timeline  
18 for when that would happen. As Elisa mentioned,  
19 we'd want that to happen within a year.

20 Should you not defer that, you know,  
21 as Peter suggested, what we're going to do is  
22 we're going to break these into five groupings

1 and talk about each grouping and have five  
2 separate votes.

3 And let's say in the event, you know,  
4 say physical safety, Number 19, it's voted down.  
5 And this could be the case for any of these  
6 groupings. If any of them go down, as in are not  
7 passed at any of the must-pass criteria, we would  
8 still, as we've done before, we continue the  
9 discussions. But we don't continue voting for  
10 each of those additional criteria. Again, to  
11 give the developers more information.

12 In that case, where either the  
13 consensus is not reached or the measures are not  
14 passed at this meeting, they still go out for  
15 public comment. And the developer still has a  
16 request or is still able to bring more  
17 information back, but it's on a much shorter time  
18 period. And you would re-vote at the post  
19 comment call. Is that clear?

20 CO-CHAIR STILLE: Linda?

21 MEMBER MELILLO: So I was just -- I  
22 feel like that it's a little premature to defer

1 without having had more discussion about some of  
2 the actual items. Is there a way to continue to  
3 review the items and then decide whether or not  
4 we -- you know, that that could be an option at  
5 the end, is to defer?

6 MS. SAMPSEL: I think we can do that.  
7 I mean, as long as it's before the overall  
8 suitability vote, the very last vote.

9 MEMBER MELILLO: So that's my thought.  
10 I don't know how the rest of the panel feels.

11 CO-CHAIR STILLE: So should we maybe  
12 have a structured discussion, relatively briefly,  
13 on sort of the five different chunks? You know,  
14 the evidence things and the usability and use  
15 things. And then maybe have a vote to defer  
16 based on how that's going? Should we give  
17 ourselves like a time limit perhaps? Okay.

18 So we're supposed to be starting on  
19 the other measures, like, in two more minutes.  
20 Okay. Well, this is important enough. Let's  
21 give ourselves 15 minutes. Does that sound okay?  
22 Is that too long? Okay. Len?

1                   MEMBER PARISI: So, clarification, yet  
2                   again. What's the implication of looking at this  
3                   document in buckets? And if one component is not  
4                   acceptable, what's the implication of that?

5                   CO-CHAIR STILLE: For the others?  
6                   Yeah, that's a good question.

7                   MS. SAMPSEL: So, I mean, I think  
8                   what we've heard is that, you know, there seems  
9                   to be a level of discomfort in voting on 19  
10                  measures separately and doing 19 separate votes.  
11                  And so our suggestion is, we'll talk about the  
12                  scale measures and go through the voting on the  
13                  scale measures. And then do it on global rating,  
14                  do it on recommendations, do it on unmet needs.

15                  In the event any of these buckets or  
16                  individual measures are not passed, it's the same  
17                  implications of that, you know, there could be  
18                  something that comes up during public comment.  
19                  There would be a reconsideration of that vote  
20                  post-meeting.

21                  CO-CHAIR STILLE: Okay. Great. Well,  
22                  let's do this: let's start to kind of go through

1 one-by-one with an eye toward, okay, what's  
2 needed, what's not needed for these generally.  
3 Because obviously they're all related because  
4 they're part of the same instrument.

5 Should we maybe get up the evidence  
6 thing and start going through there? And I'll  
7 rely on the primary discussants to put in a point  
8 or two to kind of jump start the discussion.  
9 Nicole?

10 MEMBER FRIEDMAN: I guess one of my  
11 thoughts of this is some of the questions on the  
12 scale measures are pretty similar to Press Ganey  
13 in like, staff reliable and helpful, listen and  
14 communicate. And I'm just thinking about how  
15 many surveys people potentially get. And would  
16 this be duplication of other surveys that they're  
17 getting, whether or not their home and community-  
18 based service is separate from their primary care  
19 health system. And is that a concern?

20 DR. JACKSON: Typically, an HCBS  
21 program would only field a survey like this, at  
22 most, once a year. Certainly, individuals who



1 receive their services, you know, from primary  
2 care or a specialist, go to a hospital, of  
3 course, they're going to be receiving surveys as  
4 well.

5 But these will be different in that,  
6 for the most part, they will be administered  
7 face-to-face or over the phone. So it's a  
8 different type of survey than what most of us and  
9 most of them will receive from our healthcare  
10 providers.

11 I think the states who would be  
12 responsible for paying for, for the most part,  
13 and choosing a survey vendor, and fielding these  
14 surveys with their beneficiaries would be very  
15 careful about participant burden and would not do  
16 it very frequently.

17 Plus it would be a cross-section, it  
18 would be a sample. It would not be everyone, in  
19 most instances.

20 CO-CHAIR STILLE: So, again, this is  
21 sort of evidence that this is needed and that  
22 kind of thing. So, I mean, your question was

1 great. I think it was probably more about  
2 feasibility. Katherine?

3 MEMBER BEVANS: A question about the  
4 data presented for evidence for performance gap.  
5 I just want to make sure I understand the means  
6 that are presented on Page 6 of the report, which  
7 are things like staff are reliable and helpful,  
8 the mean is 93.23. Could you tell us how that  
9 was calculated? I understand that the measure  
10 itself is a composite. And then there must be a  
11 cut point and a percentage calculated?

12 DR. MALLERY: So each of the measures,  
13 or each of the items in the underlying measure,  
14 is on a "never, sometimes, usually, always"  
15 scale. And then we transform those to a 0 to 100  
16 scale, primarily, so they're easier to  
17 understand.

18 MEMBER BEVANS: Is it a T-score?

19 DR. MALLERY: Between the means and  
20 the -- that's right.

21 MEMBER BEVANS: No? Okay. No.

22 DR. MALLERY: Oh, no, I'm sorry. So

1       you're saying is this a Z-score? Oh, right, no.  
2       It's just, you know, take all the items, they're  
3       "never, sometimes, usually, always." So, one,  
4       two, three, four. Create a mean and then  
5       transform that to 0 to 100.

6               MEMBER KAPLAN: I think I can help out  
7       here.

8               DR. MALLERY: Okay.

9               MEMBER KAPLAN: What's usually done in  
10      that kind of transformation is you take the item  
11      mean, or the average item mean, and you subtract  
12      the theoretical minimum from that. And then you  
13      divide that by the theoretical maximum of the  
14      scale score minus the theoretical minimum and  
15      multiply it by 100.

16              So it's not a transformation in the  
17      sense that you're thinking.

18              CO-CHAIR STILLE: We're finding the  
19      table that you're talking about. I know exactly  
20      -- there you go.

21              MEMBER BEVANS: Understanding that a  
22      little bit more, it might be worth noting that

1 the scores are quite high on the possible range  
2 of 100, with obvious exceptions, which suggests  
3 there may be not the strongest evidence for room  
4 for improvement. Although it's kind of  
5 surprising given the content of the items.

6 And so I'm wondering whether you have  
7 any thoughts about sampling, who actually  
8 responded to this, how the measures were  
9 administered, that may be explaining those  
10 extraordinarily high scores on some measures that  
11 we know there are certainly more variability in  
12 prior literature.

13 DR. MALLERY: Yeah, I agree, the  
14 scores are quite high. In terms of sampling, you  
15 know, I mean, it was a random sample of  
16 participants within the programs. Now, in terms  
17 of people that responded, there were those  
18 cognitive screening items. So that's a  
19 consideration. So, only respondents who screened  
20 into it past this sort of cognitive screening  
21 piece. And that was just -- they asked whether  
22 or not they received services. So that might be

1 one consideration.

2 In terms of -- I think we already said  
3 that all surveys were administered in person or  
4 via phone. So I think the administration was  
5 appropriate for the population. So that would  
6 sort of mean, you know, we made every  
7 accommodation to the participants in that sense.

8 CO-CHAIR STILLE: Sherrie and then  
9 Lee.

10 MEMBER KAPLAN: This is a follow-up to  
11 Katherine's question, I think. If you look at  
12 the interquartile ranges, you get fairly narrow -  
13 - you've got ceiling effect problems with some of  
14 the measures. And the standard deviations are  
15 pretty, you know, pretty tight.

16 So then the question becomes, is there  
17 going to be enough -- you know, an effect size,  
18 for example, of .3, which means you multiplied  
19 the standard deviation times .3 and you get 1.  
20 Well, is one unit difference a meaningful  
21 difference?

22 And so that's going to happen to these

1 kind of ceiling measures. Now, since this is  
2 voluntary, your data are voluntary, it's sort of  
3 like what happened the last time. You get high  
4 performers participating in these voluntary kind  
5 of exercises.

6 On the other hand, when you look down  
7 at some of the unmet needs things, you've got a  
8 huge standard deviation. And therefore, you  
9 know, you've got kind of the opposite problem.  
10 Some of these things you might even have floor  
11 effect problems. Especially, you know, for some  
12 of the measures.

13 So when we're kind of trying to wrap  
14 our heads around -- I think this is the issue  
15 that Peter brought up. When we're trying to wrap  
16 around, the collective here, there's a lot of  
17 differences here that we're going to have to  
18 struggle with. And how to help us, how you can  
19 help us understand the potential utility, that  
20 gets to the use, but it also gets to the  
21 variability and understanding the attributions of  
22 the program versus other kinds of things that may

1 be causing all of this wide variation in some of  
2 these measures, but not very much and may not  
3 even be meaningful in some of the others.

4 CO-CHAIR STILLE: Okay. So Lee and  
5 then Linda.

6 CO-CHAIR PARTRIDGE: If you step back  
7 away from the detail, and overall, as I've worked  
8 with these measures over the past two weeks, you  
9 know, there's no question that Peter is right.  
10 We would very much like to have solid quality  
11 measures in the HCBS realm.

12 It used to be as the states struggled  
13 with them -- and I'm sure some of these are still  
14 out there -- what you did was what I would  
15 consider sort of dumb stuff. You pulled a sample  
16 of the care plans and then you went and checked  
17 and found out whether or not Mrs. X got three  
18 hours or two-and-a-half hours of personal care  
19 each day. Well, that's silly. You need  
20 something more global.

21 In a discussion with a bunch of HCBS  
22 providers a few years back, unanimously they

1       said, you know, what we really care about is  
2       whether people are doing well. Doesn't really  
3       matter about all this detail in between. What  
4       happened? Are they still functioning okay? If  
5       they're not functioning okay, why aren't they  
6       functioning okay?

7               At that point, you start to need the  
8       detail underneath to say are they not doing well  
9       because the agency is letting them down and are  
10      not supplying, meeting their needs.

11             So, you know, everything in me wants  
12      to say, I want to bless this measure.  
13      Nevertheless, I kept looking at some of our  
14      criteria. The performance gap really isn't  
15      apparent, except with respect to the unmet needs  
16      group where you do have a lot of indication that  
17      people are feeling that their needs are not being  
18      adequately met. Some of that may be under the  
19      control of the program. Some of it may be under  
20      the control of the state budget office.

21             But I am really terribly, terribly  
22      conflicted on taking our standard algorithm and



1 working through this measurement set, whether we  
2 do it in chunks or whether we do it one-by-one.

3 CO-CHAIR STILLE: Just with the  
4 differences in data ranges, data analyses, data  
5 requirements --

6 CO-CHAIR PARTRIDGE: Right. And you  
7 know, if you look further in the testing realm --  
8 and I'm jumping ahead a little bit. I was  
9 stunned by your comment this morning that there  
10 were 2,300 respondents in this material that you  
11 gave us. If you had counted the proxy data, you  
12 would have had another 1,000. Well, what did  
13 that look like? So.

14 CO-CHAIR STILLE: Okay. And then  
15 Linda. Then I think we should talk about some of  
16 the other realms just to get to the end of this  
17 15-minute block so we can decide on whether to  
18 defer or not.

19 MEMBER MELILLO: When I worked for the  
20 behavioral health organization in Vermont, they  
21 had a community service program. And one of the  
22 challenges was that any time you have a staff

1 person who is working with a developmentally  
2 disabled young adult, older child, they are  
3 heavily influenced by that person. And if  
4 they're the person administering this set of  
5 measures, I don't know that you're going to get  
6 real values that way.

7 So I also wanted to see that other  
8 1,000 data points to see if you're going to be  
9 getting different types of responses that way. I  
10 think the administration of the survey, and  
11 really narrowing that down, would be really  
12 important because there's just way too many  
13 variables.

14 DR. MALLERY: Can we clarify that the  
15 survey is administered in-person but not by the  
16 providers. It's administered by trained survey  
17 vendors.

18 MEMBER MELILLO: Okay. Thank you.

19 DR. MALLERY: So no case managers.

20 MEMBER MELILLO: Okay. And family  
21 members, would they be able to answer as well?

22 DR. MALLERY: Well, so, that's the

1 difference, is that initially, no, they weren't  
2 able to answer. So they would never be  
3 administering the survey. It would be a trained  
4 survey vendor.

5 MEMBER MELILLO: Right.

6 DR. MALLERY: But that was sort of the  
7 point we were getting to, is that part of the way  
8 through we did allow family members to respond,  
9 not on behalf, or along with or to assist with  
10 the survey process.

11 MEMBER MELILLO: Okay. And that data  
12 is not in this set?

13 DR. MALLERY: It's not in here, right,  
14 because it wasn't consistent throughout

15 MEMBER MELILLO: Yeah, I wouldn't want  
16 it to be.

17 DR. MALLERY: So we couldn't reliably  
18 say, you know, these are the differences between  
19 proxies and non-proxies because it wasn't -- that  
20 wasn't how it was designed, the field test.

21 CO-CHAIR STILLE: Okay. Any other  
22 last important comments on evidence?

1           MEMBER THOMAS: Only that this is a  
2           patient-reported outcome measure. And so, in  
3           terms of evidence, you're asking the very people  
4           who are receiving the services what they think  
5           about the various components of what they're  
6           getting. I'm kind of sensing that we're maybe  
7           making this too complicated. This strikes me as  
8           being a real step forward from where we are now.  
9           And I guess I'm kind of left with that as a  
10          bottom line.

11          CO-CHAIR STILLE: Nicole?

12          MEMBER FRIEDMAN: Sometimes, in my  
13          experience, too, working with patients and asking  
14          them about their service, especially around  
15          Medicaid and help in the home, is a fear of  
16          losing the service. And so I'm wondering, is  
17          there scripting, when you're delivering this,  
18          that this is not about whether or not we're going  
19          to take away hours or et cetera, but this is a  
20          care optimizing tool.

21          DR. JACKSON: That's part of the  
22          consenting process of the survey.

1 CO-CHAIR STILLE: Okay. So just in  
2 the spirit of dividing up chunks of measures  
3 versus not, Sarah was raising the point that we  
4 haven't heard anything in the discussion about --  
5 at least on the evidence part, just thinking  
6 about evidence -- that there are big differences  
7 between chunks of questions.

8 So we were thinking we should vote on  
9 the evidence kind of by itself and then think  
10 about the next few things. Does that seem okay  
11 to people? Beth?

12 MEMBER AVERBECK: Specific to  
13 evidence, I guess that's my question around the  
14 19 and the physical harm. I don't know if you  
15 want me to raise that now or if you want me to  
16 wait.

17 CO-CHAIR STILLE: Sure.

18 MEMBER AVERBECK: Because I think one  
19 of the -- you know, obviously, it's considered a  
20 never event. This is a patient-reported, so it's  
21 not necessarily a verified result. And so I  
22 think that may play into, you know, my

1 consideration on whether it's just reported and  
2 verified or just reported, especially if we're  
3 going to start looking at comparative data or  
4 public reporting.

5 CO-CHAIR STILLE: Over to Desi for a  
6 vote on evidence, then. And then we'll continue  
7 the discussions.

8 MS. QUINNONEZ: We are going to open  
9 the vote. Voting is now open for evidence,  
10 importance to measure and report. The rationale  
11 supports the relationship of health outcome, or  
12 PRO, to at least -- what are we voting on?  
13 Sorry.

14 Oh, thank you. I can get you the  
15 screen.

16 The rationale supports the  
17 relationship of health outcome, or PRO, to at  
18 least one healthcare structure process,  
19 intervention, or service. Option 1 is yes,  
20 Option 2 is no. Voting is now open.

21 MS. THEBERGE: We're down to 19  
22 Committee members now.

1 MS. QUINNONEZ: Thank you.

2 CO-CHAIR STILLE: It doesn't seem  
3 open.

4 MS. QUINNONEZ: It's calculating.  
5 We're looking for one more vote.

6 MS. THEBERGE: Deb, are you still  
7 there? Operator, is Deb Saliba still on the  
8 line?

9 OPERATOR: I do not see her joined.

10 MS. THEBERGE: Okay. So I think we're  
11 good.

12 MS. QUINNONEZ: So we're at 18. All  
13 votes are in. So voting is now closed for  
14 Measure 2967 for evidence. We have 94 percent --  
15 that voted no. That's 94 yes and 6 percent no.  
16 This measure passes.

17 CO-CHAIR STILLE: Are there other  
18 evidence sub-questions? Okay. Performance gap.  
19 Okay. Any other questions about performance gap  
20 related to this table? I think we've talked  
21 about it fairly extensively. Becky and Sherrie?

22 MEMBER BRADLEY: I just had one

1 question. Or comment I guess. In terms of now  
2 that you're allowing proxies, I think there might  
3 -- it's been my experience in working with  
4 patients and families that sometimes the  
5 caregiver's perception is very different from the  
6 patient's perception, in terms of adequacy of  
7 service.

8 And so now that you've added those  
9 kind of as one of the acceptable responses, I  
10 think there should be more research into, is  
11 there a difference between the patient's and  
12 caregiver's responses to adequacy of service?  
13 Because if you're just basing this on the  
14 patient, there may be a big gap there.

15 CO-CHAIR STILLE: And Sherrie?

16 MEMBER KAPLAN: Okay. So this is  
17 already where I'm hitting the wall on, is this a  
18 bundle or a bunch of individuals? Yes and no. I  
19 mean, if you stare at this, you know, what are we  
20 supposed to do? Because I can't answer the  
21 question.

22 CO-CHAIR STILLE: Right. Answer



1 Number 5.

2 MS. SAMPSEL: I mean, at this point we  
3 can separate. You can go ahead and say, okay,  
4 we're now going to do one vote on the scale  
5 measures, if that's what the suggestion is. Then  
6 do one vote on unmet needs, one vote on, you  
7 know, through each five.

8 CO-CHAIR STILLE: And I think we were  
9 kind of moving toward a consensus of that. So  
10 should do that, then? The five buckets being --  
11 I don't have them up on my screen.

12 CO-CHAIR PARTRIDGE: Scale, global,  
13 recommendations, unmet needs, physical safety.

14 CO-CHAIR STILLE: Okay. Scale  
15 measures, global measures, recommend measures,  
16 unmet needs measures, and physical safety. So  
17 then we'll have five quick votes on 1(b), right?  
18 Okay. So, good. So this will be on the scale  
19 measures.

20 Is voting open yet?

21 CO-CHAIR PARTRIDGE: Desi, is voting  
22 open?

1 CO-CHAIR STILLE: I think it's not  
2 open yet. Yes, sorry. The splitting causes  
3 technical difficulties but we just want to try  
4 and get this right.

5 MS. QUINNONEZ: Okay. We will open up  
6 the vote for importance to measure and report for  
7 performance gaps. Performance gap data  
8 demonstrated considerable variation or overall  
9 less than optimal performance across providers  
10 and/or population groups or disparities in care.  
11 And this will be for scale measures. And that's  
12 a part of 2967. Voting is now open.

13 MEMBER DOWDING: Hi, this is Dawn.  
14 Could you just say what the numbers represent  
15 again, please?

16 MS. QUINNONEZ: Absolutely. We're  
17 going to be voting for measure -- we're going to  
18 be voting. The criteria is 1 is high, 2 is  
19 moderate, 3 is low, and 4 is insufficient.

20 CO-CHAIR STILLE: Dawn, was that your  
21 question? Or was it the 100 point scale that the  
22 --

1                   MEMBER DOWDING: No, that was my  
2 question. Thank you.

3                   CO-CHAIR STILLE: Okay.

4                   MS. QUINNONEZ: We're looking for one  
5 more vote.

6                   And all votes are in. Voting is now  
7 closed. We have 6 percent voted for high, 11  
8 percent for moderate, 72 percent for low, and 11  
9 percent for insufficient.

10                  CO-CHAIR STILLE: So this is on the  
11 scale measures. Okay. Do we continue to vote on  
12 the other sets then, right? Yes, we do. Okay.  
13 And the next set is global ratings.

14                  MS. QUINNONEZ: Okay. Voting is now  
15 open for the importance to measure and report  
16 performance gaps for global ratings. Performance  
17 gap data demonstrated considerable variation or  
18 overall less than optimal performance across  
19 providers and/or population groups or disparities  
20 in care. The criteria is 1 for high, 2 for  
21 moderate, 3 for low, and 4 for insufficient.

22                  We're looking for two more votes.

1                   And all votes are in. Voting is now  
2 closed. We have 0 percent for high, 56 percent  
3 moderate, 39 percent voted low, and 6 percent  
4 voted insufficient. And this is on global  
5 ratings.

6                   CO-CHAIR STILLE: So that's consensus  
7 not reached, because it's 40 to 60 percent.

8                   MS. QUINNONEZ: Would you like to  
9 continue?

10                  CO-CHAIR STILLE: Okay. Yes. The  
11 next group is recommendations. Would you  
12 recommend X, Y, Z provider?

13                  MS. QUINNONEZ: Okay. Importance to  
14 measure and report, performance gap for  
15 recommendations. The first criteria is high,  
16 second criteria is moderate, third criteria is  
17 low, and fourth is insufficient.

18                  Okay. All votes are in. Voting is  
19 now closed. Zero percent for high, 67 percent  
20 moderate, 28 percent low, and 6 percent  
21 insufficient.

22                  CO-CHAIR STILLE: Okay. So that group

1 passes. And the fourth group is unmet needs.

2 MS. QUINNONEZ: And the last group is  
3 unmet needs.

4 CO-CHAIR STILLE: That's the fourth of  
5 five. There's five groups and this is number  
6 four.

7 MS. QUINNONEZ: Got it. Unmet needs  
8 for the performance gap. The first option is  
9 high, second option is moderate, third option is  
10 low, and fourth option is insufficient.

11 Okay. All votes are in. Voting is  
12 now closed. We have, the results are 50 percent  
13 voted for high, 39 percent voted moderate, 11  
14 percent voted low, and 0 percent voted  
15 insufficient.

16 CO-CHAIR STILLE: Okay. So that one  
17 passes. And then the last one is physical  
18 safety.

19 MS. QUINNONEZ: For our last category  
20 for safety for performance gap, our first option  
21 is to vote high, second option moderate, third  
22 option low, and fourth option insufficient.

1 All votes are in. Voting is now  
2 closed. We have 100 percent high.

3 CO-CHAIR STILLE: No, really? No.

4 MS. QUINNONEZ: Zero percent moderate  
5 obviously, 0 percent --

6 CO-CHAIR STILLE: No.

7 MS. QUINNONEZ: It's not right?

8 CO-CHAIR STILLE: It's not right. No.

9 MS. QUINNONEZ: What's not right?

10 Let's try this again. One second. Okay. We're  
11 going to re-vote on our last category for safety.  
12 And it's going to be option number 1 high, option  
13 number 2 moderate, option number 3 low, and  
14 option 4 insufficient.

15 Voting is now closed. All votes are  
16 in. The results are 0 percent high, 22 percent  
17 moderate, 39 percent low, and 39 percent  
18 insufficient.

19 CO-CHAIR STILLE: All right, 39 and  
20 39. Okay. So it does not pass. So we have some  
21 groups that passed. Sarah, have you been  
22 tallying those?

1 MS. SAMPSEL: I have. So we have the  
2 scale measures failed on evidence -- or on  
3 performance gap. The global measures, consensus  
4 not reached. The recommendation measures passed.  
5 The unmet needs measures passed. Physical safety  
6 measure did not pass.

7 CO-CHAIR STILLE: Okay.

8 MS. SAMPSEL: However, what we'll do  
9 though is, as we move forward, we'll still have  
10 the discussion about all of these for the benefit  
11 of the developers. But we'll only vote on those  
12 sets that either consensus was not reached, so  
13 the global measures and the recommendation and  
14 unmet needs measures.

15 CO-CHAIR STILLE: Okay.

16 MS. SAMPSEL: But we'll discuss all of  
17 them still.

18 CO-CHAIR STILLE: Yes, great. Okay.  
19 Good, thank you. Okay. Let's move on.  
20 Composite measure. What? No, never mind. Okay.  
21 All right, so let's move to discussion on  
22 reliability then. Do the primary discussants

1 want to talk about a couple things? Lee, Len, or  
2 Nicole, any thoughts about reliability adjusting?

3 There are two people with their cards  
4 up. Are you waiting? No? Katherine, are you  
5 waiting? You are waiting? Why don't you talk?  
6 That's fine.

7 MEMBER BEVANS: I think that, for me,  
8 the primary concern that I have about this  
9 measure relates to the specifications. Most  
10 notably the exclusion of people with cognitive  
11 limitations that, for the items that are being  
12 used, prohibit them or prevent them, perhaps,  
13 from providing reliable or valid scores.

14 And the reason, of course, I'm  
15 concerned about that is because, presumably, that  
16 makes up a large percentage of the population  
17 that you're targeting.

18 On the other hand, I might have missed  
19 it in the report. I wasn't sure if you had data  
20 on how many people were excluded because of those  
21 criteria, which I think will be critically  
22 important to know.



1           This, to me, also suggests a couple  
2 things. First, there's obviously been a lot of  
3 discussion about proxy reporters, which I think  
4 is important. But it's also been noted, and this  
5 relates to specifications as well, that there are  
6 typically quite a lot of disagreement,  
7 differences in opinions, between proxy reporters  
8 and people reporting on their own behalf.

9           So, getting at specifications, I think  
10 that moving forward -- I know that the data you  
11 presented were just for the self-report component  
12 of the measure. But moving forward, considering  
13 whether those, a proxy report measure and a self-  
14 report version of the measure, should even be  
15 considered comparable, or considered as two  
16 separate measures for consideration.

17           And the last thing I'll say about  
18 that, again, related also to reliability: did you  
19 do any cognitive testing with the items  
20 themselves to get a better understanding or, for  
21 those not excluded, how they understood the  
22 items, whether they were they meaningful, whether

1 they were well-understood?

2 DR. MALLERY: So, to answer the last  
3 question about cognitive testing, we did do two  
4 rounds of cognitive testing in both English and  
5 Spanish.

6 MEMBER MORT: Actually, we did three  
7 rounds.

8 DR. MALLERY: Three rounds. Sorry,  
9 Elizabeth.

10 MEMBER BEVANS: I'm bringing this up  
11 just to say that I think that -- and perhaps I  
12 missed it, there's a lot of material to look  
13 through. But, really, a clear description of  
14 that, that's so critically important for the  
15 target population -- and for everyone, really,  
16 but the target population in particular. Some  
17 more information about the results of those  
18 cognitive testing I think would go a long way to  
19 support the measure.

20 MEMBER MORT: Okay. Do you want  
21 written material or do you want a verbal  
22 description?

1 CO-CHAIR STILLE: We can follow up  
2 afterwards.

3 MEMBER MORT: Thanks.

4 CO-CHAIR STILLE: Okay. And let's  
5 see, Beth, did you have your --

6 MEMBER AVERBECK: One question on  
7 reliability. Were the survey methods tested  
8 compared to each other? Because you had both in  
9 person surveys and telephone surveys. And did  
10 one give you different results compared to the  
11 other? I know sometimes face-to-face compared to  
12 mail is a lot different, so I was just wondering  
13 about telephone compared to face-to-face. Thank  
14 you.

15 DR. MALLERY: We did compare, and the  
16 differences were, I think, significant on some  
17 measures but not on others. So it was not the  
18 same that you typically see in mail versus phone,  
19 perhaps because they were both in-person. And I  
20 can dig up those, you know, which measures were  
21 different.

22 But we do recommend that as a case mix

1       adjustor, the survey mode, to account for the  
2       differences.

3                   CO-CHAIR STILLE:   Lee and then  
4       Sherrie.   And then I have a question.

5                   CO-CHAIR PARTRIDGE:   I had a quick  
6       question about the testing here.   You said that  
7       you tested in 26 different programs and the total  
8       number of respondents was 2,300.   That's a fairly  
9       small average number of respondents.   How  
10      comfortable should we be -- or why should we be  
11      comfortable with numbers of that size?

12                   I assume that's an average.   I assume  
13      you had, in some programs, a much smaller number  
14      and a much larger number.   But just to have a  
15      tiny bit of conversation, if we could.

16                   DR. MALLERY:   Sure.   So I think there  
17      is a table that I can show, I believe in this  
18      package, that shows the numbers.   But you're  
19      exactly right.   There's a range, I think 150 is  
20      about the average.   In some programs it was  
21      smaller.   So some of the programs are smaller.  
22      So it was smaller.

1                   And based off of this field test, we  
2                   are recommending a larger sample size moving  
3                   forward based on calculations for the -- in order  
4                   to get a reliability of .7 for these measures  
5                   moving forward, we're recommending an effective  
6                   sample size of 400 for program moving forward.  
7                   And we can talk about that a little bit more.

8                   But I mean, that is what most of the  
9                   programs are aiming for, for this next round.  
10                  Maybe I'm over-speaking. But that's the guidance  
11                  we've given for the next round. So on many of  
12                  the programs, it is feasible.

13                  CO-CHAIR PARTRIDGE: Yeah, I'm  
14                  surprised. I actually think in some of these  
15                  cases, you'd have a pretty small number of  
16                  respondents. I mean, some of the incidence of  
17                  this population is going to be quite small,  
18                  right? For example -- but anyway. Thank you.

19                  CO-CHAIR STILLE: And then Sherrie.

20                  DR. JACKSON: I actually have  
21                  statistics on that, if you'd like to hear them.  
22                  This is for 2012, the data that's most recently

1 available in the HCBS 1915(c) waivers. Twenty-  
2 right percent have enrollees under 400; 30  
3 percent between 400 and 3,000; and 41 percent  
4 between 3,000 and 50,000-plus.

5 So there's definitely a range. And  
6 the other thing to consider moving forward is,  
7 with the 2014 HCBS rule, CMS is allowing  
8 consolidation of waiver programs. So your size  
9 of your waiver programs are going to -- may grow  
10 over time.

11 Also with managed long-term services  
12 and supports, that, essentially, for many  
13 programs, is consolidation. So the size of your  
14 programs over time is likely to grow.

15 CO-CHAIR STILLE: Sherrie, you had a  
16 point?

17 MEMBER KAPLAN: Let me follow up  
18 because I'm old and I forget things like crazy.  
19 So let me follow up on that point first. The  
20 issue of, you know, if you're sampling, if you  
21 fix the sample size, you're going to get a very  
22 much different, and probably more stable,

1 estimate of the smaller programs than you are of  
2 the larger programs, depending on how you do that  
3 sampling.

4 Because you're going to have to be  
5 careful about who you're representing in that.  
6 You know, it's really going to have a very strong  
7 randomization and sort of random sampling issue  
8 to get a stable estimate.

9 So if you fix the sample size, it  
10 raises more of a validity than a reliability  
11 question. But you're going to estimate some of  
12 these programs with half of their population and  
13 others with a very small portion.

14 So the other issue is that some of  
15 your scales have fairly good precision, in terms  
16 of at the patient level anyway. And I'm looking  
17 at Exhibit 2. I forget what page it's on. But  
18 the three scales that are really fairly strong  
19 are staff reliability and helpfulness, staff  
20 listening and communication, and case manager  
21 helpfulness.

22 And then it drops to choosing the

1 services that matter to you. And the reason I'm  
2 going into this I'll come back to in a minute.  
3 And that actually drops pretty low. On the other  
4 hand, that only has two measures in it, two items  
5 in that measure. And that's exactly what you  
6 would expect given the way this formula is  
7 constructed.

8 And then down to, you know, sort of  
9 the personal safety and respect, that's got three  
10 items in it. And again, you would get -- you  
11 would expect that because it has fewer items in  
12 it.

13 So my first question is, have you a  
14 done a look, or could we ask you to do a look, at  
15 a Spearman-Brown prophecy formula, to say this is  
16 an important construct to us but I don't really  
17 have enough items in that construct and it's not  
18 robust enough.

19 It may actually be really good in  
20 discriminating facilities one from another, but  
21 because I don't even have very good reliability,  
22 I can't tell that. So do you need more sample



1 size? Or do you need more items? And the  
2 Spearman-Brown prophecy formula data would give  
3 you that. So that was question number one.

4 And question number two is, the inter-  
5 unit reliability issues are problematic for some  
6 of these unmet needs measures. And specifically  
7 the unmet need in toileting. It doesn't have  
8 very much variability at all. But it's got  
9 crummy IUR, it has terrible IURs. But, you know,  
10 some of them, unmet need for medication, have  
11 pretty good and pretty robust IURs.

12 So, you know, is there a possibility  
13 going forward that you can look at maybe the  
14 intraclass correlation coefficients at some of  
15 these units being compared and look at within,  
16 versus, between unit comparisons and see if  
17 there's some gain that you could, possibly, with  
18 an increase in precision of these measures, that  
19 you could actually look at.

20 Or -- and this is horrible for NQF and  
21 I apologize, Sarah -- the possibility of creating  
22 a composite out of this where you're creating a

1 composite out of unmet needs. It doesn't prevent  
2 you from drilling down to individual item level  
3 but it could help you in the precision.

4 CO-CHAIR STILLE: Great, thanks. Sam?

5 MEMBER BIERNER: I want to comment  
6 specifically on the table that's just above 1.6  
7 where you list the number of returned surveys.  
8 There were only 92 brain-injured patients  
9 surveyed that returned surveys. I don't know how  
10 many you actually surveyed, but only 92 counted  
11 in this sampling.

12 So it seems like you've under-  
13 represented TBI for purposes for drawing any  
14 conclusions about them. And I wanted to see what  
15 your comments were about that and how you would  
16 correct it.

17 There's a table that shows number of  
18 total returned surveys. From Maryland, there was  
19 zero that was thrown out. And then 72 from  
20 Minnesota and 20 from New Hampshire in that  
21 table.

22 DR. MALLERY: So in that table it

1 might be a little bit misleading. Because I  
2 think that's just within -- or maybe I'm -- in  
3 Exhibit 1 that goes through the states?

4 MEMBER BIERNER: Yes.

5 DR. MALLERY: Okay. So there were  
6 actually, overall, 262 beneficiaries with  
7 traumatic brain injury in our sample. So I'm  
8 thinking that maybe that that is one TBI program  
9 within one state that you might be looking at.

10 MEMBER BIERNER: Right. Yes, I see  
11 that in the top part of the table. But there's  
12 still a very small sampling. You said you'd need  
13 a minimum of 400. So you less than 250.

14 DR. MALLERY: That's correct.

15 CO-CHAIR STILLE: Okay. Good. Great  
16 discussion. We are now going to vote on  
17 reliability for the three remaining sets, since  
18 there seems to be some differences in numbers  
19 between the sets, with global rating, recommend,  
20 and unmet need.

21 MS. QUINNONEZ: Okay. Give me one  
22 second.

1 (Pause.)

2 CO-CHAIR STILLE: Desi, let us know  
3 when you're ready.

4 Do a hand vote? Okay. We can do a  
5 hand vote if that's easier.

6 MS. QUINNONEZ: Okay. Voting is now  
7 open for scientific acceptability and  
8 reliability, including precise specifications and  
9 testing, for the first group, which is global  
10 ratings. And the options are number 1 high,  
11 number 2 moderate, number 3 low, and 4  
12 insufficient. Voting is now open.

13 Okay. We're looking for four more  
14 votes. Two more. Okay. All votes are in and  
15 voting is now closed. The results are zero  
16 percent high, 39 percent moderate, 44 percent  
17 low, and 18 percent insufficient -- 17 percent  
18 insufficient.

19 CO-CHAIR STILLE: Okay. So that's for  
20 the global rating group, right? Okay. And that  
21 fails. Okay.

22 MS. QUINNONEZ: Okay. Voting is now

1 open for reliability, including precise  
2 specifications and testing, for the  
3 recommendations group. And the options are  
4 number 1 high, number 2 moderate, number 3 low,  
5 and number 4 insufficient.

6 All votes are in and voting is now  
7 closed. The results read 0 percent for high, 22  
8 percent moderate, 67 percent low, and 11 percent  
9 insufficient.

10 CO-CHAIR STILLE: Okay. So that fails  
11 on reliability. The last one is unmet needs.

12 MS. QUINNONEZ: Voting is now open for  
13 scientific acceptability and reliability,  
14 including precise specifications and testing, of  
15 unmet needs. The options are number 1 high,  
16 number 2 moderate, number 3 low, and number 4  
17 insufficient.

18 All votes are in and voting is now  
19 closed. The results are -- no. We'll do this  
20 one over. Give me one second.

21 MS. THEBERGE: Dawn, I don't have your  
22 vote yet.

1 MS. QUINNONEZ: We will re-vote again  
2 for reliability, including precise specifications  
3 and testing, for unmet needs. Number 1 high,  
4 option number 2 moderate, option number 3 low,  
5 and option number 4 insufficient.

6 All votes are in and voting is now  
7 closed. The results read 6 percent high, 11  
8 percent moderate, 67 percent low, and 17 percent  
9 insufficient.

10 CO-CHAIR STILLE: Okay. Absolutely  
11 right. So we're done with voting but we'd like  
12 to continue the discussion to be as helpful as  
13 possible to the developers as we can give them  
14 some recommendations for where to go next.

15 I'm just trying to recap what I  
16 remember so far. One of the points was basically  
17 more numbers for more populations. One of the  
18 points was really looking hard at proxy reports.  
19 And both doing more of them and also differences  
20 with self-report. There was one other big point  
21 and I can't remember. Anyone?

22 MEMBER KAPLAN: Intraclass correlation

1 coefficients, between unit differences.

2 MEMBER BEVANS: Maybe showing the  
3 evidence from cognitive testing for  
4 understandability of items.

5 CO-CHAIR STILLE: The other thing that  
6 just came to mind is, especially with some of the  
7 ones that seem to have the ceiling effect, some  
8 quality improvement folks do what's called a top-  
9 box reporting system. And, you know, the  
10 validity of that, it kind of depends on what  
11 you're trying to say. But that might be useful  
12 to look at, too. Lisa?

13 MEMBER SUTER: First of all, I'd like  
14 to echo Sherrie's recommendation for looking at  
15 the Spearman-Brown prophecy formula. I thought  
16 that was a great suggestion. And along those  
17 lines, I think understanding the feasibility of  
18 getting to your optimal sample size of 400 would  
19 be really helpful, since your sampling is much  
20 below that level. So, understanding what the  
21 burden on providers is to get to that level.

22 I'd also love to see information about

1       how long it takes patients or family members to  
2       fill this out. So, the burden on the individual  
3       patients or caregivers.

4               And the final thing is, can you  
5       describe a little bit more -- maybe not now, but  
6       in the materials -- what the actual patient input  
7       was to development of the questions. There's a  
8       notation, and I may have missed the more detailed  
9       information, that this population demonstrated  
10      that these were important. But I wasn't sure  
11      whether they were actually involved in the  
12      development.

13              CO-CHAIR STILLE: Okay. Peter, and  
14      then Lee.

15              MEMBER THOMAS: So we had a motion on  
16      the table at the beginning of this discussion  
17      that we never acted on. And this may be  
18      inappropriate; let me just put it on the table.  
19      You've heard this whole discussion and you've  
20      gotten the comments. Is this something that you  
21      can "cure" in two months? Or would you rather  
22      have a deferral of this whole discussion for some



1 longer period of time and come back to the table?

2 DR. MALLERY: Many of the things  
3 you've asked for we could pull together in a few  
4 days -- I mean, it's stuff we've already done. I  
5 mean the cognitive testing, how patients were  
6 involved -- they certainly were. And we could  
7 have a report on that, we could pull that  
8 together very quickly.

9 More data is a different story. So I  
10 think that's what we've have to talk about.  
11 Because there is another round -- but just more  
12 data is a whole other story.

13 MS. SAMPSEL: Chris?

14 MEMBER KAPLAN: Sorry, one more thing.  
15 If you're going to do the exercise of going back  
16 through the data, you know, factor analyzing,  
17 you've got enough subjects to do a factor  
18 analysis, would help how multidimensional this  
19 construct is. Because you're losing precision if  
20 you're doing these fine grain things.

21 It actually may help you more if  
22 you're doing a bigger composite. So, you know,

1       you're kind of crunching things into -- and  
2       that's why the Spearman-Brown prophecy formula  
3       early on would help you understand, am I needing  
4       more measures or more subjects per measure?

5               And, you know, doing that early and  
6       then giving us a factor analysis -- or doing a  
7       factor analysis and saying, geez, I've cut this  
8       too finely, the factor analysis isn't supporting  
9       it.

10              DR. MALLERY: I don't know if I should  
11       respond. But, I mean, all of these measures are  
12       based on factor analysis. So we did do that. So  
13       there was confirmatory and exploratory. And I  
14       think that that is probably written up a little  
15       bit here. But happy to give more detail about  
16       that.

17              MEMBER KAPLAN: Yeah, that data would  
18       have helped. But it depends on how you do those  
19       rotations, because these things are notoriously -  
20       - so an oblique versus a varimax rotation, for  
21       example, would help you with that issue, on how  
22       multidimensional it is.

1 MS. SAMPSEL: I guess my comment is  
2 just going to be to go back to -- I don't think  
3 we need to make a decision on voting on a  
4 deferment today. I think we need to go back and  
5 give you guys some time and be clear on what we  
6 want to do and we can have another discussion.

7 And it might make sense actually for  
8 us to mimic some of your forms so that we have  
9 five submissions, and so that we can deal with  
10 them separately and make it a little bit of a  
11 cleaner process as well. Because I think some of  
12 these are being held hostage, perhaps. Although,  
13 you know, they all failed when we got down to it.

14 So let's see what kind of additional  
15 data and we can bring it back for the post  
16 comment.

17 CO-CHAIR STILLE: And then Linda.

18 MEMBER MELILLO: I would just say, if  
19 you're going to include employment questions, to  
20 bring them, as well, if you're thinking of adding  
21 them to this grouping.

22 DR. MALLERY: I don't think we were

1 considering putting them up for endorsement. But  
2 they are available on the survey. So I think  
3 that's important to note, that for use they'll be  
4 available.

5 MEMBER MELILLO: Okay.

6 CO-CHAIR STILLE: Okay. Others?  
7 Okay. Well, thank you very much. I'm sorry this  
8 was really hard, but it was a good process. And  
9 I'm sure it will win eventually. Okay.

10 (Pause.)

11 MS. SAMPSEL: Operator, is Nick Castle  
12 on the phone?

13 OPERATOR: Yes, he is.

14 MS. SAMPSEL: Okay. Can you just make  
15 sure he has an open line?

16 OPERATOR: His line is open.

17 CO-CHAIR PARTRIDGE: All right, we're  
18 going to switch over to -- and I think we'll  
19 probably pretty easily be able to talk about them  
20 as a group. Three measures, all related to  
21 discharge -- sorry. I think I'm still tongue  
22 tied from the last one.

1           First, 2614 is a measure of taking at  
2 discharge from somebody leaving a short stay.

3           2615 is long stay resident who is presumably not  
4 leaving. And 2616, long stay, but this time the  
5 family is the respondent and not the patient. So  
6 we'll turn it over to our friends from AHCA.

7           MR. MULLER: Very good. So I will  
8 keep this brief. So the three CoreQ measures, we  
9 really wanted a short set of parsimonious and  
10 effectiveness, experience of care measures. And  
11 brought Nick Castle, who's on the line, from the  
12 University of Pittsburgh in to develop them.

13           For those who don't know, Nick was  
14 probably the core mind in developing the nursing  
15 home CAHPS measures. And essentially, this is a  
16 short form spiritual descendent of nursing home  
17 CAHPS.

18           To build it, we started with a large  
19 set of items and did rounds and rounds of  
20 exploratory factor analysis to distill down to a  
21 minimum set of measures that captured the bulk of  
22 the signal picked up in the larger measure, large

1 instrument and larger measure.

2 And then we intensively tested the  
3 kind of agreement with patients agreeing that  
4 they are important measures and clear measures  
5 and all of that. And it was backed up very  
6 nicely.

7 And so, the three measures are short  
8 stay discharge, long stay resident, and long stay  
9 family. And they're all based on a one to five,  
10 poor, average, good, very good, and excellent  
11 scale.

12 The questions, to give you a flavor of  
13 the definition of the measure are one, in  
14 recommending this facility to your friends and  
15 family, how would you rate it overall? Two,  
16 overall how would you rate the staff? Three, how  
17 would you rate the care you receive? And then  
18 just for the short stay discharge measure, how  
19 would you rate how well your discharge needs were  
20 met? So very much kind of an experience of care  
21 measure that parallels a little bit the five star  
22 branches as well. The measures then, the percent

1 of the responses who averaged, whose answers  
2 averaged good or better.

3 The last thing I'll say -- I'll not  
4 get into any of the other technical details. But  
5 we have ten customer satisfaction vendors who  
6 have all invested to incorporate the four  
7 questions into their instruments. And this is, I  
8 don't know what portion of the market for the  
9 skilled nursing market for customer satisfaction  
10 surveys is not captured by these guys. But I'm  
11 guessing that it's very small.

12 And so, what this represents is ten  
13 very serious professional survey firms  
14 effectively, you know, a free market sense  
15 endorsing the measure for it's sort of  
16 appropriateness and all of that as, eventually,  
17 kind of a uniform national standard for customer  
18 satisfaction measurement in SNFs.

19 So it's an important thing there. And  
20 it's currently being administered and it's  
21 currently being collected. And in our AHCA  
22 quality initiative, in some of our tools we're

1 beginning to collect the measurement themselves.  
2 And this will just sort of grow over time. And  
3 with that, the discussion.

4 CO-CHAIR PARTRIDGE: Our lead  
5 discussant group has gotten a little smaller.  
6 We've lost David. Now I've lost my cheat sheet.  
7 Sherrie, I think you're one on these. Am I  
8 right? And Peter is the other. Okay. Either  
9 one of you want to go first? Peter, do you want  
10 to go first? Good.

11 MEMBER THOMAS: Yes. I'll just say a  
12 couple of things. And again, you don't really  
13 want to go into evidence or anything. You just  
14 want some overarching comments? So this is a  
15 patient reported outcome measure and it's  
16 obviously a major area.

17 Skilled nursing care, skilled nursing  
18 facilities provide care to millions of Americans  
19 each year. I agreed with the -- well I was  
20 already into evidence here. Hold on. I had some  
21 real questions about the exclusions because I  
22 felt that some of them might impact the overall



1 satisfaction scores in a significant way. But I  
2 can go into that in more depth when it's time to  
3 do that, during the evidence discussion.

4 But it's obviously a very important  
5 measure for those people who go to a nursing home  
6 or a skilled nursing facility and don't stay  
7 indefinitely, don't stay a long term period of  
8 time. And that's apparently more and more folks,  
9 the more rehabilitation is being provided in  
10 those settings. And that's obviously a very  
11 important thing to measure, is them being  
12 satisfied and being ultimately discharged back  
13 into the community.

14 CO-CHAIR PARTRIDGE: Sherrie?

15 MEMBER KAPLAN: I had some -- first of  
16 all, I support all of Peter's comments. And then  
17 I had some questions, more questions than  
18 anything else to the developers. I agreed that  
19 the exclusions actually may limit the  
20 generalizability to a small proportion of  
21 facility nursing home patients.

22 And then the consistency of the

1 implementation across facilities actually could  
2 be compromised by the low response rate. So I  
3 was a little bit concerned about the response  
4 rate.

5 Second thing I was concerned about was  
6 there was test retest reliability but they give  
7 one month as the testing interval. And they give  
8 percent agreement but not intra-rater reliability  
9 at the patient level. And they didn't give ICCs  
10 at the facility level, at least I couldn't find  
11 it.

12 The other thing I was, a few other  
13 things. The pre-specify, when you do boot  
14 strapping, you can't really interpret it without  
15 pre-specifying a minimally important difference.  
16 So I would like to hear something about what you  
17 considered a minimally important difference.

18 And the sample size varied from 20 to  
19 196 per facility. So the stability of estimates  
20 across facilities is going to, that's going to  
21 affect the stability of those estimates.

22 And then I didn't get the item to

1 total correlation coefficients for the 22 items  
2 to support the item choice thing and your  
3 elimination of the items.

4 And in the validity testing, although  
5 your factor analysis looks like it supports a  
6 single dimension, you don't say if you did any  
7 varimax or oblique rotations to kick the tires on  
8 the multi-dimensionality. And so I was  
9 interested in hearing your responses on that.

10 And finally, the validity concerns I  
11 had were like because, although you note that  
12 there are these correlations, some of them are  
13 significant with the validity variables you chose  
14 but a number of them are very low. And many of  
15 them are not significant. And so, then I was  
16 wondering what we were going to conclude about  
17 the, your take of what that means.

18 CO-CHAIR PARTRIDGE: That's kind of a  
19 laundry list. So I'm not sure that we can ask  
20 you to respond to all of them right this second.  
21 But if you want to tackle, you know, a couple  
22 that seem -- either we can knock it off fast or

1       it's --

2                   DR. GIFFORD: I assume with the  
3       exclusions people are concerned with the  
4       cognitive impairment piece for it. Because the  
5       rest are really minor. And I would think  
6       clinically, seeing that makes sense. People die,  
7       can't really survey them. And we're really split  
8       out making sure it was the voice of the patient  
9       or the voice of the family. We would not combine  
10      them. So we exclude them that way.

11                   The cognitive impairment one has, you  
12      know, been really a difficult one in satisfaction  
13      in general in this setting. And I think we ended  
14      up setting on, using the BIMS score that Salida  
15      developed for MDS. So it was uniform to every  
16      nursing home resident out there. So we had a  
17      standardized way of assessing that. It wouldn't  
18      allow people to game the system.

19                   It's currently, something like that is  
20      used currently pretty much across the board in  
21      most nursing home satisfactions that are out  
22      there thought not everyone can quite do it. We

1 set it at the level of where we did because it's  
2 pretty moderate to severe. It's unclear anyone  
3 would have a short term memory to be able to  
4 recall anything overall.

5 It mainly was -- frankly we don't  
6 care. You can send it to them. But the chance  
7 that they'll fill it out or not have someone else  
8 assist them in filling it out, then their results  
9 would be excluded anyway because we don't allow  
10 proxy individuals. Then you just, you dry the  
11 sample, your response rates become a problem.  
12 And so, it was also just to help with the  
13 response rates frankly.

14 MEMBER KAPLAN: May I ask a follow up  
15 question on that? Because the response rates  
16 don't look great to begin with. And so, I know  
17 this is a vulnerable population and it's  
18 difficult to reach and all that stuff.

19 On the other hand, when you've got  
20 that limited amount of response rate, can you  
21 give us a sense of whether those, the patient  
22 characteristics match the profiles of the

1 facilities? Or anything to help us see if that's  
2 a generalizable sample you got?

3 DR. GIFFORD: I was a part of that and  
4 I don't know if we did the latter part or not.  
5 But I know that one of the things we did is we  
6 talked, we talked a lot with a lot of the, as  
7 James said, a lot of the survey vendors out  
8 there. And pretty much across the board, most  
9 everyone right now is accepting somewhere around  
10 15 to 20 percent which we thought -- yes, that  
11 was also my response too.

12 And so we boosted it up. And then we  
13 really pushed it. We're allowing right now, in  
14 sort of initiative, anyone to have any response  
15 rate. But when we calculate it or do any  
16 reporting or do any reporting, we want a minimum  
17 response rate.

18 I mean, if you look at even the states  
19 that are publicly reporting satisfaction out  
20 there and there's four or five of them, we talked  
21 to those vendors in those states and they're all  
22 accepting really low response rates. So we ended

1 up deciding to go with that from a pure usability  
2 standpoint.

3 Because while I completely agree with  
4 you, I'd love to see a higher response rate, even  
5 in the states where they're doing public  
6 reporting, you would essentially probably go down  
7 to about 10 to 15 percent of SNFs in the country  
8 having an adequate response rate. Then I'll turn  
9 it over to James for the other analysis.

10 MR. MULLER: So for the technical  
11 questions, do you want to step through them one  
12 by one?

13 MS. SAMPSEL: Actually, can we hold  
14 those until we get to scientific acceptability  
15 please?

16 MR. MULLER: All right.

17 MEMBER THOMAS: First do the  
18 exclusions for a second.

19 MR. MULLER: Sure.

20 MEMBER THOMAS: Because my concerns  
21 were a little bit broader than just the cognitive  
22 --

1 MR. MULLER: Okay.

2 MEMBER THOMAS: -- exclusion. And  
3 this is going to sound maybe a little tongue in  
4 cheek. But some would argue that the person that  
5 dies is the least satisfied with their care.

6 MR. MULLER: Yes.

7 MEMBER THOMAS: And I'm concerned  
8 about also the readmissions issue, about going to  
9 another facility. It might have nothing to do  
10 with the care being provided in the SNF. But it  
11 might have something to do with the care being  
12 provided in the SNF. And if it is because of  
13 some of the things that are being measured here,  
14 competency of the staff, you know, responsiveness  
15 of the management, if those are in fact  
16 contributing factors to why that person has to go  
17 to another facility whether they're being  
18 readmitted to the acute care hospital or to a  
19 higher intensity level of care like an IRF or if  
20 they die.

21 Those are perhaps, you might argue,  
22 the most egregious cases and they're being pulled



1 out of the sample. So can you just address that?

2 DR. GIFFORD: We talked a lot about  
3 it. We actually would prefer to see a hospice  
4 level or end of life, you know, some of the  
5 survey stuff that Joan Teno's down at Brown.  
6 Because I think she's also shown that this group  
7 is the experience and the questions -- it's not  
8 even clear in the focus groups in cognitive  
9 testing whether these are the appropriate  
10 questions to ask for people who are dying.

11 The experience of the provider  
12 community has been sending any sort of survey  
13 questionnaire to family members of people who  
14 have died has often been very offensive. And so,  
15 it was felt to be out of respect of them to  
16 collect the data a different way. And they are  
17 excluded for that reason as well.

18 MEMBER THOMAS: That's fair. I guess  
19 where I'm going is maybe something that's in  
20 politic to raise, I'm just trying to understand.  
21 If you've got a SNF that's not up to par on  
22 quality and they're actually contributing to the,

1 some of the things that are happening to these  
2 people who are then being excluded from a quality  
3 measure, isn't that biasing the data in a  
4 favorable way?

5 MR. MULLER: I think if the SNF is  
6 systematically poor, it'll be picked up as well  
7 by the patients who aren't being excluded. So  
8 that will be driven down by that signal as well.

9 DR. GIFFORD: We also have a panel of  
10 other measures that we're held accountable to  
11 that are using -- so we have discharge to  
12 community. We have rehospitalization rates. We  
13 have more functional improvements to come. So we  
14 have a whole set of other metrics that are being  
15 held accountable to that provide an opportunity  
16 to sort of balance, I think, if we're discharging  
17 inappropriately or having other problems that are  
18 out there.

19 CO-CHAIR PARTRIDGE: Before we move  
20 on, Deb you are back on the line with us. Is  
21 that right?

22 MEMBER SALIBA: Yes I'm back.

1 CO-CHAIR PARTRIDGE: And you're one of  
2 the discussants here. So maybe we should give  
3 you an opportunity.

4 MEMBER SALIBA: Yes. So I certainly  
5 agree with the premise that obtaining resident  
6 satisfaction measures is really important. And  
7 that this is a gap in the current measurement  
8 approach. So I think it's great that this is  
9 being done.

10 I was a little bit unclear if the  
11 CoreQ analysis that we're seeing is having  
12 received a full survey and then answered these  
13 summary items. Or if it's just answering these  
14 summary items. It seems like in a lot of  
15 satisfaction surveys, you tend to have the more  
16 granular items leading up to then asking these  
17 more summative kinds of scores.

18 And so, it was a little unclear to me  
19 if the testing results that you're showing us are  
20 just, you went in and just asked these three very  
21 summary questions which seem to be a little bit  
22 challenging in terms of providing an actionable

1 road map. Or if you're going in and doing the  
2 longer survey and then only scoring the last, the  
3 summative three questions.

4 The rest of my questions were about  
5 the more, along the lines of the evidence, the  
6 correlations and things like that. But I did  
7 want to ask about that question.

8 MR. MULLER: I mean -- and Nick can  
9 speak to some of this as well. There were  
10 different rounds of development. And some of the  
11 earlier rounds of development needed the full set  
12 of questions so that we could whittle things  
13 down. And I think the current form that he's  
14 collecting out there is distilled down to the  
15 minimal set.

16 Some of the vendors that are doing it  
17 have integrated into their own instruments with  
18 other questions in there and that sort of thing.  
19 So it's really a mixture of different things.

20 MEMBER SALIBA: Another thing was the  
21 choice of the response scale, poor, average,  
22 good, very good, and excellent. So it seems

1 pretty heavily weighted towards positive  
2 responses. And lumping the good, very good, and  
3 excellent together would seem to weight more in  
4 the direction of positive response.

5 And I was interested in how you came  
6 at that particular response scale.

7 DR. GIFFORD: Well we actually, and  
8 Nick had commented, we did focus groups and  
9 cognitive testing of different response scales  
10 from ten point down to four point Likert scales.  
11 And this actually is -- I mean they all worked  
12 reasonably well.

13 And Nick can talk about some of the  
14 work he's done with some of the CAHPS. But he  
15 found that most of the CAHPS surveys, no one  
16 answered below five or six. And so, that's one  
17 reason we collapsed, in general, in satisfaction,  
18 when you're asking poor or fair, it's bad.

19 To your point, we actually tested five  
20 or six different ways to calculate the measure.  
21 And I was thinking that we could find a better  
22 way of capturing it. And it turned out it did

1 not matter how you collapsed this together. You  
2 just ended up with different satisfaction scores  
3 but relative ranking was no different. The only  
4 thing that really different was if you just took  
5 the top rating of whatever scale you used, that  
6 was a fundamentally different measure.

7 But five other different ways of  
8 averaging them together, you just ended up with a  
9 different national average or group average. But  
10 it didn't vary at all.

11 And then I think, back to your earlier  
12 point, the early round testing was all the  
13 questions. And Sherrie, this may go to your  
14 points too. Our goal was to get a parsimonious  
15 measure for accountability purposes. This was  
16 not for quality improvement purposes. Let me  
17 make that really clear.

18 I mean, if you were doing quality  
19 improvement purposes, you put food in this  
20 question. It doesn't matter whether you ask  
21 food. Once you ask these three questions and add  
22 them together, your scores don't change. Your

1 quality improvement and input is tremendous.

2 And so, this was one reason we also  
3 recommended that the current vendors -- and why  
4 they all support it. It gets added as a block  
5 set of questions by themselves with the standard  
6 -- because they all used different Likert scales  
7 and do everything differently. And so it's  
8 really been important.

9 The other is -- Nick do you want to  
10 talk about? We asked, would you recommend to a  
11 friend? And how satisfied were you overall? And  
12 we put it at the beginning. And we put one at  
13 the beginning and one at the end and we flipped  
14 it beginning to the end. And it is absolutely no  
15 different.

16 DR. CASTLE: Yes, I was about to try  
17 and comment on that. And I agree with Deb's  
18 point. And we did a decent amount of testing on  
19 this because we had the opinion that if you have  
20 these aggregate items first, you do think  
21 aggregate. And then you answer the more granular  
22 questions -- is that going to have an effect? As

1       opposed to answering the very granular questions  
2       that may then impact your overall opinion of the  
3       facility at the end.

4               So in the initial testing, we had the  
5       questions at the front and at the back. And in  
6       several thousand surveys, we found really very  
7       little difference. But again, I agree with Deb.  
8       We expected to find something, we didn't.

9               But what difference we did find is if  
10      you have the block first of aggregate items, we  
11      get all of the items answered and we get a very,  
12      very good, complete response rate which of course  
13      we need for calculating the score. So it was  
14      advantageous to have the items blocked at the  
15      beginning.

16              DR. GIFFORD: So we originally  
17      calculated from -- I forgot. Nick, how many was  
18      it? Like 20 or some odd questions. But then the  
19      --

20              DR. CASTLE: 24.

21              DR. GIFFORD: 24 but then the  
22      subsequent reliability and validity of the large



1 sample size was done just on these three  
2 questions or four questions for the discharge.  
3 And they were done with, either block by vendor  
4 that was out there added within the survey.

5 CO-CHAIR PARTRIDGE: Are we ready to  
6 move on to evidence? Sorry Becky?

7 MEMBER BRADLEY: Just as a point of  
8 clarification, I guess your previous answer was  
9 that this is not in addition to the CAHPS surveys  
10 that are being done. This would be instead of  
11 for the patients who have a short stay of 100  
12 days or less in a skilled nursing facility. So  
13 it would replace a CAHPS survey for this  
14 particular post-acute setting?

15 I guess I'm -- we spent a lot of time  
16 at our last meeting talking about how CMS is  
17 trying to standardized instruments across post-  
18 acute. So I guess I'm trying to figure out where  
19 this survey would play out in the post-acute  
20 setting. And how it would be compared to other  
21 post-acute settings going forward. Or is it just  
22 unique and by itself?

1           MR. MULLER: A little bit of both. I  
2 mean, it's intended, it wouldn't make sense to do  
3 both the nursing home CAHPS survey and this  
4 survey because they will correlate very highly.  
5 Because the additional items, as Giff sort of  
6 pointed out, don't really -- it's picking up the  
7 signal. And so there's a redundancy between the  
8 two.

9           This is a shorter, sort of more  
10 parsimonious survey that will get a higher  
11 response rate because of that. So I guess one  
12 could do both. But I don't know why one would.

13          DR. GIFFORD: And nursing home CAHPS  
14 is not used right now. No one's using it.  
15 There's a handful using it for discharge. But  
16 other than that, no one is using it for long stay  
17 or anything else. And then CMS just went through  
18 the endorsement application. So it's not even an  
19 endorsed measure anymore.

20          So right now there is no standard  
21 metric out there. And this started because we  
22 made imprudent satisfaction as a primary focus of

1       our national quality initiative. And when we  
2       went out there and looked at everything being  
3       done, it's all over the map.

4               And so, the feeling was we needed a  
5       standardized way to do this. And that's why we  
6       worked with Nick and all the vendors. And  
7       everyone's been really excited because it's the  
8       first time there's a standardized metric that you  
9       can compare across everyone.

10              MEMBER BRADLEY: Across --

11              DR. GIFFORD: Across SNFs, yes.

12              MEMBER BRADLEY: But not across the  
13       post-acute?

14              DR. GIFFORD: No. We developed it for  
15       -- we don't have it to bring forth. We developed  
16       it for assisted living too. And we've tested it  
17       and we've done a lot of collecting. The problem  
18       with it, we don't know how to test the validity  
19       of it because there aren't good measures of other  
20       external measures for validity out there.

21              MEMBER BRADLEY: Okay. Thank you.

22              CO-CHAIR PARTRIDGE: Can we move on to

1 evidence? Any comments or questions from either  
2 our discussants or the rest of our membership on  
3 evidence starting with 2614 which is the CoreQ  
4 for short stay discharge? Sherrie?

5 MEMBER KAPLAN: Can I just say  
6 something positive?

7 CO-CHAIR PARTRIDGE: Yes.

8 MEMBER KAPLAN: So yes, one, I really  
9 liked there was a conceptual framework that was  
10 provided at the beginning that linked the measure  
11 with other things that were going on. Second  
12 thing I liked, they really did cite our  
13 literature review kind of as a really, a more  
14 comprehensive literature review that documented  
15 the evidence for a lot of variation.

16 And then they showed that there was a  
17 considerable -- although it's still favorably  
18 skewed, there was a gap, there was a demonstrated  
19 gap. And the interquartile range was like 13  
20 points which is unusual in these satisfaction  
21 measures because you get them always bumped up to  
22 the top. So I did think there was strong

1 evidence provided both for the gap and for  
2 disparities by age and gender.

3 CO-CHAIR PARTRIDGE: Thank you.  
4 Linda?

5 MEMBER MELILLO: Yes. I would just  
6 like to say there is no required reporting or  
7 measurement in the SNF population currently. And  
8 I appreciate it's short. Because especially in  
9 that population, which tends to be very sparse in  
10 terms of staffing, that would be much more doable  
11 than one of the lengthy surveys.

12 MR. MULLER: Yes. We all hate  
13 paperwork.

14 CO-CHAIR PARTRIDGE: So are we ready  
15 to --

16 DR. GIFFORD: There's like five states  
17 that do public reporting in the nursing home but  
18 none national. And three other states have  
19 incorporated this into their questionnaire.

20 MEMBER MELILLO: Massachusetts has a  
21 state survey that they do annually. But yes, but  
22 again, it's very length. So this would be

1       preferable by far.

2                   CO-CHAIR PARTRIDGE:   Desi?

3                   MS. QUINNONEZ:   Okay.   We are now  
4       voting on Measure 2614 CoreQ short stay discharge  
5       measure on evidence, the rational supports the  
6       relationship of the health outcome to at least  
7       one healthcare structure, process, intervention,  
8       or service.   The voting options are number one  
9       for yes and number two for no.   Voting is now  
10      open.

11                   Looking for two more votes.   Voting,  
12      all votes are in and voting is now closed.   The  
13      results read 94 percent voted yes and 6 percent  
14      voted no.

15                   CO-CHAIR PARTRIDGE:   Okay.   Moving on.  
16      I think Sherrie has already touched briefly on  
17      gap.   Any comments specifically on this  
18      particular aspect?   Deb, chime in here where you  
19      wish.   And Lisa, you were, I can see your card.

20                   MEMBER SUTER:   So yes, could I just  
21      clarify, are we only voting on one measure  
22      through all criteria?

1 CO-CHAIR PARTRIDGE: Yes. I'm sorry.  
2 We are going to go through -- because they are  
3 slightly different, we are going to go through.  
4 And we also happen to have a discussion of the  
5 other two. So I'm sorry, back to voting on --  
6 Desi.

7 MS. QUINNONEZ: Are we ready for gaps?  
8 Okay. Voting is now open for Measure 2614 for  
9 gaps, performance gap data demonstrated  
10 considerable variation or overall less than  
11 optimal performance across providers and/or  
12 population groups. Option number one is high,  
13 option number two is moderate, option number  
14 three is low, and option number four is  
15 insufficient.

16 Waiting for one more vote. Okay. All  
17 votes are in and voting is now closed. The  
18 results read 39 percent voted high, 56 percent  
19 voted moderate, 6 percent voted low, zero percent  
20 voted insufficient.

21 CO-CHAIR PARTRIDGE: Okay. Moving on  
22 to scientific acceptability. First one, our

1 friend reliability. Floor is open for comments,  
2 concerns. Sherrie?

3 MEMBER KAPLAN: This is for the  
4 developers, do you have a sense of, do you have  
5 the intraunit reliability, the intraclass  
6 correlation coefficients at the facility level  
7 for these, for this measure?

8 MR. MULLER: Nick?

9 DR. CASTLE: Actually I do not. But  
10 when you say interunit, do you mean nursing home  
11 unit or --

12 MEMBER KAPLAN: Yes, facility level.  
13 Whatever unit is being compared. If it's the  
14 facility that's being compared, then evidence  
15 that it's --

16 DR. CASTLE: Oh so this was at just  
17 the facility level. I would love to do it at the  
18 unit level. But we had names and addresses of  
19 residents, clearly. But we don't know which  
20 units they were on.

21 MEMBER KAPLAN: I guess I'm asking the  
22 facility level with intraclass correlation



1 coefficients showing that it was more between  
2 than within unit facility variability.

3 DR. CASTLE: No I do not. I was  
4 actually trying to look that up right now when  
5 you mentioned it earlier. I haven't found that  
6 yet, no.

7 MEMBER KAPLAN: And then one quick  
8 question on battery reduction. So in this  
9 battery reduction exercises -- because these  
10 things are going to be really highly correlated  
11 with each other, they tend to be. To get from 22  
12 items to 4 items, this is back to the Spearman-  
13 Brown prophecy formulation, you're going to lose  
14 some precision when you shrink the number of  
15 items. But you know, if you're losing variation  
16 -- I didn't get the item to total correlation  
17 coefficients for the 22 items.

18 So if you went through that data, as  
19 you probably already did, how did you choose the  
20 top performers there? Because if these all have  
21 kind of a fairly strong relationship to the total  
22 body of items included, how did you pick which

1 ones to --

2 MR. MULLER: Again, a question for  
3 Nick.

4 DR. CASTLE: So some of this, as you  
5 might have guessed by the application, that this  
6 was extremely iterative. We did this many  
7 hundreds of times. But some of it was when we  
8 dropped our doors with the highest correlation.  
9 Then we continued to drop out that way. We would  
10 go partially down and then add some back in to  
11 see, as you're saying, that we hadn't actually  
12 mis-dropped something.

13 So it was almost a reverse process  
14 from what folks often do. We were trying to get  
15 items that almost were capturing the most  
16 satisfaction information that wasn't within  
17 another item. So if the items really correlated  
18 very, very, very highly, it made sense to drop  
19 one of those items. But once we had, later on we  
20 would put it back in until we were comfortable  
21 with dropping the individual items.

22 Now the other thing that was going on

1 with this is with the three instruments, we were  
2 also trying to do, to get items that were similar  
3 in the three instruments also. So it was almost  
4 a family of instruments.

5 DR. GIFFORD: The other thing that was  
6 going on at the same time is we were trying to  
7 look for a personalized number for a measure. So  
8 it wasn't that we were just trying to get a  
9 scale. Because they perform well as a full  
10 scale. And you can pick, sort of different  
11 numbers. But it was, what was the minimum number  
12 to get an aggregate measure to hold to assess the  
13 facilities overall satisfaction?

14 DR. CASTLE: Actually I think Giff  
15 just answered that way better than I did. If I  
16 answered a different way, I'd say, so if we had  
17 three or four items in there. Let's say we have  
18 four and we would calculate the score with those  
19 four items. We got somewhere, depending on which  
20 instrument we're talking about, 84 percent to 89  
21 percent or in some cases 91 percent of the score  
22 we would get with the full instrument, or with a

1 score using the CAHPS instrument which seems to  
2 indicate that we're capturing overall  
3 satisfaction. And if we added another item in,  
4 we might go up to 86 percent rather than 84  
5 percent.

6 So the addition of the item wasn't  
7 getting, wasn't capturing much for us.

8 MEMBER KAPLAN: I get it at the  
9 patient level. What I was looking for was at the  
10 between facility variance versus the within  
11 facility variance. And when you've got only 20  
12 subjects for some of these facilities, what  
13 you've got to go back, what it would be really  
14 good to go back and do is look at the Spearman-  
15 Brown prophecy formula to see how close to the  
16 bone are you getting with four items. Especially  
17 as you get sample sizes that shrink that far.

18 So you know, if you're getting too  
19 much noise, then you're going to get a lot more  
20 within facility variability that's going to mess  
21 up your ability to discriminate between  
22 facilities. So that's, it's related to that

1 question.

2 It doesn't necessarily -- I don't  
3 Sarah. It doesn't make the bar right now of the  
4 things that NQF is going to ask for. But it may  
5 make the next round. Is that right? Or is this  
6 a legitimate question for this round?

7 MEMBER SAMPSEL: I don't think so. I  
8 mean, because basically what we would like you to  
9 get out is have they provided the level that we  
10 have, you know, kind of -- go back to the  
11 algorithm, Sherrie, that you questioned earlier.  
12 And that, you know, what we've already  
13 communicated to the developers is that we want  
14 facility level testing in order to be able to  
15 interpret the measurement score.

16 So anything beyond that is something  
17 we want to see in the future. But we haven't  
18 stated it.

19 MEMBER KAPLAN: This would be within  
20 then, what you just said. It would be asking for  
21 between facility, evidence that there is between  
22 facility variation that's not a function of

1 within facility variation. And my only concern  
2 is, when you're getting that small number of  
3 items, that you could noise up your variable and  
4 start causing yourself trouble.

5 CO-CHAIR PARTRIDGE: I see Peter's  
6 hand up.

7 MEMBER THOMAS: Real quick, there's no  
8 risk adjustment here, right?

9 MR. MULLER: Correct.

10 MEMBER THOMAS: And is that because  
11 the four questions were, you didn't feel that you  
12 needed to do risk adjustment when you're asking  
13 those four patient reported outcome measures?

14 MR. MULLER: It's really the concept.  
15 So we thought about is there like a clinical  
16 driver that would make one person more satisfied  
17 than other? If it's appropriate to control that.  
18 And we couldn't think of anything.

19 Sociodemographic characteristics, so  
20 race or something like that there's, I think  
21 there is a small correlation with race. But  
22 again, it's like, it feels very inappropriate to,

1 if one race is systematically more satisfied than  
2 another, to control that difference.

3 So we sort of could not find a  
4 reasonable set of factors or any factor to adjust  
5 for.

6 MEMBER THOMAS: You've also got --

7 DR. CASTLE: I would answer that we  
8 searched, as James said. We did look at SES.  
9 And whatever factors we had available, we  
10 searched the scores to see if any kind of risk  
11 adjustment was appropriate. And it's actually  
12 also not standard to risk adjust for most  
13 satisfaction surveys in long term care. But we  
14 did look into it and it didn't seem to make  
15 sense.

16 MEMBER KAPLAN: Following up on that,  
17 in 1B you do note age and gender differences. Is  
18 that what you're excluding for risk adjustment?

19 DR. GIFFORD: We don't do any risk  
20 adjustment. I mean there are age and gender  
21 differences. Part of it also is the general  
22 membership of, felt that they want to be held

1 accountable for who they take care of and not  
2 risk adjust away differences.

3 MEMBER KAPLAN: But no, older people  
4 are more satisfied and women are less satisfied?

5 DR. GIFFORD: Yes.

6 MEMBER KAPLAN: Independent of the  
7 care they get?

8 DR. GIFFORD: Yes.

9 MEMBER KAPLAN: Okay.

10 CO-CHAIR PARTRIDGE: Are we ready to  
11 move on to voting? Sarah's nodding. Everybody  
12 else? Are we all awake? Okay. Desi?

13 MS. QUINNONEZ: Yes. Voting is now  
14 open for Measure 2614 on reliability including  
15 precise specifications and testing. Option  
16 number one is high, option number two is  
17 moderate, option number three is low, and option  
18 number four is insufficient.

19 We're looking for one more vote. All  
20 votes are in. Voting is now closed. The results  
21 are 33 percent voted high, 44 percent voted  
22 moderate, 22 percent voted low, and 0 percent for



1       insufficient.

2                   CO-CHAIR PARTRIDGE:   Variability,  
3       again, floor is open for comments.   Sherrie is  
4       that card up or down?

5                   MEMBER KAPLAN:   It's up.   And I only  
6       have one question.   My question is on Table  
7       2B2.3.J on Page 61, you got a variable going in  
8       the wrong direction with respect to readmissions.  
9       And because most of your variable evidence, the  
10      validity evidence is modest at very best and in  
11      many cases nonsignificant, what do you make of  
12      the one that's going in the wrong direction?

13                  MR. MULLER:   Which page was that?

14                  MEMBER KAPLAN:   Page 61.

15                  DR. GIFFORD:   I remember this.

16                  MR. MULLER:   Yes.

17                  MEMBER KAPLAN:   It's a strong  
18      positive.   It's one of your strongest  
19      correlations and it said it in the wrong  
20      direction.

21                  DR. GIFFORD:   I remember that.   And we  
22      went back and reexamined that to make sure we

1        didn't enter it in wrong. We thought it was a  
2        typo too. We elected not to make up an excuse  
3        because we just couldn't figure how to do it.

4                But you know, with any of these  
5        correlations, we could always change our  
6        hypothesis after the fact to make them fit. And  
7        we elected not to. We felt the preponderance was  
8        in the way we wanted. And I have no idea  
9        Sherrie. I really do not know.

10               MEMBER KAPLAN: If they had a done a  
11        Fisher's exact test and counted up the number  
12        signs that were in the correct direction, this  
13        wouldn't have screwed you up, wouldn't have  
14        messed you up. But on the other hand --

15               DR. GIFFORD: That's kind of what we  
16        did.

17               MEMBER KAPLAN: I'm just very curious.  
18        It's the highest correlation.

19               DR. GIFFORD: I know.

20               MEMBER KAPLAN: And it's going in the  
21        opposite direction.

22               DR. GIFFORD: You should have seen the

1 reaction. Actually we didn't even pick it up on  
2 the first draft of this. We talked about how  
3 this was the strongest correlation and  
4 everything. And then someone on the review said,  
5 but it's the wrong direction. And we had to go  
6 back and rewrite. We just elected to -- I don't  
7 know. I don't know how to explain it. It's just  
8 one of those things.

9 MEMBER MELILLO: I may have an answer  
10 for you. Pressure ulcers, is that what we're  
11 talking about?

12 DR. GIFFORD: No, rehospitalization.

13 MEMBER MELILLO: Oh, nevermind then.  
14 Oh okay.

15 MEMBER SALIBA: So this is Deb. My  
16 only comment was just that the Fleishman that you  
17 point to as indicating understanding is more just  
18 a reading level test than understanding. You may  
19 have also done some cognitive testing with the  
20 items to see if people are answering the  
21 questions we think they're answering. But the  
22 test that you used is probably just a first step

1 and not really a test of comprehension.

2 DR. CASTLE: I can answer that one  
3 Deb. Yes, we did cognitive testing with family  
4 members, with residents, and with short stay  
5 residents. We went to facilities in Pittsburgh.  
6 And with the cognitive testing, I think we had  
7 more than 100 in each group by the time we were  
8 finished.

9 And we did it the classic way of  
10 reading questions and having them respond back on  
11 what they thought we were asking and if we could  
12 ask it differently and what they understood with  
13 words.

14 The Fleishman was put in there because  
15 it also passed that test. But the cognitive  
16 testing was exactly as you describe, the classic  
17 way of doing it.

18 MEMBER SALIBA: Great. I figured you  
19 probably had. Thank you.

20 DR. GIFFORD: Deb, I think it's in the  
21 appendix. We're looking for it right now.

22 CO-CHAIR PARTRIDGE: Okay. Are we

1 ready to vote on variability? I'm sorry,  
2 validity.

3 MS. QUINNONEZ: Okay. Voting is now  
4 open for validity including specifications  
5 consistent with evidence, testing and threats  
6 adjust, exclusions, risk adjustment  
7 stratification, meaningful differences,  
8 comparability, multiple specifications, missing  
9 data. The options are one high, two moderate,  
10 three low, and four insufficient.

11 Okay. We're still waiting for two  
12 votes. All votes are in. Voting is now closed.  
13 The results read 33 percent voted high, 50  
14 percent voted moderate, 17 percent voted low, and  
15 0 percent voted insufficient.

16 CO-CHAIR PARTRIDGE: Next item or  
17 category is feasibility. We've talked about this  
18 a tiny bit. Linda was excited that it was short  
19 which is the whole point. Are there other  
20 comments? Are we ready to vote? Yes?

21 MS. QUINNONEZ: Voting is now open for  
22 Measure 2614 for feasibility including data

1 generated during care, electronic sources, and  
2 data collection can be implemented. And the  
3 options are number one high, two for moderate,  
4 three for low, and four for insufficient.

5 We're waiting for two votes. One more  
6 vote. All votes are in. Voting is now closed.  
7 The results are 28 percent voted high, 72 percent  
8 voted moderate, 0 percent for low, and 0 percent  
9 for insufficient.

10 CO-CHAIR PARTRIDGE: Finally we are at  
11 usability. Usability, again, any comments?  
12 Okay. Desi, over to you.

13 MS. QUINNONEZ: Voting is now open for  
14 Measure 2614 usability and use, accountability,  
15 transparency, and improvement progress  
16 demonstrated and benefits outweigh evidence of  
17 unintended negative consequences. The options  
18 are one for high, two for moderate, three for  
19 low, and four for insufficient information.

20 Looking for two more votes. All votes  
21 are in and voting is now closed. The results are  
22 28 percent voted high, 61 percent voted moderate,

1 11 percent voted low, and 0 percent for  
2 insufficient information.

3 CO-CHAIR PARTRIDGE: Before we go on  
4 to the final question of recommending  
5 endorsement, Peter?

6 MEMBER THOMAS: Real quick, it says,  
7 there's a note on the bottom of Page 12 that says  
8 that although there's no public reporting now  
9 that ACHA is planning on public reporting with  
10 the CoreQ measures as part of the quality  
11 initiative for 2016 through '18 with 9,600 SNFs.

12 I'm just wondering how that compares  
13 or contrasts with the measures under the Medicare  
14 program that CMS is implementing on the IMPACT  
15 Act. Are they duplicative of one another? Are  
16 they done together? Or what's happening with  
17 that?

18 DR. GIFFORD: IMPACT Act does not  
19 require satisfaction. We have shared this with  
20 CMS and have asked them that they add this to  
21 five star at some point in the future. I know  
22 five star is thinking about, in the next five

1 years, probably adding satisfaction at some  
2 point.

3 MEMBER THOMAS: Thanks.

4 DR. GIFFORD: As an organization, we  
5 support and endorse that. Why we undertook this  
6 whole process.

7 CO-CHAIR PARTRIDGE: Okay. So final  
8 question is whether or not we recommend that this  
9 measure be forwarded for with recommendation for  
10 endorsement by MQF. And Desi?

11 MS. QUINNONEZ: Voting is now open for  
12 Measure 2614 for recommendation for overall  
13 suitability for endorsement. Option number one  
14 is yes. Option number two is no.

15 We're looking for two more votes.  
16 We're ready. All votes are in. The results are  
17 94 percent voted yes and 6 percent voted no.

18 CO-CHAIR PARTRIDGE: In the past, as  
19 we have here, three measures that are almost  
20 identical, they're not obviously identical but  
21 almost, we have taken the votes on the first  
22 measure. And said after discussion, we first



1 discussed and then made a decision as to whether  
2 we would be comfortable about accepting the votes  
3 on those, on the first measure. And moving the  
4 scores, essentially saying the scores would be  
5 the same for the second and third, we don't need  
6 to go through all the individual items.

7 Before we even consider such a step,  
8 I want to give the people who have so patiently  
9 been working and studying as lead discussants,  
10 both Number 2615 and 2616, an opportunity to say  
11 what they want to say. And that's specifically  
12 at Lisa and Sharon Cross and Lisa Morrise. So  
13 Lisa, do you want to start? Lisa Suter will  
14 start.

15 MEMBER SUTER: Thank you. This is  
16 Lisa Suter. So I actually think that's a great  
17 recommendation. Because, having listened to the  
18 discussion of the first measure, I actually find  
19 2615 which is for the long term resident measure  
20 less controversial, I think, in terms of its  
21 exclusions to the denominator than the prior  
22 measure. And the liability and validity testing

1 is very similar across the board.

2 So I actually think it's a very  
3 reasonable recommendation to translate scores  
4 from, at least my scores from that initial vote  
5 to this second measure as well as to the third  
6 measure which assesses family member care.  
7 Family member inputs, excuse me.

8 MEMBER MORRISE: I agree. I don't see  
9 that there's that much difference. In fact, in  
10 reading through all of them, I thought this is  
11 the same thing over and over again. It's great.

12 MEMBER CROSS: I agree. I was  
13 thinking the same thing as I was reading through  
14 them, that they were all very similar. So  
15 there's nothing additional that I think I'd want  
16 to add to the conversation at this point.

17 CO-CHAIR PARTRIDGE: Then I think we  
18 should have a formal vote that we do that.  
19 Peter?

20 MEMBER THOMAS: On both the long and  
21 short measures, you don't, one of the exclusions  
22 is guardians that respond, correct?

1 DR. GIFFORD: Yes, the legal  
2 guardians.

3 MEMBER THOMAS: Guardians.

4 DR. GIFFORD: Yes or court appointed  
5 guardians.

6 MEMBER THOMAS: So at first, I was a  
7 little concerned about that. Then I read that  
8 the next measure is the family.

9 DR. GIFFORD: Correct.

10 MEMBER THOMAS: And I don't remember  
11 whether guardians are included in -- I guess  
12 guardians, that wouldn't be relevant there. So  
13 it's really not related. I was thinking about  
14 someone else answering on behalf of the patient.  
15 But --

16 DR. GIFFORD: We don't let anybody  
17 answer on behalf of the patient.

18 MEMBER THOMAS: Because it's patient  
19 reported, you want to make sure that they are the  
20 ones doing it.

21 DR. GIFFORD: Yes.

22 MEMBER THOMAS: Thank you.

1           MEMBER SALIBA: This is Deb. The only  
2 concern I have on the long stay one was it looked  
3 like -- and I may have misread your data. But it  
4 looked like you were allowing the facility member  
5 to fill out the survey for the individual if they  
6 were unable to do it themselves.

7           DR. GIFFORD: Well there's no way to  
8 stop them. But if they indicate as such, their  
9 data is excluded.

10          MEMBER SALIBA: Okay. So I was  
11 misreading it. It looked like it was allowed.  
12 And that, obviously -- so are individuals -- how  
13 are we making sure that there is no provider  
14 influence on scoring with these? I'm assuming  
15 the short stay people have a little bit more  
16 autonomy. With the long stay people, how are you  
17 assuring that they're sort of being able to  
18 independently answer these surveys?

19          DR. GIFFORD: Well there's no way of  
20 assuring it Deb.

21          MEMBER SALIBA: Okay.

22          DR. GIFFORD: I mean, but it's

1 administered, it's in the rules and it's in the  
2 guidance that's out there. But as you know, a  
3 lot of places do provide some level of assistance  
4 out there. You know, we're trying to push that  
5 out there.

6 MEMBER SALIBA: So it does not require  
7 to use an independent --

8 DR. GIFFORD: Yes, they have to use an  
9 independent vendor.

10 MEMBER SALIBA: To analyze them or to  
11 administer them?

12 DR. GIFFORD: Well to both. But  
13 independent vendors often have the facility  
14 distribute the survey and then collect them and  
15 mail them back. So at that point, you can't  
16 really -- I mean, I can't assure one way or the  
17 other.

18 But yes, this requires an independent  
19 vendor to both make sure the samples being drawn  
20 and the things being calculated as being  
21 administered. But they're not coming in and  
22 doing and doing face to face or doing it in the

1 building.

2 MEMBER SALIBA: I mean, I guess that's  
3 just the biggest concern, you know, in terms of  
4 threats to validity with the long stay ones,  
5 would be someone's comfort level if it's being  
6 handed to them by a facility staff member and  
7 then collected by a facility staff member. As  
8 you know, I mean that could be a little bit of an  
9 issue.

10 DR. GIFFORD: I agree. It's just  
11 inherent with the whole population.

12 MEMBER MORRISE: I agree that it could  
13 be an issue. I also had a concern as I was  
14 reading through it and they had to dig deeper to  
15 find that it is allowed in the administration of  
16 this survey for somebody to act as a scribe which  
17 I see as being very important. Especially since  
18 my daughter has upper trunk CP and doesn't write  
19 well at all. And so, she has me fill out  
20 everything for her.

21 So I realize that could have some bias  
22 that enters in. Because an individual could fill

1 out something other than what is being reported.  
2 But that's probably minimal.

3 DR. GIFFORD: We do ask did someone  
4 help, yes, no? And then we ask how they helped.  
5 And so, if it's in your scenario and you're just  
6 translating the thing, yes we will count them.  
7 So we wanted to make sure that we didn't lose  
8 individuals.

9 MEMBER THOMAS: In this day and age of  
10 electronic everything, this is a mailed survey?  
11 Good old fashioned U.S. mail, right? I mean I  
12 don't doubt the fact that --

13 DR. GIFFORD: We've not tested the app  
14 for it yet.

15 MEMBER THOMAS: I doubt you'd get very  
16 far in this population.

17 DR. GIFFORD: Well it is interesting  
18 you say because a number of the different survey  
19 vendors out there that approached are using  
20 different vehicles for how to administer it. And  
21 as we're collecting data is getting much wider  
22 use, we're looking at whether the method of

1 collecting data differs in any way. But right  
2 now it's a paper version, yes.

3 CO-CHAIR PARTRIDGE: Becky?

4 MEMBER BRADLEY: Given the population  
5 that you're talking about, is there any  
6 accommodation for patients with visual  
7 impairments or language? Will this be offered in  
8 other languages?

9 DR. GIFFORD: Right now it's offered  
10 in English only. Other than a handful of SNFs,  
11 would that really cross a sample size? But it  
12 definitely is something we would want to pursue  
13 down the road to explore that on how to get that  
14 broader. Especially as the demographics are  
15 changing and the cohorts are aging in other  
16 demographics. We'd like to do that.

17 CO-CHAIR PARTRIDGE: Sharon?

18 MEMBER CROSS: Regarding the family  
19 measure, I just wanted to ask for clarification  
20 about the comparison to related or competing  
21 measures. Because there was a mention about a  
22 CAHPS nursing home family. Can you just respond



1 to that?

2 DR. GIFFORD: Yes. That was before it  
3 was withdrawn for endorsement. We submitted this  
4 prior to the March 3, 2016 NQF.

5 MEMBER CROSS: Yes. And I'll just, in  
6 comment on that, we reached out to the AHRQ folks  
7 repeatedly. And they indicated they did not want  
8 to continue endorsement because, while they're  
9 keeping the survey and they're maintaining the  
10 survey, as Dave already mentioned, it's not being  
11 used.

12 We also followed up with CMS. And CMS  
13 said they had no plans to be putting that into  
14 any of their programs any time soon. So you  
15 know, that's right, we're dropping that.

16 CO-CHAIR PARTRIDGE: As a formal  
17 matter, Sarah tells me that we should vote, to do  
18 only the final vote. That is, do we recommend  
19 for endorsement both Number 2615 and 2616. So  
20 we'll go ahead and do that vote.

21 MS. QUINNONEZ: Voting is now open for  
22 the recommendation for overall suitability for

1 endorsement for Measure 2615. Option number one  
2 is yes --

3 CO-CHAIR PARTRIDGE: Before we vote,  
4 Linda?

5 MEMBER MELILLO: Yes. I just, if I  
6 understand correctly, you're mailing these to  
7 their homes? Yes?

8 DR. GIFFORD: The discharge home, it's  
9 going to whatever address the SNF has on file to  
10 communicate with them. For family members, it's  
11 going to the primary person that they have on  
12 record. And for residents, it's going to the  
13 resident who's living in the home because they're  
14 not, that is their home.

15 MEMBER MELILLO: Okay. So for those  
16 that have no potential to discharge, are you  
17 serving them as well?

18 DR. GIFFORD: On the long stay, yes.

19 MEMBER MELILLO: So the institution  
20 then would administer the survey?

21 DR. GIFFORD: You know, actually it  
22 tends to be a little bit different depending on

1 the survey vendor. Some will mail it to the  
2 nursing home so it arrives in their mail. Others  
3 will go around and deliver it to them in their  
4 room and let them then submit it.

5 MEMBER MELILLO: Okay.

6 CO-CHAIR PARTRIDGE: So I think now we  
7 are back to you Des.

8 MS. QUINNONEZ: Okay. If there are no  
9 more comments, we will have open vote now for  
10 Measure 2615 to score the recommendation for  
11 overall suitability for endorsement.

12 CO-CHAIR PARTRIDGE: One is yes?

13 MS. QUINNONEZ: We're still waiting  
14 for three votes. All votes are in. Voting is  
15 now closed. The results read 94 percent vote  
16 yes, 6 percent vote no.

17 CO-CHAIR PARTRIDGE: Okay. And going  
18 on --

19 MS. QUINNONEZ: The voting is now open  
20 for overall suitability for recommendation for  
21 endorsement for Measure 2616. Voting option  
22 number one is yes, voting option number two is

1 no.

2 Looking for two more votes. All votes  
3 are in. Voting is now closed. The results read  
4 94 percent voted yes and 6 percent voted no.

5 CO-CHAIR PARTRIDGE: Thank our friends  
6 from AHCA for taking us through so expeditiously.

7 MR. MULLER: Thank you very much  
8 everybody.

9 DR. GIFFORD: Thanks Nick.

10 DR. CASTLE: Thank you. Take care.

11 (Whereupon, the above-entitled matter  
12 went off the record at 2:44 p.m. and resumed at  
13 3:03 p.m.)

14 CO-CHAIR STILLE: We're going to start  
15 again, and what we're going to do -- for the six  
16 measures developed by UDSMR, is split them into  
17 two groups, and actually the agenda reflects  
18 that.

19 There are three that apply to skilled  
20 nursing facilities and then three more that apply  
21 to long term acute facilities. And the three in  
22 each group are change in self care score, change

1 in mobility score, and change in motor score, all  
2 from the FIM instrument if I remember correctly.

3 So similar to what we've done in the  
4 last hour, we'll have a rather extensive  
5 discussion on the first one and then have some  
6 discussion about how much that could be applied  
7 to the other two in the group.

8 There are many primary discussants.  
9 And so I think there will be a lot of discussion  
10 with everyone. We will start with Measure 2769  
11 which is up on your screen right now.

12 (Off microphone comments.)

13 CO-CHAIR STILLE: Yes. Sure.

14 MS. THEBERGE: Do we have the audio  
15 working again, Operator? Deb, Dawn, can you hear  
16 us and can you speak?

17 MEMBER DOWDING: Oh hi, yes I can hear  
18 you now. Thank you.

19 MS. THEBERGE: Okay, great. Thank  
20 you.

21 MEMBER SALIBA: Yes, we're good.  
22 We're good. Thanks for checking.

1 MS. THEBERGE: Thank you.

2 CO-CHAIR STILLE: Okay. So we'll  
3 start with Measure 2769 which is the first  
4 skilled nursing facility measure. The functional  
5 change, change in self-care score by UDSMR.

6 The primary discussants will be Beth  
7 Averbeck, Dawn Dowding, and Peter Thomas. And we  
8 have the measure developers here, so take it away  
9 for about three minutes.

10 MS. DANN: Okay, thank you. I'm Kathy  
11 Dann, director of operations for UDSMR. On  
12 behalf of UDSMR and our subscribers, we are  
13 pleased to be here to offer for endorsement  
14 functional quality measures for both the skilled  
15 nursing facilities and the long term care  
16 populations.

17 These measures have already been  
18 endorsed by NQF for inpatient rehabilitation  
19 facilities. So endorsing them for these two  
20 populations will allow standardization of  
21 measurement, of function across all of post-acute  
22 care using a common metric which in effect

1 fulfills the charge of the IMPACT Act.

2 With me today I have our Director of  
3 Research, Dr. Paulette Niewczyk. Am I too close  
4 to the microphone? Okay, good. Who is here to  
5 answer any questions related to the measurement  
6 development process and to answer any questions  
7 related to the testing of the measures data that  
8 we provided to you already.

9 I have Dexanne Clohan, a doctor of  
10 physical medicine who also has an expertise in  
11 functional assessment here also. On the line we  
12 have Dr. Maggie DiVita who did some of the  
13 analysis that we might defer to for some of your  
14 questions.

15 Now these measures were developed out  
16 of extensive research and experience with a  
17 functional measure known as the FIM instrument.  
18 It's already mandated by CMS for rehab hospital  
19 reporting.

20 Here are a few of the measure's key  
21 features. First and foremost, the measures  
22 utilize a standardized set of items,

1 calculations, and risk adjustment methodology  
2 regardless of post-acute care setting.

3 This will provide the ability to  
4 compare and contrast post-acute care sites and  
5 outcomes at a common metric, a truly apples to  
6 apples comparison.

7 Secondly, the measures are based on  
8 data that's been collected for over 20 years in  
9 all these sites. Third, the measures require  
10 data collection of only 20 unique items that  
11 already has training materials, industry  
12 knowledge available for public use.

13 And lastly, while only mandated for  
14 use in the IRFs as part of the Medicare payment  
15 system already, CMS does have the rights to a  
16 royalty-free license to utilize a FIM instrument  
17 in any setting.

18 We thank National Quality Forum and  
19 the person and family centered care committee  
20 that is here today for their time, and for their  
21 consideration of our measures. We stand ready to  
22 answer any questions that you might have related



1 to our university affiliated not for profit  
2 organization, the measures we've submitted, or  
3 the FIM instrument. Thank you.

4 CO-CHAIR STILLE: Thank you for that  
5 very concise presentation. Thanks. I would like  
6 to have any discussion from the primary  
7 discussants.

8 Again, start general as much as  
9 possible, and then after everybody's sort of  
10 talked about general things, we'll go into some  
11 of the more specifics about evidence and stuff  
12 like that. So Len is first.

13 MEMBER PARISI: I didn't review the  
14 first measure, I'm not one of the lead  
15 discussants of the first measure. But this is an  
16 overall question about the use of the instrument.  
17 Is this going to be in the public domain or is  
18 this now something that still has to be purchased  
19 using the ability to use the FIMs instrument?

20 MS. DANN: The ability to use the FIM  
21 has been offered to CMS. The exact term public  
22 domain needs to be debated. The reason for us

1 not putting it in the public domain already is  
2 simply because we want to maintain the integrity  
3 of the instrument through uniformity.

4 We are offering it free, but that's  
5 the concept of the integrity of the instrument,  
6 gets maintained through uniformity.

7 MEMBER PARISI: So it will be free.

8 MS. DANN: Yes.

9 MEMBER PARISI: Okay. I just wanted  
10 clarity on that. Thank you.

11 CO-CHAIR STILLE: And Linda?

12 MEMBER MELILLO: The FIM as it stands  
13 in rehab requires certification of those who  
14 administer the tool. Is that something that  
15 would also be required for these?

16 MS. DANN: CMS does not require that  
17 certification. UDS provides that as part of its  
18 services to its subscribers. So I don't believe  
19 that CMS would require something they don't  
20 require today for IRFs in the future.

21 DR. NIEWCZYK: There are training  
22 manuals available for use. So certification

1 would be something that if you were subscribing  
2 to our services, our data reporting services  
3 would be requested. But not for use.

4 MEMBER MELILLO: So for the data  
5 reporting component of this, they can get that  
6 for free as well?

7 DR. NIEWCZYK: Not through us.

8 MEMBER MELILLO: But there's a venue  
9 for that?

10 DR. NIEWCZYK: Yes. There could be  
11 other than use for that. Correct.

12 MS. DANN: Just the way the IRFs now  
13 submit the data to CMS and they're going to have  
14 IRF quality reporting, if they were to choose to  
15 use the FIM, they would have the rights to report  
16 on that.

17 MEMBER MELILLO: Or other health  
18 information systems for instance, yes.

19 CO-CHAIR STILLE: Beth, you're one of  
20 the primary discussants. Why don't you go?

21 MEMBER AVERBECK: Thanks. And I would  
22 encourage those of you that also reviewed this to

1 chime in as well. The measure looks at the  
2 change in the self care on admission and on  
3 discharge. I think it's really important that we  
4 have some measure of assessment for those  
5 patients that are in skilled nursing facilities.

6 I did have some questions going  
7 through that are just more general questions  
8 around some of the specifications and then a  
9 couple of the exclusions and some missing data,  
10 so maybe I'll go ahead and just raise those right  
11 now.

12 DR. NIEWCZYK: Sure.

13 MEMBER AVERBECK: I'm curious as to  
14 why a 12 month measure was used for a short term  
15 stay. I mean, most of these patients would be  
16 discharged beforehand. I'm wondering about what  
17 happens for patients that are readmitted to the  
18 hospital, you know, that if they are excluded if  
19 they're under 18 or if they die, but what happens  
20 with hospital re-admissions and those patients.

21 And then there was a comment around if  
22 data is missing, so if we don't have complete

1 data, then those patients are excluded. But I  
2 wasn't able to tell based on the information  
3 submitted what percent does the same across  
4 facilities? Is it low, did it not --

5 (Simultaneous speaking.)

6 MEMBER AVERBECK: -- just curious  
7 around how the missing data is accounted for and  
8 whether that might affect the results as well.  
9 So I think those were the main questions I had as  
10 I went through this. Thank you.

11 DR. NIEWCZYK: Thank you. And I'll  
12 try to answer all your questions. Maggie, I may  
13 ask you to chime in on a couple of them.

14 In terms of the age, the measures  
15 could be used by patients of any age. However,  
16 we have this at 18 and older just because we  
17 understand that sometimes, you know, pediatric  
18 populations require different modifications to  
19 items and there's the function of development  
20 versus impairment and so forth.

21 So to simplify things, we kept it as  
22 adults early. Clearly, if a patient dies while

1 under care, we don't have any discharge scores to  
2 go on. So we have an admission but we have  
3 nothing else so certainly can't assess what the  
4 change, you know, would have been.

5 And that's a typical standard way that  
6 others have within the industry have excluded on  
7 that basis. In terms of missing data, we  
8 actually have a very, very small percent.

9 Maggie, do you happen to know on average how many  
10 cases each year would be missing? I would guess  
11 about less than two percent, but I don't want to  
12 make something up here.

13 MS. DIVITA: In terms of missing the  
14 required elements for the measure, I would say  
15 zero because they're required in our system. So  
16 something like creating age from birthdate, we  
17 need that information, or all of the items are  
18 required items. And so there really isn't  
19 missing data as it stands.

20 DR. NIEWCZYK: So they could refuse to  
21 do the assessment altogether on a patient but  
22 they can't, like, --

1 (Simultaneous speaking.)

2 MS. DIVITA: They could but then, yes,  
3 but then it wouldn't be transmitted through our  
4 system. So there would be really no way for us  
5 to understand or to know, you know, the  
6 percentage of population they decide not to  
7 collect the data on.

8 My gut would be that it would be very  
9 small, because otherwise I'm not sure why they  
10 would bother, you know, utilizing the measure  
11 essentially.

12 DR. NIEWCZYK: And Maggie, can you  
13 also speak to the 12 month window?

14 MS. DIVITA: Yes, I am, it's a good  
15 question. It's been quite a while now since we  
16 developed these. You know, I think that we tend  
17 at UDS to look at things in a really 12 month way  
18 to sort of look at how people are doing.

19 We wanted to give them a long enough  
20 timeframe to allow for, you know, a good number  
21 of patients so that you're not looking at a  
22 smaller number of patients. And so I think it's

1 just sort of something that we tend to utilize at  
2 UDF.

3 And so the 12 month timeframe sounded  
4 pretty good to us. It also gives, you know, a  
5 good amount of time and are we talking about SNFs  
6 right now or are we talking about long term care?  
7 I can't remember. But in general --

8 (Simultaneous speaking.)

9 DR. NIEWCZYK: We're talking about  
10 SNFs, but it's the same method for both.

11 MS. DIVITA: Right, yes. It gives us  
12 a good amount of time to follow through. You  
13 know, average length of stays aren't nearly a  
14 year long, but that 12 month period should allow  
15 us to get a good view of a true length of stay.

16 DR. NIEWCZYK: And certainly  
17 internally we do look at things by quarter as  
18 well. Our facilities do get quarterly reports.  
19 But as we indicated in the submission files,  
20 facilities had to have at least 30 cases over a  
21 year, over that 12 month period.

22 So it's really a function to allow



1       those smaller facilities to have an adequate case  
2       count for representation.

3               MS. DIVITA:   Correct.

4               CO-CHAIR STILLE:   Dawn, you were one  
5       of the primary reviewers as well.   Would you like  
6       to chime in?

7               MEMBER DOWDING:   Oh yes.   Hi.   My main  
8       question was to do with issues to do with data  
9       burden because a lot of the measures, the things  
10      that you're collecting on the FIM are actually  
11      included in the MDS assessment and would also be  
12      in the catch all when it institutes this hostile  
13      approach to acute care settings.

14              And I guess my main concern with all  
15      of these measures is that we're, you know, is it  
16      going to be something that is instead of the CARE  
17      tool or replace those item measures because  
18      otherwise there's increased data burden on the  
19      users in terms of having to complete these  
20      measures more than once.

21              DR. NIEWCZYK:   So I can try to speak  
22      to that.   Yes, you know, certainly we understand

1       that function as something that's assessed in  
2       other instruments and often a variety of  
3       different ways.

4               Our measures that we have submitted  
5       here today are part of a larger tool which is the  
6       FIM. Certainly, you know, when you get through  
7       the measure files, you'll see under concurrent  
8       validity that was our gold standard. Right?

9               So how did those measures compare to  
10       the full FIM. But this is not, you know, it's  
11       not identical to the FIM. How it relates to  
12       those other instruments, be it MDS or to the CARE  
13       tools, those are measuring components of function  
14       as well, although some of the items are quite  
15       different.

16              You know, for instance, I'm not sure  
17       what measure we're talking, I think it's self-  
18       care. But for self-care, we have both cognitive  
19       items as well as physical function, physically  
20       function items.

21              And the CARE measure for self-care  
22       includes only physical functioning. There's no

1 cognitive items. In terms of the MDS, you know,  
2 the MedPAC reports from 2013 stated that skilled  
3 nursing facilities did not demonstrate any change  
4 over 2011 to 2013 from those functional items.

5 So we certainly, and as is indicated  
6 within our files, we did see a great deal of  
7 change in terms of some of the functional values  
8 over the years that have been indicated. So I  
9 believe they probably measure different  
10 functional domains.

11 CO-CHAIR STILLE: Peter?

12 MEMBER THOMAS: I've got a -- I'm  
13 sorry, was there a follow up?

14 MEMBER DOWDING: Yes, I mean, I'm not  
15 disputing that they might measure different  
16 things. But a lot of the items of information  
17 that go into the different tools are the same.

18 So are you going to ask them to  
19 collect the same information twice, or are you  
20 going to use the information you collect for the  
21 FIM or for CARE tools to feed into the methods  
22 because otherwise you're asking a group of very

1 busy clinicians to fill out more than one item to  
2 do somebody's function is my concern, that's all.

3 MEMBER THOMAS: So the last set of  
4 measures excluded readmissions to either an acute  
5 care hospital or being sent over to a different  
6 post-acute care setting as well as death of a  
7 patient. How do you handle, in this measure how  
8 do you handle those readmissions or transfers to  
9 another setting of care? Are they excluded from  
10 the calculation or not?

11 DR. NIEWCZYK: I do not believe that  
12 that's an exclusion criteria. Just those that  
13 are under ages 18 and who had died while in care.

14 MEMBER THOMAS: Right, those are the  
15 only two?

16 DR. NIEWCZYK: That's the only two.

17 MEMBER THOMAS: So I'm just wondering,  
18 I mean, which I'm in favor, I appreciate that.  
19 I'm just wondering how would you score if someone  
20 gets readmitted to the acute?

21 DR. NIEWCZYK: Oh, excellent. Yes, we  
22 do have one of the additional data collection

1 points that's not part of the measure is  
2 discharge location.

3 So clearly, we do ask about discharge  
4 back to the community, discharge to another post-  
5 acute care venue like maybe inpatient rehab or  
6 home health outpatient care, back to acute care.  
7 So all of that is still collected as part of data  
8 elements.

9 MEMBER THOMAS: Okay. So last time we  
10 were here and looked at a whole other set of  
11 measures, I raised this same issue, I'm going to  
12 raise it again now and that's the Jimmo versus  
13 Sebelius settlement.

14 And that is a case that states that  
15 Medicare law is, and CMS agrees that Medicare law  
16 is or requires that skilled nursing facilities,  
17 outpatient therapy, and home healthcare provide  
18 services, skilled care, skilled therapy or  
19 nursing, to an individual, beneficiary who may  
20 not be improving in order to maintain their  
21 function or prevent deterioration of function.

22 And I'm less concerned in the IRF

1 because that settlement really doesn't do all  
2 that much in the IRF setting. But I'm very  
3 concerned in the SNF setting because it does  
4 apply to SNFs.

5 And if you've got a quality measure  
6 that's based on, and you say it a number of times  
7 in your document, the emphasis on restoration.  
8 Now you do admit, I will admit you say or  
9 maintenance of function which is important. But  
10 in other areas you say the primary benefit of  
11 rehab is functional improvement, improvement,  
12 improvement.

13 And I'm hopeful, I'm trying to figure  
14 out a way that you don't create a quality  
15 measurement tool that is going to disadvantage  
16 individuals who won't necessarily improve but  
17 still gain something from their experience in a  
18 SNF.

19 And those folks are going to become  
20 persona non grata because that SNF doesn't want  
21 to have those people in its data mix. Can you  
22 tell me how you address that fairly difficult,

1        what I consider to be a fairly difficult problem?

2                DR. NIEWCZYK:    So that's an excellent  
3        question.    And our measures are sensitive to the  
4        fact that patients may gain, may not change, so  
5        maintenance, or may decrease in function.

6                So certainly an aggregate score would  
7        be at the measure level, right?    But you can also  
8        look at each item level.    So you may see that a  
9        patient improved in one item but decreased in  
10       another.    If you look only at that measure score,  
11       it's going to show no change, but there was some  
12       changes.

13               So it works at both the patient level  
14       as well as the population or facility level.  
15       Additionally, it's understood that it's a change,  
16       it's not a gain.    So these measures are not  
17       functional gain.    These are functional changes.  
18       So it could be in either direction.

19               We understand that in skilled nursing  
20       in particular, you have sometimes two patient  
21       populations where you have those that are there  
22       for restorative care and those that are there as

1 residents that might also be getting some  
2 rehabilitation.

3 Within those residents, in all  
4 likelihood, you may be seeing more maintenance of  
5 functioning, which might be the goal, just not to  
6 decrease. So certainly our measures can work in  
7 that capacity.

8 And facilities know which patients are  
9 which. So there would be, you know, no  
10 difficulty in building in an additional variable  
11 asking is this patient here for restorative  
12 treatment or patient or resident? And certainly  
13 we could then look and stratify on those basis.

14 MEMBER THOMAS: I don't know if this  
15 is appropriate to ask, but in the documents, in  
16 the writeups as you proceed there's a number of  
17 measures that have the same concern that I've  
18 got, that has been raised.

19 Can you please, can we encourage or  
20 require there to be some recognition that it's  
21 not just about improvement in function and that,  
22 you know, these tools should not be used in any



1 way to bias admission against people who won't  
2 improve --

3 DR. NIEWCZYK: Absolutely.

4 MEMBER THOMAS: -- something to  
5 protect against that.

6 CO-CHAIR STILLE: Yes, yes. I had the  
7 same concern with 2775 which it says change in  
8 motor function, so same kind of thing. Whether  
9 it's stratifying among people who are expected or  
10 not expected or something.

11 DR. NIEWCZYK: So certainly we can add  
12 some language in, you know, in the documentation  
13 stating that the measures could be used, you  
14 know, to assess maintenance of function as well  
15 as to identify decreases in functioning.

16 We have users in some outpatient as  
17 well as adult day programs. And really the goal  
18 there is maintenance. But they sometimes see  
19 patient populations that will decrease function.  
20 And then it's an early warning sign to add  
21 additional patient referrals or resources, or  
22 maybe to modify the patient's care plan.

1 CO-CHAIR STILLE: Could I ask one more  
2 real quick? And that is my understanding, and  
3 correct me if I'm wrong, is that the FIM really  
4 has a very strong connection to the inpatient  
5 rehab hospital and unit.

6 It was created around that patient  
7 population and that setting, and it was really  
8 geared toward trying to measure function in that  
9 setting. So is it really that easy to just take  
10 that same functional measurement tool and apply  
11 it to a SNF or an LTAC? It's an open question.  
12 I'm not doubting that it is. But please explain  
13 how --

14 DR. NIEWCZYK: In post-acute care it  
15 is. But what we found through the 20 plus years,  
16 I don't know what's happening to my mic, but the  
17 20 plus years of study on the tool is that  
18 function can be measured and can be assessed with  
19 a very small number of items.

20 Now it's not all-encompassing, it's  
21 not a perfect instrument in any capacity. But a  
22 rough estimate in terms of where the patient's

1 functional status is, and the fact that you could  
2 use it in other post-acute care venues, even  
3 those like the long term care facilities where  
4 you may not see drastic improvements in  
5 functioning.

6 It gives you a point as to where that  
7 patient's status was when they came in, when they  
8 left, and then when they went to another, you  
9 know, downstream post-acute care venue using the  
10 same items with the same rating scale.

11 CO-CHAIR STILLE: Thank you.

12 MS. DANN: Could I just add to that  
13 that with our submission, I believe we put a  
14 bibliography of something called burden of care,  
15 and the instrument can measure that latent trait  
16 in any venue.

17 Therefore it is viable to be used in  
18 any venue because it can measure the burden of  
19 care regardless. And I don't know how many  
20 publications are in that bibliography. I think  
21 it's 15.

22 DR. NIEWCZYK: I think we gave a very,

1 we give an annotated one, yes.

2 CO-CHAIR STILLE: Beth?

3 MEMBER AVERBECK: Just a follow up on  
4 a question to Peter's comment on the patients  
5 that aren't improving. Does a case mix  
6 adjustment then account for that, that what you  
7 might expect since it's a measure to expectation  
8 that if someone wasn't seeing improvement and a  
9 change that would be taken care of by the way  
10 that it's case mix grouped?

11 DR. NIEWCZYK: So certainly case mix  
12 may come into play, impairment group code would  
13 likely be a greater indicator. But, you know,  
14 oftentimes it's really hard. Those are things  
15 that are probably more obvious in the medical  
16 records. But yes.

17 CO-CHAIR STILLE: Okay. Any more  
18 general comments before, oh I'm sorry, Linda?

19 MEMBER MELILLO: I'll come back to it.

20 CO-CHAIR STILLE: Okay. And yes?

21 DR. CLOHAN: I just wanted to make a  
22 comment about Mr. Thomas' remark which is very

1       pertinent on the Jimmo versus Sebelius case. And  
2       I think it's a very good suggestion to put  
3       something in NQF's write up as well could enter  
4       that.

5               The fundamental question you raise  
6       though is endemic across all quality measures of  
7       whether there could be an inadvertent consequence  
8       of a quality measure of suddenly making a patient  
9       who is at higher risk to "fail" that quality  
10      measure become less desirable to a provider.

11             You can look at it on new or worsened  
12      pressure sores, you can look at it at fall risk,  
13      you can look at it on do you want to take  
14      somebody in your site who has refused a pneumonia  
15      or flu vaccine.

16             It's an inherent risk. But I think  
17      there will be good protection on this one, and I  
18      think it's important for us to keep separate in  
19      our minds the coverage criteria for Medicare or  
20      other payers that entitle people to coverage and  
21      care.

22             And that's what Jimmo sort of

1 addresses, that people are entitled to that level  
2 of care whether they're expected to improve in  
3 their function or whether the purpose of that  
4 care is to maintain or even slow deterioration.  
5 It could be that a person is known to, that their  
6 function will deteriorate but medical  
7 intervention could slow that deterioration.

8           So I think it's great that you brought  
9 it up, and I think this organization, everybody  
10 else interested in quality measures always has to  
11 be mindful of potential for unintended  
12 consequences. And this one I think you can help  
13 by having, making sure your literature addresses  
14 that point.

15           MEMBER MELILLO: So one of my  
16 questions is I have a fear that this data may be  
17 used to try to compare the various levels of  
18 post-acute care. And they are very different in  
19 terms of what a patient or family could expect in  
20 terms of services and what patients and families  
21 can expect in terms of length of stay.

22           I mean, all of these metrics vary

1 substantially. So that is a concern of mine.  
2 And whether or not the patient had an interim  
3 stay in an IRF before they went to a SNF. These  
4 levels of care are not interchangeable is the  
5 point that I'm trying to make. And so I'm just -  
6 - be cautious of that.

7 DR. NIEWCZYK: We sort of believe that  
8 too. But unfortunately, there's many others that  
9 don't believe that, that think that post-acute  
10 care is maybe the same across the board.

11 I don't think we'll ever really know  
12 until we collect it, collect outcomes in a  
13 standardized way. But it needs to be the same  
14 types of questions asked upon the same patients  
15 in all venues.

16 It can't be this item applies to this  
17 venue but not this venue. Otherwise you won't  
18 know, right?

19 MEMBER MELILLO: Yes, there is some  
20 research out there, some new research that I'm  
21 sure you're familiar with that helps to  
22 differentiate. But I hear what you're saying.

1 But it is a concern of mine that if we have these  
2 like measures, that they're going to assume that  
3 they're measuring the same thing. And they're  
4 not but they are. You know what I mean?

5 DR. NIEWCZYK: Well, function is  
6 important I believe to all persons.

7 MEMBER MELILLO: Of course.

8 DR. NIEWCZYK: Whether you're a  
9 patient in a facility or, you know, you're  
10 sitting here like us today. So I believe it's  
11 important in, you know, all capacities.

12 So looking at some aspects, some very  
13 basic aspects of function in terms of things like  
14 communication or expression and, you know,  
15 ability to eat and how you're, are you eating  
16 with assistance of a tube or not. All of those  
17 factors do mean something.

18 And certainly, they can be asked in  
19 all of those venues because they deal with  
20 patients that have those issues in all of those  
21 venues.

22 MEMBER MELILLO: So I don't know if



1       this is the right time to have this discussion.  
2       But I did want to also mention the data that you  
3       used, the data sets.

4               DR. NIEWCZYK:   So these should be  
5       really general.

6               MEMBER MELILLO:   Okay.

7               (Simultaneous speaking.)

8               CO-CHAIR STILLE:   Yes, we'll talk  
9       about data in probably section two.   Yes, okay.

10              MEMBER THOMAS:   Really quickly, I just  
11       would quarrel somewhat with the fact that your  
12       statement that we don't really know.   We know  
13       what's required of an IRF.

14              DR. NIEWCZYK:   Oh yes, yes.

15              MEMBER THOMAS:   We know what's  
16       required of a SNF.

17              DR. NIEWCZYK:   The care, yes.

18              MEMBER THOMAS:   We know what's  
19       required.   So there are different levels and  
20       intensities and coordination of care being  
21       provided now.   We all know that.

22              We may not know how risk adjusted, how

1 they all correlate based on outcomes and I get  
2 that. But the fact is these are different  
3 products.

4 DR. NIEWCZYK: So there's parameters  
5 what's differentiated both from a SNF, right?  
6 But certainly, like, a hip replacement could be  
7 treated at either venue. What are the outcomes?  
8 Did one perform better? Was the care the exact  
9 same?

10 We don't know. The cost certainly is  
11 different, right, and the intensity of the  
12 rehabilitative services could be different. Some  
13 skilled nursing facilities believe they're just  
14 at par with the requirements of an inpatient.

15 The point is we don't know what those  
16 outcomes truly are. And if we're looking at  
17 measuring function, I think we need the same  
18 types of items within those settings to be able  
19 to assess that.

20 CO-CHAIR STILLE: Sam, go ahead.

21 MEMBER BIERNER: I just wanted to say  
22 that it's not just, I fully understand what you

1       said about the function. But when we're looking  
2       at different levels of care, there are other  
3       issues such as the medical complexity, the acuity  
4       of the medical problems that the patient has and  
5       so forth that are not always captured directly in  
6       this instrument which was intended just to look  
7       at the patient's physical and cognitive function.  
8       I understand that.

9               But I just wanted to make that clear  
10       in case there are others who aren't as familiar  
11       with the difference in the IRF versus the skilled  
12       nursing and other things.

13              DR. CLOHAN: And thank you for that  
14       clarification because it's very true. I share  
15       your concern of sort of the potential for wrong  
16       use of any measure.

17              But I think probably as a Committee  
18       and as NQF and as all of us operating under the  
19       IMPACT Act, pretty much the marching orders have  
20       been put out there for site neutral measurement  
21       techniques.

22              And so I think we feel very proud to

1 be bringing you measures that have been used in  
2 all of these different settings. They've been  
3 used in, you know, we're talking specifically  
4 about one use in skilled nursing facility now.  
5 But you'll see all these six measures, three  
6 different functions being measured and then two  
7 different sites over which they're being  
8 measured, proposed to be measured.

9 And so the instrument has worked  
10 effectively in all of those settings, then I  
11 guess it becomes the next stage after endorsement  
12 to make sure that these are used properly.

13 And if some day somebody says oh,  
14 let's compare this with this, we know the  
15 measurements are equal, apples to apples. What  
16 conclusions people may draw from that if they  
17 don't properly look at different populations,  
18 different intensity of care, they could be  
19 drawing wrong conclusions.

20 But I think the IMPACT Act pretty much  
21 sets the requirement out there for us to find  
22 common measures. And we believe this is one

1 that's very strong, has a long history behind it  
2 and a lot of data, published research.

3 And these measures can actually be  
4 used, I'm very proud of them because they can be  
5 used for the purpose that I think we all believe  
6 quality measures are for, not just a measurement  
7 but giving us some leverage to improve quality in  
8 the future.

9 So in 2015 there was an article  
10 published using FIM data and comparing that with  
11 patients who were found to have new or worsened  
12 pressure ulcers. And it was discovered that  
13 these functional measures correlated with  
14 predictive quality.

15 And so that's what I think the quality  
16 measurement game is all about, to tell us  
17 something that is then actionable. So then we  
18 can say oh, we've identified some people who are  
19 particularly vulnerable. So that's what we're  
20 hoping this can do.

21 CO-CHAIR STILLE: Okay, thank you. I  
22 think we're ready to move on to start talking

1 about the evidence. So let's start with 1A,  
2 evidence for the measure. Any specific  
3 discussion that hasn't already been covered?

4 MEMBER THOMAS: I already said  
5 everything, all the comments I had.

6 CO-CHAIR STILLE: They're in there?  
7 Okay, we're good. Okay. Should we vote on  
8 evidence then, if I can find my clicker. There  
9 it is. 2769 1A evidence.

10 MS. QUINNONEZ: Okay, we will now be  
11 opening voting on Measure 2769, functional change  
12 in self care score as for skilled nursing  
13 facilities, and this is for the evidence.  
14 Rationale supports the relationship of health  
15 outcome or PRO to at least one healthcare  
16 structure process, intervention, or service.

17 Option number one is yes, option  
18 number two is no. Looking for two more votes.  
19 Okay, all votes are in, voting is now closed.  
20 The results of this vote was 100 percent yes,  
21 zero percent no.

22 CO-CHAIR STILLE: All right. And we

1 will move on to performance gap. I actually had  
2 a question. And mine as primary reviewer is in a  
3 couple more, but it's still one of the SNF ones.

4 You mention that almost half of  
5 facilities are below expectations in 2014. But I  
6 can't find what expectations are.

7 DR. NIEWCZYK: Okay. So what we did  
8 is we took all of the facilities and I believe we  
9 used 174 facilities, skilled nursing facilities.  
10 And we took the admission and the discharge score  
11 within the Rasch modeling.

12 We put them together so it, a  
13 progression to the mean in essence, to come up  
14 with where an average patient's function would be  
15 on each item within that measure.

16 So that gave us our, like, expected  
17 values. And then you could look to see a given  
18 facility, were they above that threshold or  
19 below? And then were they that way at admission  
20 and then again at discharge.

21 CO-CHAIR STILLE: Okay.

22 DR. NIEWCZYK: So that way we could

1 see if patients had been maybe low before and now  
2 they came up really high. Certainly they would  
3 have --

4 CO-CHAIR STILLE: So it's not a  
5 benchmark but rather basically a statistical  
6 place where all the other places are. Okay.

7 DR. NIEWCZYK: Exactly.

8 CO-CHAIR STILLE: Okay, great.  
9 Thanks.

10 MEMBER MELILLO: Did you include IRF  
11 and LTAC into that?

12 DR. NIEWCZYK: Not into the, so I know  
13 in the measure files you have it broken down so  
14 you're able to see what the values are for IRFs  
15 as well as LTACs. But we had those separate.

16 MEMBER MELILLO: Okay.

17 CO-CHAIR STILLE: Others? Lisa?

18 MEMBER SUTER: I may have missed it,  
19 I was looking at some of these in more detail  
20 than others. But anywhere do you provide actual  
21 distributions of the facility level scores? I  
22 know you provide the average and you provide sort



1 of percent above and below expected.

2 But it's a little bit hard to tell  
3 what the actual distribution of scores at the  
4 facility level is and do you have that  
5 information anywhere in any of the applications?

6 DR. NIEWCZYK: I don't believe we  
7 included it in the measure files, but certainly  
8 we're able to do that internally, yes.

9 MEMBER SUTER: I think that would be  
10 really helpful because in determining a  
11 performance gap, I will tell you I really can't  
12 interpret the information that's provided.

13 CO-CHAIR STILLE: Right, I agree with  
14 that. You know, if half of the facilities are  
15 below expectation but it's just below the mean or  
16 whatever, okay what's the distribution. That  
17 would be super helpful. Sherrie?

18 MEMBER KAPLAN: Yes. Lots has been  
19 going on over the last six years to try and  
20 improve functional status. Do you have any data  
21 on whether or not this change in function is  
22 mutating in response to efforts to improve

1 quality?

2 DR. NIEWCZYK: We have noticed changes  
3 over the years, yes, not only in terms of rating  
4 and scoring patterns but also in terms of patient  
5 populations.

6 MEMBER KAPLAN: But your data don't  
7 show it. Your data look rock solid stable.

8 DR. NIEWCZYK: If you stratify certain  
9 ways it becomes pretty clear. It's just that,  
10 you know, we've already incorporated a ton of  
11 information already, so we didn't want to belabor  
12 you with so much more. But yes, I mean,  
13 certainly we could provide you more specific if  
14 you want.

15 CO-CHAIR STILLE: Any other discussion  
16 of performance gap? Okay, should we vote?

17 MS. QUINNONEZ: Voting is now open for  
18 Measure 2769 for importance to measure and report  
19 performance gaps. Data demonstrated considerable  
20 variation or overall less than optimal  
21 performance across providers and/or population  
22 groups.

1           Option number one is high, option  
2           number two is moderate, option number three is  
3           low, and option number four is insufficient.  
4           We're looking for one more vote. All votes are  
5           in, voting is closed.

6           The results are 16 percent voted high,  
7           68 percent voted moderate, 5 percent voted low,  
8           and 11 percent voted insufficient.

9           CO-CHAIR STILLE: Okay. So we move on  
10          to reliability. The psychometrics discussion. I  
11          believe that there were some questions related to  
12          this that resulted in data being submitted over  
13          the last couple of weeks about inter-class  
14          correlations. So I'll call your attention to the  
15          one pager that got submitted about two weeks ago  
16          that's in your bunch of documents.

17          (Off microphone comments.)

18          CO-CHAIR STILLE: No, no. it was  
19          available, just relatively late. It was, I  
20          think, on May 24th. Yes, it should be in there  
21          if you have everything printed out.

22          CO-CHAIR PARTRIDGE: Maybe you would

1       like to -- maybe we should --

2                   (Simultaneous speaking.)

3                   CO-CHAIR STILLE:   Maybe we should put  
4       that on screen, or the developers can talk about  
5       it too.

6                   DR. NIEWCZYK:    I could certainly speak  
7       to it if you would like.   It might be easier for  
8       me to just summarize it for you.

9                   CO-CHAIR STILLE:   Sure, okay.

10                  DR. NIEWCZYK:    So for, there's  
11       actually a couple different measures for  
12       reliability.   So what's included in the  
13       specification was done on 174 skilled nursing  
14       facilities with 3,984 patients.

15                  And this is a sample, a random sample  
16       of patients.   And it was pulled on the patient  
17       level data which is why you're seeing such a, you  
18       know, variety of facilities represented.

19                  The Cronbach's alpha was 0.92.   The  
20       intra-item correlations were 0.70 to 0.84.   And  
21       then subsequently we were requested by the  
22       Committee to perform inter-class correlations at

1 the facility level.

2 So we took a random sample of 25  
3 skilled nursing facilities. They had to have at  
4 last a 30 case patient count in order to be  
5 included. And we split, each facility we split  
6 randomly into two data sets, and then we did  
7 averages at the facility level to run the ICC and  
8 compare across facilities.

9 So for the self-care, the ICC was, and  
10 this is between facilities, -0.03 with a P value  
11 of 0.59. So that's pretty bad. But that's  
12 actually good because it shows that there is a  
13 good amount of variability between facilities,  
14 thus we could identify, you know, performance  
15 gaps for instance.

16 We did the same exercise using the  
17 exact same data, and we ran within facility  
18 inter-class correlations. So within facility,  
19 the self-care ICC was 0.87 with a P value of less  
20 than 0.001 which means at the facility level  
21 there's a very strong degree of consistency in  
22 patient function ratings.

1 But between facilities, it varies.

2 And that's what we see pretty much within the

3 field as well.

4 CO-CHAIR STILLE: And Sherrie?

5 MEMBER KAPLAN: I am concerned about

6 what you did because what you're looking for with

7 between facility and class correlation

8 coefficients is you want to see a thumbprint

9 across patients within a facility and you want to

10 see a lot of consistency within the facility and

11 you want to see big between facility differences.

12 You're not seeing that. Now what you

13 did within the facility says you have a lot of

14 within facility, you have a lot of within patient

15 across items consistency. So there's tight

16 variations that are not a lot of within patient

17 variation.

18 But there is a lot of between patient

19 variation within the facility. That would drive

20 those results. That's what your bottom paragraph

21 says. So within a facility there's a lot of

22 between patient variation.

1           But between facilities, there isn't.  
2       And there is a lot of within facility variation  
3       across patients and that's a problem for these  
4       kinds of analyses.

5           Another thing you could do in this  
6       kind of circumstance is do generalized estimation  
7       equations which give you approximately the kind  
8       of same between facility variation.

9           But the concern here is that you don't  
10      have a real strong thumbprint across patients  
11      within a facility, and that's trouble for these  
12      kinds of your ability to then make sense of any  
13      between facility variability that you see.

14           DR. NIEWCZYK: So the within facility  
15      ICC was 0.87.

16           (Off microphone comments.)

17           MEMBER KAPLAN: That's across  
18      patients. The within facility is across items  
19      within patients. When you're looking at a within  
20      facility, all you're seeing is between patients.

21           DR. NIEWCZYK: Yes.

22           MEMBER KAPLAN: And then across items

1 within a patient.

2 DR. NIEWCZYK: Yes.

3 MEMBER KAPLAN: So the error variance  
4 is within patient variability. And that's what  
5 you would expect to see given the Cronbach's  
6 alpha as you know.

7 DR. NIEWCZYK: Yes.

8 MEMBER KAPLAN: But between facility  
9 variation --

10 DR. NIEWCZYK: -0.03.

11 MEMBER KAPLAN: Yes, that's trouble.

12 DR. NIEWCZYK: Why would that be  
13 troubling? We wouldn't want to see a really high  
14 --

15 MEMBER KAPLAN: Oh yes you do, yes you  
16 do. It's exactly the opposite. You want to see  
17 a lot of tight, you don't want to see, you want  
18 to see a thumbprint across patients within a  
19 facility.

20 DR. NIEWCZYK: Yes, which we see.

21 MEMBER KAPLAN: And then -- no. And  
22 then you want to see a lot of between facility



1       variability. See, the coefficient is between --

2               DR. NIEWCZYK: I think we're saying  
3       the same thing.

4               MEMBER KAPLAN: No we're not. Here's  
5       the dilemma. Within facility variation looks at  
6       you got a patient level. You got patients saying  
7       there's pretty much the same thing across these  
8       items in the measure.

9               And then you got a lot of between  
10      patient, within facility variation. So patients,  
11      within a patient you're saying the same thing.  
12      But between patients within a facility, there's a  
13      lot of difference.

14              That's a problem at the next level  
15      because if there's a lot of within facility  
16      variability at the patient level, you're going to  
17      have trouble seeing between facility variability.

18              DR. NIEWCZYK: So it's kind of, I  
19      think you're --

20              (Simultaneous speaking.)

21              DR. NIEWCZYK: So Maggie, maybe you  
22      could speak to this better because I don't think

1 I'm communicating it the right way.

2 MS. DIVITA: So I will start off by  
3 saying that we did the analysis that was  
4 suggested to us by someone in the Committee. The  
5 ICC, just my general knowledge of it, I didn't  
6 really understand how to do it with our data  
7 which is why we had presented it with previous  
8 measures.

9 And so someone had suggested well,  
10 what you would do is you would, you know,  
11 randomly assign half the patients to one data  
12 set, randomly assign the other half to look at  
13 the averages across your measure.

14 And then do an ICC across facilities  
15 in that sense, and that's what we did. And so  
16 when we looked across facilities comparing the  
17 measures across, so between facilities, that's  
18 when we got that very low ICC.

19 When I changed the data just slightly  
20 so that we were comparing within, again at the  
21 measure level, not at the person level, this is  
22 average facility, you know, two data sets, two

1 data points essentially per facility, one random,  
2 one random and half, you know, done half, that's  
3 where we get the 0.8.

4 So perhaps that we're misunderstanding  
5 what we were required to do. But our, what we  
6 thought we found is exactly what Paulette was  
7 saying. So I guess I'm not following you either.

8 MEMBER KAPLAN: That may be a problem  
9 that NQF has in how it's communicating exactly  
10 what's wanted here because it wouldn't be fair to  
11 hold the measures developer to a standard that  
12 they didn't understand.

13 MS. DIVITA: Right. We just argued  
14 that the ICC, because, you know, in my  
15 understanding the ICC is looking across perhaps  
16 items or perhaps a person within Ravers, but  
17 that's not really the data that we have.

18 So we sort of did the ICC as suggested  
19 to us and those are the results that you see.

20 MEMBER KAPLAN: So Sarah, is this  
21 something that we should just then kind of ignore  
22 because it isn't clear that the information got

1       communicated correctly, or could we ask them to  
2       go back and communicate and re-do? How would you  
3       want to handle this?

4               MS. SAMPSEL: Well, I think we should  
5       do a couple things. There's also another  
6       document, Maggie, if you remember that you  
7       submitted and I think you resubmitted --

8               MS. DIVITA: Right.

9               MS. SAMPSEL: -- for this as well.

10              MS. DIVITA: Yes.

11              MS. SAMPSEL: And I don't know if that  
12       will get to some of these as well. And so, you  
13       know, Sherrie, I think this goes back to our  
14       conversation we had last Friday is really trying  
15       to understand that within and between and how  
16       we're communicating for the developers.

17              And you're right, we can't change the  
18       rules now. At the same time, you know, I think  
19       the Committee needs to make sure that they're  
20       comfortable with what this information is, what  
21       the data is, and is it truly, is it a good  
22       indication of quality.

1                   And so I think, is this, no that's not  
2                   it. There's another document, sorry. Suzanne,  
3                   it was the one that was submitted after Phase 2  
4                   and then they resubmitted it --

5                   MS. DIVITA: Yes, there was, it should  
6                   have a bunch of graphs, right?

7                   MS. SAMPSEL: Yes. And Maggie, you  
8                   resubmitted it for this one as well I think.

9                   MS. DIVITA: Yes. I did, yes.

10                  MS. SAMPSEL: Yes, I think it's all  
11                  the way at the end. It might be --

12                  MS. DIVITA: So for the item level  
13                  analysis across facilities to show the  
14                  consistency.

15                  MS. SAMPSEL: Page 308, 308, 309. Yes  
16                  and it still might not be, Sherrie, what you're  
17                  looking for.

18                  MEMBER KAPLAN: Yes, no.

19                  MS. SAMPSEL: But yes, I mean, so I  
20                  think though that, because I would also say that  
21                  this is very much the same type of information  
22                  that was supplied in Phase 2 for the IRF

1 measures.

2 And as a recollection, you know, the  
3 measures were recommended for endorsement at the  
4 in-person meeting and then the additional data  
5 was still supplied, and additional questions did  
6 not come up.

7 So I mean, I think Sherrie, back to  
8 your question, it's kind of a consistency as  
9 well. It's a consistency in determinations and  
10 the level of information we had in front of us.

11 MEMBER KAPLAN: So help us then. What  
12 are we to do with the, because --

13 (Simultaneous speaking.)

14 MEMBER KAPLAN: Yes, that's not going  
15 to help, because of the way the analysis was  
16 done, this is not going to help us. So either we  
17 say you know, this isn't, there was some not  
18 clear, in clarity, unclarity in the way that the  
19 kinds of data that were being looked for were  
20 communicated, in which case we pretty much have  
21 to deal with not the facility level reliability  
22 or how do you want us to think about this.

1 MS. SAMPSEL: So first I'm going to  
2 ask Paulette and Maggie. I mean, from what  
3 Sherrie explained that she would like to see, how  
4 quickly could something like that be turned  
5 around?

6 DR. NIEWCZYK: I mean, we would be  
7 happy to get you what you want. And we, you  
8 know, we have access to a lot of data. It's just  
9 the matter that first of all, our repositories  
10 are set up at the patient level.

11 We know facility level information,  
12 but it's not set up by facilities. So we have,  
13 you know, for instance we could have a year's  
14 worth of data and we have a half a million or a  
15 quarter of a million cases.

16 They may then be from, you know, 200  
17 facilities or 800 facilities. So then first we  
18 have to restructure our data, and then it depends  
19 on, you know, which is why we did the subset, why  
20 we pulled a sample just because we had to  
21 reconfigure everything.

22 We would be happy to do what you want

1 to do. It just depends on what it is, and how  
2 long it takes will depend on what the request is.

3 MS. SAMPSEL: So I mean, I think where  
4 I'm trying to go with this is kind of, you know,  
5 obviously there have been past discussions based  
6 on this level of data if not less on endorsement  
7 of UDSMR measures.

8 And you know, we also have, although  
9 they were less so we're not going to deal with  
10 that yet. But we would only ask for a subset of  
11 data again. So what I'm asking for, you know, so  
12 Sherrie, we know you've expressed some discomfort  
13 and not only the interpretation of this is saying  
14 that the measure is reliable.

15 And that really is the charge, is the  
16 measure reliable. And if you don't feel like you  
17 can make that decision, then you know, that's  
18 kind of how you have to vote on this. And we  
19 would just have to work with UDSMR to get the  
20 right data.

21 MEMBER KAPLAN: Well it kind of  
22 depends. Is the measure reliable at the patient



1 level? Looks to me. I mean, you know, we've had  
2 a lot of experience with these kind of measures  
3 at the patient level. So at the patient level it  
4 is reliable.

5 Then the question was at the unit  
6 being compared is it reliable. And that's where  
7 I get uncomfortable given what's gone on. And I  
8 don't know how to deal with that issue yet.

9 But you know, you have a lot of data.  
10 And even you said there were 20 cases per, 30  
11 cases per facility.

12 MS. SAMPSEL: Thirty cases per  
13 facility.

14 MEMBER KAPLAN: So even on that set of  
15 data, never mind splitting it up into halves, you  
16 could do generalized estimation equations on  
17 that, you could to the intra class correlation  
18 coefficients on that.

19 You could do the analysis that would  
20 probably address this issue. What the results  
21 show is a whole other issue in how you interpret  
22 them. But the analysis could be done fairly

1 straight away I think.

2 CO-CHAIR STILLE: Good, so I think all  
3 the issues are laid out on the table. I think  
4 people's understanding is the best it can be.  
5 Should we go ahead and vote? Oh, I'm sorry.  
6 Linda, one more thing. Yes?

7 MEMBER MELILLO: Do you have data  
8 within facilities -- I'm sorry. Do you have the  
9 data within facilities stratified by diagnostic  
10 group? I know the FIM has proven to be extremely  
11 sensitive to diagnostic group.

12 DR. NIEWCZYK: Yes. So certainly we  
13 can look within facilities at impairment group,  
14 as well as CMG. Yes. And we do have a cross  
15 over CMG that's applied to a skilled nursing  
16 facility as well.

17 MEMBER MELILLO: Okay, because that  
18 might be able to break out that inter facility  
19 different spread, variability.

20 CO-CHAIR STILLE: Okay.

21 MS. QUINNONEZ: Are we ready to vote?

22 CO-CHAIR STILLE: I think we're ready

1 to vote.

2 MS. QUINNONEZ: Okay, voting is now  
3 open for the reliability of Measure 2769  
4 including precise specifications in testing.  
5 Voting option number one is high, option number  
6 two is moderate, option number three is low, and  
7 option number four is insufficient.

8 Looking for one more vote. All votes  
9 are in and voting is now closed. The results are  
10 16 percent voted high, 47 percent voted moderate,  
11 11 percent voted low, and 26 percent voted  
12 insufficient.

13 CO-CHAIR STILLE: So it passes. Okay.  
14 On to validity. Specific points about validity,  
15 any of the primary discussants.

16 MEMBER MORRISE: I think my question  
17 I had earlier was around missing data elements.

18 CO-CHAIR STILLE: Yes.

19 MEMBER MORRISE: And I think that  
20 that's been answered. So thank you.

21 CO-CHAIR STILLE: Yes. And I'll put  
22 in my usual plug for patients under 18 in the

1 future. If this can be adapted to or analyzed  
2 with same, similar data for somewhat younger age  
3 groups it would be very useful.

4 MS. SAMPSEL: Well, and I think this  
5 isn't part of this review. But I can throw it  
6 out there.

7 DR. NIEWCZYK: I'll let you comment on  
8 that.

9 MS. SAMPSEL: We do have a separate  
10 measure called the WeeFIM, and that's meant for  
11 the pediatric population. Maybe we'll submit  
12 those measures someday.

13 CO-CHAIR STILLE: Yes, maybe not the  
14 range of facilities you've got here. But you  
15 know, one of the rehab facilities, sure.

16 MEMBER SUTER: Do you have data on the  
17 response rate at each facility? I know the  
18 reliability and validity testing was done on  
19 large numbers. But I was just wondering in terms  
20 of data collection what the average response rate  
21 is across facilities.

22 DR. NIEWCZYK: So that's a good

1 question. We don't have it because right now,  
2 the skilled nursing facilities that are electing  
3 to use our measures are doing so voluntarily.

4 So they're coming to us, they're using  
5 the measures on top of the MDS and any other  
6 functional measures that they or other medical  
7 indicators and so forth. So it's likely that  
8 there's an intrinsic drive that they're  
9 interested in assessing function and quality and  
10 so forth.

11 So they're probably capturing the  
12 majority, but we cannot be certain of that.

13 MEMBER SUTER: And you don't ask them  
14 to report --

15 DR. NIEWCZYK: We ask them to --

16 MEMBER SUTER: You don't ask them to  
17 --

18 (Simultaneous speaking.)

19 DR. NIEWCZYK: -- assess all patients.  
20 That's sort of what we request.

21 MEMBER SUTER: But to include a  
22 question that says how many of your --

1 DR. NIEWCZYK: Patients did you  
2 submit?

3 MEMBER SUTER: -- of eligible patients  
4 did you submit data on.

5 DR. NIEWCZYK: Yes, no.

6 CO-CHAIR STILLE: Any other discussion  
7 about validity? Should we vote?

8 MS. QUINNONEZ: Okay. Well voting is  
9 now open for Measure 2769 on scientific  
10 acceptability of measure properties and validity  
11 including specifications consistent with  
12 evidence, testing, exclusions, risk adjustment,  
13 stratifications, meaningful differences,  
14 comparability in multiple specifications, and  
15 missing data.

16 Option number one is high, option  
17 number two is moderate, option number three is  
18 low, and option number four is insufficient.

19 All votes are in and voting is now  
20 closed.

21 The results are 21 percent voted high, 68 percent  
22 voted moderate, 5 percent voted low, and 5

1 percent voted insufficient.

2 CO-CHAIR STILLE: Okay, we discuss  
3 feasibility. Lee?

4 CO-CHAIR PARTRIDGE: I was actually  
5 looking at another one of the SNF measures, but I  
6 think the issue is equally relevant here. And  
7 that has to do with -- I'm sorry. It's on the  
8 next one, usability.

9 CO-CHAIR STILLE: Okay.

10 CO-CHAIR PARTRIDGE: But I'm not quite  
11 sure, yes. I think it's more appropriate for  
12 usability so I'll hold.

13 CO-CHAIR STILLE: Oh, we'll have a  
14 little bit of discussion there, great. Any  
15 feasibility comments? All right, let's vote on  
16 feasibility.

17 MS. QUINNONEZ: Voting is now open for  
18 Measure 2769 on feasibility including data  
19 generated during care, electronic sources, and  
20 data collection can be implemented.

21 Vote option number one is high, voting  
22 option number two is moderate, voting option

1 number three is low, and option number four is  
2 insufficient. Waiting for two votes.

3 All votes are in and the voting is now  
4 closed. Results for feasibility are 26 percent  
5 voted high, 58 percent voted moderate, 16 percent  
6 voted low, and 0 percent voted for insufficient.

7 CO-CHAIR STILLE: Okay, now usability.  
8 Lee, it's all yours.

9 CO-CHAIR PARTRIDGE: Okay. We've  
10 talked about this before in the context of the  
11 USMDR measures. But Linda raised it again. One  
12 of the important characteristics is having the  
13 staff trained in knowing how to use the tool.

14 And I know that for your purposes, you  
15 actually require that the staff be certified. I  
16 know CMS does not. But I just wanted to -- I  
17 don't think this, it's kind of a measure of down  
18 the road what we might expect would happen with  
19 this measure being used more widely.

20 It is a burden for the facility that  
21 hasn't trained their staff. And if they want to  
22 participate, they're going to have to engage in



1 the training. How extensive you expect that  
2 would be I don't know.

3 But I remember Sam raising it last  
4 time around these measures. So maybe Sam, you  
5 could comment a tiny bit too.

6 MEMBER BIERNER: I had put that in my  
7 written comments about review of this. The  
8 implementation in the inpatient rehab setting  
9 requires some involvement of all your therapy  
10 staff, nursing, and physician staff in learning  
11 how to do the rating and establishing good inter  
12 rater reliability.

13 So the groups that will be doing this  
14 will probably be nurses, patient care  
15 technicians, and therapists in the SNF or LTAC  
16 settings. So it will require an investment by  
17 the facility to train their staff.

18 It does require periodic retraining  
19 depending upon your turnover of staff at your  
20 facility which I think, just anecdotally I know  
21 it's somewhat higher in SNFs and LTACs than it is  
22 in inpatient units.

1 CO-CHAIR PARTRIDGE: I don't think  
2 that it's particularly an issue from the  
3 technical sense. It's just that I would caution  
4 that maybe other than your members and the few  
5 others, it may not be as adopted as widely as we  
6 would like.

7 DR. NIEWCZYK: So here's the thing.  
8 There are extensive educational materials, so  
9 there is a training guide. Certainly, you know,  
10 clinicians can self study. We have a master  
11 exam.

12 But again, that could, you could  
13 certainly use the tool without passing the master  
14 exam. However, what we maintain is that if you,  
15 you know, function isn't always easy to assess.

16 So if you want to have an accurate  
17 measure that you want to invest the time in to  
18 know about how to assess the construct of  
19 interest. It is an interdisciplinary tool.

20 So it doesn't matter, it's sort of  
21 discipline free. It could be done by nurses, it  
22 could be done by therapists, it could be done,

1       you know, by physicians.

2               Often whoever does the rating doesn't  
3       have to do the full measure. So you could have a  
4       couple of items be rated by one clinician and a  
5       couple by somebody else.

6               However, if you don't understand what  
7       you're measuring, then it's, I use the term  
8       garbage in, garbage out. So if you want to  
9       measure quality, you want to know that you're  
10      measuring function correct.

11              CO-CHAIR STILLE: And just to  
12      reiterate, oh I'm sorry. I skipped the line.  
13      Sorry, Nicole first and then I think Linda, Lisa,  
14      and Becky. I think. Nicole's first, I know  
15      that.

16              MEMBER FRIEDMAN: Sorry. One of the  
17      comments was potentially this leading to longer  
18      length of stays to increase the ability for  
19      patients to get a higher score. So of course  
20      that leaves increased cost. Is that something  
21      that has been a concern?

22              DR. NIEWCZYK: Well, what we've found

1       anecdotally is that the trend sort of follows the  
2       policy. So if length of stay is shortened than  
3       actual length of stay will be shorter.

4               It seems to be less driven by the  
5       patient's actual function and more driven in  
6       terms of payment. But that's, again that's out  
7       of our realm.

8               MEMBER MELILLO: It concerns me that  
9       if you're using it as a crosscutting measure that  
10      you in a rehab setting there's an intense level  
11      of rigor. Many rehab facilities have purchased  
12      additional software with branching logic that  
13      helps them score the FIM.

14              All of that will not, I mean, they  
15      would have to pay for these in other settings  
16      that aren't currently using the instrument. And  
17      you will get a very different, I would think,  
18      level of assessment from an OT assessing self  
19      care as opposed to a nurse or a nursing aid  
20      assessing self care.

21              So those are just some concerns that  
22      I have with the level of rigor and the level of

1 assessment I think you'll see variations in.

2 DR. CLOHAN: I think from a clinical  
3 point of view that's always going to be a  
4 challenge unless you are willing to specify  
5 exactly what clinician or staff person or  
6 technician will perform measures. And so I think  
7 a number of measures don't specify who will  
8 actually perform them.

9 And it goes both ways of whether the  
10 more rigorous end up with higher scores, lower  
11 scores. What we're looking for accurate and  
12 consistent scores. You know, we've measured  
13 reliability and validity on that to show  
14 distinction.

15 Some level of training is going to  
16 have to be required of any measure that's  
17 adopted. But you raise good questions. All of  
18 these things can go wrong. But to try to, we've  
19 tried to come up with a measure that is as  
20 reliable and usable as possible and I think it's  
21 done that and they're variations of types of  
22 facilities where it's used now, and it's

1 successfully being used by different clinicians.

2 So I feel very optimistic that that's  
3 been well demonstrated.

4 MEMBER BRADLEY: And I appreciate  
5 Lee's comment about the amount of training that  
6 may be required and how UDS is held to a standard  
7 for making sure that their users go through a  
8 training credentialing because we've seen these  
9 measures over the years being used for quality  
10 and comparing facilities and now for payment.

11 I think it is important. I think  
12 that's a question we should raise on any of the  
13 measures that come forward is how much training  
14 burden and consistency is there among these tools  
15 and among providers using these tools because  
16 they are, ultimately, many of them are going to  
17 be used for payment and there are ways to game  
18 the system if there is not some type of oversight  
19 on how clinicians are trained or people  
20 administering these tools are trained.

21 So I guess it's more of a question for  
22 CMS in terms of why would there not be that

1 requirement for some of these measures that could  
2 end up in the payment world.

3 CO-CHAIR STILLE: Lisa?

4 MEMBER SUTER: Thanks. I guess my  
5 question about usability is what information is  
6 actually given back to the facility to help them  
7 use information to understand their performance?

8 Obviously they're submitting the data  
9 so they have the individual patient level  
10 results. But in terms of comparative data, what  
11 does the score look like? Are they given their  
12 expected rate, you know, their actual to expected  
13 ratio? Are they given national results or state  
14 results, a spectrum?

15 You know, I'm still struggling how to  
16 interpret the value. And so it would be helpful  
17 to know what information the hospitals, the  
18 facilities, excuse me, get back. And if you  
19 mention that somebody was using this information,  
20 how are they using it.

21 An anecdote would actually be really  
22 helpful in terms of wrapping my brain around

1       that.  Thanks.

2                   MEMBER BIERNER:  And I'll try to just  
3       tell you something practical about its use in the  
4       IRF is that there's something that's not  
5       mentioned here is something called FIM efficiency  
6       where you look at change in FIM over length of  
7       stay.

8                   And so we get data as being a  
9       participating member with the UDS system from a  
10      regional level.  You can look at it at a national  
11      level.  So you can compare your results to  
12      various other larger entities and see where you  
13      are.

14                   And by looking at things like FIM  
15      efficiency, you can see is it an issue of my  
16      length of stay or is it more, you can look also  
17      at your level of intensity of the type of  
18      patients, things like that.

19                   So there's a lot of reporting that is  
20      available, at least in the IRF.  Whether that  
21      will be available in this new setting, I think it  
22      remains to be determined.



1 MS. DANN: I just want to reiterate  
2 one thing if I could two, three questions ago.  
3 The measures are derived from the FIM instrument  
4 which has been around for 25 or greater years.

5 And we have created things which we  
6 have given to CMS over time. When you mentioned  
7 branching logic, we do flow charts. They're a  
8 part of the training manual. And we are willing  
9 to continue giving the refinements to whomever.

10 CO-CHAIR STILLE: Sherrie?

11 MEMBER KAPLAN: I just have a concern  
12 about the relationship between reliability,  
13 validity, and usability because if a measure can  
14 be unreliable but it's usually when it's  
15 unreliable it's not valid.

16 It's very unusual to have a measure be  
17 unreliable and valid. It can be consistent and  
18 wrong like my bathroom scale. I love my bathroom  
19 scale, it's consistently wrong. But it's very  
20 unusual to have it be inconsistent and right.

21 So what we just did was kind of said  
22 okay, this is inconsistent and it's right. And

1 then the question is can you use it under those  
2 circumstances. And I think, you know, I think we  
3 may have not been thinking along those lines.

4 But it raises the issue of then can  
5 you use this measure with any confidence that  
6 you're going to do something -- that's why I  
7 raise the issue of how responsive is this  
8 facility to their efforts to try and manipulate,  
9 to try and improve their performance.

10 Is this responding to quality? That  
11 would have helped me a lot, have more confidence  
12 that this is actually valid and therefore usable  
13 by facilities to act to improve quality.

14 DR. NIEWCZYK: So to answer the  
15 question, the FIM is very reliable. It's been  
16 heavily published on the stability, the intra  
17 rater, the inter rater, and it's been extensively  
18 tested.

19 So it is reliable. Our Cronbach's  
20 alpha was very strong. Our intra item  
21 correlations were all high, you know, highly  
22 correlated and statistically significant.

1           So I don't know where the assumption  
2           is that it's not reliable. Maybe, you know, it's  
3           tracing back to the ICCs that we were asked to  
4           provide, we were hesitant. But if we know what  
5           you want, we will give it to you.

6           But yes, it's a reliable measure and  
7           it is highly predictive. It's predictive in  
8           terms of function, it's predictive in terms of  
9           discharge location.

10          And additionally, what we do provide  
11          facilities is what we call the PEM report. So  
12          it's a program evaluation model. And it takes  
13          into account the average patient's functional  
14          change as well as discharge disposition and it  
15          also adjusts for the facility case mix, so the  
16          type of patients that are within the facility as  
17          well as if it's a freestanding or a unit. So  
18          there's other variables that go into this model  
19          as well so we're able to rank outcomes.

20          MEMBER KAPLAN: Yes. I just want to  
21          be really clear. I'm not talking patient level,  
22          it is absolutely reliable. It's the facility

1 level now that we're worrying about because  
2 that's the unit being compared.

3 So we kind of left behind the patient  
4 level reliability which is absolutely totally on  
5 board with everything you said. The facility  
6 level reliability we're not, we're now struggling  
7 with.

8 DR. NIEWCZYK: And it's extremely rare  
9 to find a low performing facility in one quarter  
10 jump to the best performing facility in the next  
11 quarter. So what we find is that the high  
12 performing facilities are usually relatively  
13 stable, the mid, you know, the average and then  
14 the low stay pretty consistent over time.

15 There's sometimes a bump up or two but  
16 you don't see some of those really drastic  
17 changes without having some other change occur  
18 like administration or something of that nature.

19 CO-CHAIR STILLE: Okay, great.  
20 Jennifer and then Linda. And then I think we  
21 need to -- oh sorry, okay.

22 MEMBER MELILLO: So the research that

1       you're citing was done on --

2                   (Simultaneous speaking.)

3       MEMBER MELILLO:  -- correct?

4       DR. NIEWCZYK:  Yes.

5       MEMBER MELILLO:  First level patient?

6       DR. NIEWCZYK:  We have published  
7       papers on IRF patients as well as SNF patients.

8       So it's not exclusive to IRF.

9       MEMBER MELILLO:  Okay.  But did all of  
10       those undergo the same training and --

11       DR. NIEWCZYK:  Yes, they would all  
12       have passed a master exam if they're used in our  
13       repository.  Yes.

14       MEMBER MELILLO:  Okay.  So, in that  
15       case, it's apples to apples.

16       DR. NIEWCZYK:  Correct.

17       MEMBER MELILLO:  But in order for that  
18       to stay apples to apples, then the SNFs and the  
19       LTACs would have to invest in that same level of  
20       training?

21       DR. NIEWCZYK:  Yes, if they wanted to  
22       be included in our repository.  If they wanted to

1 use the tools, the instrument and the training  
2 guide and materials, it would be at their own,  
3 you know.

4 MEMBER MELILLO: And that would be a  
5 subscriber fee?

6 DR. NIEWCZYK: Not for use.

7 MEMBER MELILLO: For yours?

8 DR. NIEWCZYK: But yes, for the  
9 services, correct.

10 MEMBER MELILLO: Okay, thank you.

11 MEMBER BRIGHT: So I have two  
12 questions and probably the first one piggybacks  
13 off of what Linda was just asking. So walk me  
14 through a facility that's not a subscriber. I  
15 mean okay, they have access to the tool which  
16 they have to use as is for free. And they can  
17 take advantage of your published training guide,  
18 but on their own.

19 Where does that information go? Then  
20 are they on their own to determine what that says  
21 about their facility? Is that information that  
22 they're submitting to CMS? I guess what I'm

1 failing to see is the connect point between a  
2 facility that is currently not using any kind of  
3 valuation and suddenly they have this quality  
4 measure tool available to them. But then what?

5 And is it -- I understand the free  
6 thing, but by definition it's kind of forcing  
7 everybody to be a subscriber in order for it to  
8 be of value. That's what I'm hearing, so  
9 disabuse me of that conclusion. That's why I'm  
10 asking the question.

11 MS. DANN: That's not the case. Go  
12 ahead.

13 MEMBER BRIGHT: Okay. And then my  
14 second question is kind of following on that  
15 which is, is it important -- I'm hearing a lot of  
16 concern about inter-facility comparison and being  
17 able to use this tool and come out the other end  
18 with a picture of what it looks like in one  
19 skilled nursing facility but then being able to  
20 compare that with 20 others.

21 So does there need to be accompanying  
22 guidance to this quality measure that talks about

1 its appropriate use because I'm concerned like  
2 other members are that we're using the word use  
3 and it could come out a lot of different ways,  
4 and there's nothing here that says it's  
5 appropriate to use it this way, it's not  
6 appropriate to use it this way.

7 So, sorry, two questions.

8 CO-CHAIR PARTRIDGE: I think I'm going  
9 to forestall that a little bit because Jennifer's  
10 a new member and the issue that you raised gets  
11 raised around this table all the time. To what  
12 extent should the NQF endorsement be accompanied  
13 by recommendations for how the measure is used.  
14 Is it a QI measure, is it an internal reporting  
15 measure and so on.

16 Theoretically, everything that we  
17 endorse is supposed to be able to be used for  
18 public reporting. I think that's become to some  
19 degree somewhat, I don't want to say soft. But  
20 as we have studied the measures, we aren't always  
21 saying, is it ready to be publically reported  
22 right now.



1                   So help me you all. I don't want to  
2 be the only person saying this. But it does come  
3 up time after time throughout NQF standing  
4 committees. We need to keep talking about it.

5                   MS. DANN: And I want to clarify what,  
6 if the measures are endorsed and adopted, our  
7 offer to CMS is to be able to use the measures  
8 royalty-free in any venue they choose. So if  
9 they choose to report on them in their quality of  
10 reporting, we will have given them everything  
11 they need to do that

12                  DR. NIEWCZYK: Or an industry as a  
13 whole. I mean, certainly they'd be at, you know,  
14 be within reach.

15                  DR. CLOHAN: And all sorts of quality  
16 measures can be useful within your site or within  
17 your organization, even if you don't have  
18 national benchmarks.

19                   I mean, even something as simple as  
20 hand washing, for example, people all over like  
21 to use sort of a consistent methodology of how  
22 you score hand washing so that then within your

1 own site you can make improvements based on that,  
2 even if you don't have access to other people's  
3 hand washing data.

4 And so functional measurement can  
5 serve that same purpose. How can you identify  
6 which functional areas were strong in achieving  
7 improvement or were avoiding any diminution of  
8 function in those patients who aren't capable of  
9 improving.

10 So there's value to it, I think, even  
11 if you don't have the broadest array of  
12 comparison information.

13 CO-CHAIR STILLE: Okay. Are we ready  
14 to vote? Oh, I'm sorry. I didn't see, one more  
15 --- oh, Lisa, down there. No, everybody? Okay,  
16 false alarm. Okay. Usability and use.

17 MS. QUINNONEZ: Voting is now open for  
18 usability and use of Measure 2769, which includes  
19 accountability, transparency, improvement,  
20 progress demonstrated, benefits outweighed,  
21 evidence of unintended negative consequences.  
22 And the option number 1 is high, option number 2

1 is moderate, option number 3 is low, and Option  
2 Number 4 is insufficient information.

3 Okay, it looks like all votes are in.  
4 Voting is now closed. The results are 16 percent  
5 voted high, 58 percent voted moderate, 11 percent  
6 voted low, and 16 percent voted insufficient  
7 information.

8 CO-CHAIR STILLE: Okay. So overall  
9 suitability of 2769. And then we'll have a  
10 discussion about the ones that are like it in a  
11 few minutes.

12 MS. QUINNONEZ: Voting is now open for  
13 overall suitability for endorsement of measure  
14 2769. Voting option number 1 is yes, voting  
15 option number 2 is no. Okay, all votes are in.  
16 Voting is now closed. The results are 84 percent  
17 voted yes, 16 percent voted no.

18 CO-CHAIR STILLE: Okay. So, good. So  
19 similar to our discussion previously today, 2774  
20 and 2775 may be enough alike that we can kind of  
21 put them together. But I think we need to have a  
22 little bit of discussion, just to make sure there

1 are no major issues if we do decide to do that.  
2 Anyone, particularly the primary reviewers for  
3 the other two, Peter?

4 MEMBER THOMAS: With respect to the  
5 motor measure and the mobility measure, the motor  
6 measure is inclusive of all the same  
7 characteristics as the mobility measure. And it  
8 seemed quite redundant. Why would you have two  
9 separate ones?

10 The obvious answer is because maybe  
11 all you want to measure is mobility. And you  
12 don't want to measure the other things. But it  
13 just seemed redundant. Can you explain why we  
14 should approve two when we can approve one?

15 DR. NIEWCZYK: Yes. So the motor is  
16 really encompassing both self care and mobility.  
17 So that's the sort of gross, you know, functional  
18 assessment. And then the other two are, you  
19 know, sub-domains.

20 So certainly if a patient has, you  
21 know, very restricted mobility, and that's not  
22 going to be functional goal, then it might

1        behoove the facility to use the self care  
2        measure.

3                Perhaps they may want to use both, but  
4        the self care would probably be a better  
5        assessment in terms of change from admission to  
6        discharge. It's just providing various levels of  
7        functional measurement for the facility's use.

8                MEMBER THOMAS: It's currently not  
9        required, right, it's all voluntary right now.  
10       If they were ever to require, CMS, for instance,  
11       were ever to require something along these lines,  
12       my presumption is that they wouldn't have you do,  
13       you know, duplicate efforts in that way. So this  
14       is almost just kind of protecting the different  
15       domains. And maybe you want it all in one, or  
16       you want it broken out.

17               DR. NIEWCZYK: Exactly, yes.

18               MEMBER THOMAS: Okay.

19               DR. NIEWCZYK: It wouldn't be  
20       duplicate data collection, so it would be looked  
21       at only as a composite score if it was done in  
22       its entirety.

1 MEMBER THOMAS: Great.

2 DR. NIEWCZYK: Yes, same elements.

3 CO-CHAIR STILLE: Beth, you're next.

4 MEMBER AVERBECK: This would have  
5 applied to the previous measure. So it's more  
6 just a question of understanding if it changes  
7 what we would do with it.

8 You did do some stratification on  
9 socioeconomic and the demographics. I couldn't  
10 tell if anything looked like it was statistically  
11 significant or not. It didn't appear that it was  
12 in looking at it. And so I appreciate you taking  
13 a look and at least reporting that. But just for  
14 the discussion, if this applies to all the  
15 measures it would at least worth noting.

16 DR. NIEWCZYK: Yes. I don't believe  
17 there is. Maggie, you can speak to it if I'm  
18 misspeaking here.

19 MS. DIVITA: No. I didn't actually do  
20 any statistical testing with the large case  
21 count. And we always are a little bit wary of  
22 looking at p values. But I can certainly do that

1 if that's something you need.

2 DR. NIEWCZYK: In terms of what the  
3 averages are, they're almost equal, so yes.

4 MS. DIVITA: Yes. They're pretty  
5 close across, yes.

6 CO-CHAIR STILLE: Other comments?  
7 Peter?

8 MEMBER THOMAS: Seeing no others, I'll  
9 take the opportunity to gratuitously volunteer  
10 that I like the measures. There's obviously a  
11 very long history in data collection on all these  
12 elements.

13 But these really stop somewhat short  
14 of the longer term outcomes. And now that we're  
15 getting into measuring outcomes, and functional  
16 restoration, and functional improvement, and  
17 status, I think it's really important that we  
18 begin to measure things that people really care  
19 about a lot, like the ability to live  
20 independently, the ability to return to work, the  
21 ability to be active in the community, and to  
22 return to their previous leisure, recreational,

1 athletic activity.

2 All those things that people really  
3 care about in terms of long term, functional  
4 restoration or status, I think is really  
5 critical. So obviously not completely relevant  
6 at all to this but just on a broader issue,  
7 broader scale, I would encourage you to continue  
8 to do more work in the area to try to get into  
9 those areas. Because they're really important.

10 DR. NIEWCZYK: Agreed.

11 CO-CHAIR STILLE: Thanks, great  
12 comment. So I think there seems to be consensus,  
13 please let me know if there isn't, about  
14 considering 2774 and 2775 just in terms of their  
15 overall suitability, having had the discussion  
16 about 2769 previously. Okay, let's do it.

17 MS. QUINNONEZ: Okay. Voting is now  
18 open for the recommendation for overall  
19 suitability for endorsement for Measure 2774.  
20 Option Number one is yes, Option Number 2 is no.

21 Looking for two more, three more  
22 votes. Did everyone on the phone submit their



1 votes?

2 Can we have you submit one more time,  
3 just click one more time. We're missing two  
4 votes. Okay, then we're good. Okay. Voting is  
5 now closed. All votes are in. All votes are now  
6 in, and voting is closed. The results are 79  
7 percent voted yes, and 21 percent voted no.

8 Voting is now open for the overall  
9 suitability for recommendation for endorsement of  
10 Measure 2775. Option Number 1 is yes, Option  
11 Number 2 is no. All votes are in, and voting is  
12 now closed. The result is 100 percent yes, zero  
13 percent no.

14 We are going to re-vote that one, one  
15 second. Okay. I'll have you resubmit your votes  
16 for the overall suitability for endorsement of  
17 Measure 277, Option 1, yes, Option 2, no. All  
18 votes are in, and voting is now closed. Okay.  
19 The results are 79 percent yes, and 21 percent  
20 voted no.

21 CO-CHAIR PARTRIDGE: Home stretch.

22 Next up we have, again, our colleagues from

1 UDSMR. We're moving to the other set, which is  
2 related to long term acute care facilities, one,  
3 two, three measures beginning with 2776, and then  
4 2777, and 2778. And so the floor is now open for  
5 discussion. Let's start again with 2777, which  
6 is the self care.

7 MEMBER BIERNER: Well, I was one of  
8 the leads on that one.

9 CO-CHAIR PARTRIDGE: Good.

10 MEMBER BIERNER: I think it's very  
11 similar to the issues that have been raised in  
12 the previous, just to point out that the LTAC,  
13 this is really a new setting for its use. And so  
14 I don't really, I'll ask the UDSMR to tell us,  
15 but I don't think there's as much data, if any,  
16 from LTACs. They said 23 LTACs, I think is what  
17 you had. Is that right?

18 DR. NIEWCZYK: So I agree in terms of  
19 our repository for the long term care facilities.  
20 It is our smallest data site, and it is still --  
21 use of the measures are still in its infancy in  
22 this post-acute care setting.

1                   However, the files that I had  
2                   submitted for the measures did include almost  
3                   4,000 patients, so 3,922 patient level data  
4                   points from six facilities. In the ICC, we  
5                   exploded that out to 16 facilities. So we do  
6                   have, you know, a respectable number of  
7                   subscribing facilities, but it's nothing compared  
8                   to our 800-plus IRFs or, you know, almost 200  
9                   SNFs. So yes, I agree.

10                  MEMBER BIERNER: And I found, I put in  
11                  my comments, in terms of the patients that are  
12                  ventilator dependent, you quoted a study on your  
13                  website that about 28 percent of ventilator  
14                  dependents were discharged to home. And is that  
15                  --- I'm just concerned about -- what do you think  
16                  the sensitivity is to detect changes, given the  
17                  level of some patients like that that might be a  
18                  much lower level?

19                  DR. NIEWCZYK: So often we don't see  
20                  as drastic functional improvement as we do in  
21                  other post-acute care venues. However with, you  
22                  know, measurement of function in mind, there is

1       some slight improvement.

2                   And certainly, you know, we can assess  
3 maintenance or those that are, you know, starting  
4 to decline and likely to be readmitted to acute  
5 care or other intensive care. So there is some  
6 utility still to assessing patient function.

7                   And again, if we take this in mind  
8 with patients measured across the post-acute care  
9 continuum, it is noteworthy to know what they  
10 look like in the other venues prior to admitted  
11 to the, you know, subsequent facilities.

12                   The rating scale is seven levels. So  
13 it's from one to seven. So there is some, you  
14 know, good degree of sensitivity within the  
15 functional assessment ranges.

16                   MEMBER SUTER: So I agree with  
17 Samuel's comments. I was also a lead discussant  
18 on the self care measure. And I have very much  
19 the same concerns as with the earlier measures,  
20 particularly around usability, particularly for  
21 this patient group and particularly the fact that  
22 it's a change measure.

1 I'm wondering how the information is  
2 presented to the facilities, and how that's  
3 useful, and whether or not it's broken out so  
4 that they can understand how to use the  
5 information, I guess.

6 DR. NIEWCZYK: So the same, you know,  
7 the same protocol for long-term care as it would  
8 be for skilled nursing or for IRF. So if they  
9 are subscribing facilities, they have access to  
10 all of our materials and credentialing.  
11 Certainly they'd have use of those materials,  
12 even if they weren't subscribers.

13 But I believe that there is utility  
14 for measuring function for patients even that are  
15 medically complex and need, you know, stability.  
16 And we do capture at the lowest level which is  
17 complete dependence. So we can even see small,  
18 incremental changes that can be captured.

19 CO-CHAIR PARTRIDGE: Stephen?

20 MEMBER HOY: Are we doing 2777 or 2776  
21 still?

22 CO-CHAIR PARTRIDGE: We're beginning

1 with 2776.

2 MEMBER HOY: Okay.

3 CO-CHAIR PARTRIDGE: But that's fine  
4 if you --

5 MEMBER HOY: I'm going to hold then.

6 CO-CHAIR PARTRIDGE: Well, no, don't.  
7 Go ahead. Because quite possibly it's general.

8 MEMBER HOY: Well, I was a lead  
9 discussant on 2777.

10 CO-CHAIR PARTRIDGE: That's okay.

11 MEMBER HOY: And I did notice possibly  
12 a shrinking gap in care. Their numbers in this  
13 set stops at 2011 data set, I know. But I know  
14 you had some limited data. And I don't know what  
15 we're supposed to assume about trends, but I just  
16 wanted to call attention to the shrinking gap of  
17 facilities performing above expectations going  
18 into 2010, 2011.

19 And I know we can't really speak too  
20 much to the distribution yet of the samples, but  
21 could you speak a little to that trend or if  
22 you've seen anything else that might suggest a

1 shrinking gap?

2 DR. NIEWCZYK: Yes. I mean, I would  
3 love to think that there's a shrinking gap. I  
4 think this is just an artifact of small samples.  
5 So when we have it at the facility level, you  
6 know, the patient count samples are respectable,  
7 nearly 5,000 and sometimes well over that.

8 However, when you're looking at the  
9 number of facilities, you know, ten versus three,  
10 so you're going to see some, you know, slight  
11 differences. But the percentages really, you  
12 know, exaggerate those differences.

13 MEMBER HOY: Which is interesting  
14 though in the LTAC utilizations kind of trending  
15 up right now.

16 DR. CLOHAN: I'll just make a  
17 clinical comment. It harkens back to the  
18 committee's discussion much earlier today on  
19 measurement of pain and the question of the  
20 importance of asking the question if you want the  
21 care to change.

22 And so I think LTACs have not

1 traditionally measured function. And so I think  
2 there's logic behind believing that asking  
3 questions about function could, in fact, lead to  
4 significant improvements in care.

5 I would use, as an example, if you're  
6 not thinking about the importance of helping a  
7 patient become more independent in transfer, say  
8 moving from bed to chair, whatever, and you don't  
9 think about it, it becomes very easy just to do  
10 that function for the patient, not try to help  
11 them become more independent.

12 And we know there's good data to show  
13 the more a patient can move around, the less  
14 they're at risk for pressure ulcers, pneumonia,  
15 other things. So I think that the mere asking of  
16 the question could be a good leverage to improve  
17 on the quality.

18 CO-CHAIR PARTRIDGE: Actually, this is  
19 a question of mine for Sam. What's the case load  
20 like in the long term acute care facility,  
21 typically? Who are your patients?

22 MEMBER BIERNER: So they're usually



1 medically debilitated persons that have had a  
2 long hospital stay and require, you know,  
3 intravenous therapy or drug therapy. They may  
4 require respiratory therapy, ventilator  
5 dependency, things like that. So they're a  
6 fairly debilitated group of, well, my term,  
7 medically complex patients.

8 CO-CHAIR PARTRIDGE: That's what I  
9 kind of thought, but I wasn't sure. And this is  
10 a new, more or less, new venture for you too.  
11 And I gather, therefore, we've got a really  
12 significant small numbers problem. Yes.

13 Are we ready to vote on the evidence  
14 question? I think I am. Peter?

15 MEMBER THOMAS: Well, I did ask that  
16 question earlier in the day about how you could  
17 take a measure set that was primarily developed  
18 around IRFs and apply it to SNFs, and then LTACs,  
19 and was that doable.

20 And you tended to say yes, because  
21 what you're measuring is similar across those  
22 settings. And so it may be a small measure set,

1 but you didn't seem uncomfortable with it then.

2 Is that --

3 DR. NIEWCZYK: So if you have a  
4 facility, and you have providers that did improve  
5 function, but you didn't measure it, and then  
6 they were discharged and maybe admitted  
7 downstream to an IRF or to a SNF, how are you  
8 going to capitalize on the changes that you've  
9 made for that patient if you don't measure it?

10 Clearly, they just might maintain.  
11 And maybe for the majority that's what happens.  
12 But we did see some change within patient  
13 function from admission to discharge. So there  
14 are LTACs that are completing the assessments on  
15 patients that are making some functional gains.

16 DR. CLOHAN: And the measurements, the  
17 technique of measuring function is consistent  
18 across venue. You're looking at, you know, can  
19 the patient take steps, how much assistance do  
20 they need to move from a wheelchair to a toilet,  
21 those kinds of things.

22 And so the measurement technique is

1 consistent. And these things being measured,  
2 just like a person, who once they're discharged  
3 out of post-acute care they're interested in the  
4 things that you talked about, return to job,  
5 access to community, recreation, those kind of  
6 things.

7 When you're at LTAC level, and  
8 inpatient level, SNF, whatever, you're very  
9 interested can you walk, can you get to the  
10 bathroom, can you feed yourself, those things.

11 DR. NIEWCZYK: Eat, yes. I mean if --  
12 come in with a feeding tube and then were  
13 discharged eating independently, even with some  
14 modifications, I mean, that's a big improvement.

15 MEMBER THOMAS: Last comment. Yes, my  
16 understanding of LTACs is that there is some  
17 variation in them. And the ones that come to  
18 mind are the ones that are kind of the premier  
19 LTACs to me, Craig Rehabilitation Hospital in  
20 Denver, Colorado, or Shepherd Center in Atlanta,  
21 Spaulding in Massachusetts. You know, they  
22 provide significant rehabilitation services to

1 people with brain injury, spinal cord injury.

2 That's not an endorsement of those  
3 individual places, they're examples. But they  
4 certainly provide rehabilitation to improve and  
5 to, you know, to address functional status, for  
6 sure, so for what it's worth.

7 CO-CHAIR PARTRIDGE: I think, Peter,  
8 my question wouldn't be so -- would be if you've  
9 got -- all you know is something about six  
10 facilities.

11 It's kind of hard to sit back and say,  
12 well, we're comfortable with a significant  
13 variation in performance among six facilities.  
14 That's all, as opposed to the other two  
15 categories we've discussed here. On the other  
16 hand, that doesn't mean it isn't valuable to  
17 start.

18 MEMBER BRADLEY: Then my comments may  
19 relate more to usability, but since we're talking  
20 about change, there is another element to this  
21 scale, as well as in terms of how we use it in a  
22 hospital.

1           Even if there is no change in a  
2     patient, it measures, it kind of goes back to  
3     more of the earlier research that was done. It  
4     measures the burden of care a patient requires.

5           So even if a patient doesn't make any  
6     functional change, it provides providers the  
7     information that they need to train the family,  
8     to teach the families, and to do the education  
9     needed if these patients are projected to go  
10    home.

11           So it provides information even if it  
12    doesn't measure any change as useful information.  
13    And I think sometimes we forget that we're using  
14    it for other purposes other than just measuring  
15    did the patient go from A to B.

16           MEMBER FRIEDMAN: Yes, I just have a  
17    question about -- in any of these measures and  
18    questions, is there anything that addresses  
19    caregiver stresses? As a lot of these patients  
20    that are going home will likely have a caregiver  
21    who need to support them a great deal.

22           DR. NIEWCZYK: It's a great question.

1 It does not directly measure caregiver stress,  
2 however there is published studies whereby the  
3 functional status that the patient is at, in  
4 terms of where their, you know, total score is,  
5 equates to a number of hours of one-on-one helper  
6 care.

7 So it can be useful for communications  
8 with families and caregivers in terms of, you  
9 know, instead of mom's going to need a lot of  
10 help, it quantifies what that lot of help would  
11 be, meaning eight or more hours per day versus  
12 one to two hours per day.

13 CO-CHAIR PARTRIDGE: If there are no  
14 more comments, and in view of the time -- I'm  
15 sorry, Linda, I don't mean to cut you off. Go  
16 ahead.

17 MEMBER MELILLO: So just very quickly,  
18 my concern is that, while there were six LTACs,  
19 three of them were in Massachusetts. So I think  
20 that's very narrow. Also, did you collect your  
21 data pre or post 25 percent rule?

22 DR. NIEWCZYK: So this, when was our

1 first step -- so there would have been, you know,  
2 pre-75 percent rule. Absolutely.

3 MEMBER MELILLO: And then just a  
4 general comment. It concerns me that quality  
5 would be assessed in LTAC populations that may  
6 not include measures that are already existing  
7 for IRF. So like swallowing, vent weaning, you  
8 know, that those would also be very good measures  
9 to include --

10 DR. NIEWCZYK: Absolutely.

11 MEMBER MELILLO: -- in a quality of  
12 LTAC service line. And so I just have that  
13 concern that, you know, by limiting it to  
14 existing measures, that we may not be capturing  
15 the essence of what is an LTAC.

16 DR. NIEWCZYK: Absolutely. This is  
17 not an all-encompassing measure. This is only  
18 looking at a narrow focus of function.

19 And I just want to add that the data  
20 we supplied for you is from six SNFs, but we  
21 don't only have six SNFs in our repository or,  
22 I'm sorry, LTAC. I'm on previous --- you know,

1 in the ICCs we had included 16 facilities.

2 We do have much more data. We  
3 initially had compiled this at roughly 5,000  
4 patients per venue when we submitted for Phase 2  
5 measures and had all sites included in our  
6 applications. So that's why it's looking like  
7 it's only six. Rest assured, there is more data  
8 behind the scenes that we could provide if you  
9 would like.

10 CO-CHAIR PARTRIDGE: Are we ready to  
11 vote on evidence with 2776?

12 MS. QUINNONEZ: We are now voting on  
13 measure 2776, functional change, change in motor  
14 score, and long term acute care facilities.  
15 Rationale supports the relationship of health  
16 outcome or PROs to at least one healthcare  
17 structure, process, intervention, or service.

18 Option Number 1 is yes, and Option  
19 Number 2 is no. Okay, all votes are in. Voting  
20 is now closed. The results are 95 percent voted  
21 yes, and five percent voted no.

22 CO-CHAIR PARTRIDGE: Moving on to gap,



1 et cetera.

2 MS. QUINNONEZ: Okay. We're voting on  
3 the gaps. Performance gaps, data demonstrated  
4 considerable variation or overall less than  
5 optimal performance across providers and/or  
6 population groups.

7 Option Number 1 is high, Option Number  
8 2 is moderate, Option Number 3 is low, and Option  
9 Number 4 is insufficient.

10 All votes are in, and voting is now  
11 closed. The results are 11 percent voted high,  
12 37 percent voted moderate, 21 percent voted low,  
13 and 32 percent voted insufficient.

14 Voting on reliability for measure  
15 2776, reliability including precise  
16 specifications and testing. Option Number 1 is  
17 high, Option Number 2 is moderate, Option Number  
18 3 is low, and Option Number 4 is insufficient.

19 Looking for three more votes. All  
20 votes are in. And voting is now closed. The  
21 results are 11 percent voted high, 42 percent  
22 voted moderate, 16 percent voted low, and 32

1 percent voted insufficient.

2 Are we ready to vote on validity?

3 We're voting on validity for Measure 2776,  
4 validity including specifications consistent with  
5 evidence, testing, exclusions, risk adjustment,  
6 stratification, meaningful differences,  
7 comparability, and multiple specifications, and  
8 missing data. Option Number 1 is high, Option  
9 Number 2 is moderate, Option Number 3 is low, and  
10 Option 4 is insufficient.

11 All votes are in, and the voting is  
12 now closed. The results read five percent voted  
13 high, 53 percent voted moderate, 21 percent voted  
14 low, and 21 percent voted insufficient.

15 Feasibility of Measure 2776, data  
16 generated during care, electronic sources, and  
17 data collection can be implemented. Option  
18 Number 1 is high, Option Number 2 is moderate,  
19 Option Number 3 is low, and Option 4 is  
20 insufficient.

21 We're waiting for two more votes. And  
22 we have them. All votes are in, and voting is

1 now closed. The results are 21 percent voted  
2 high, 58 percent voted moderate, 16 percent voted  
3 low, and five percent voted insufficient.

4 We are now voting on usability and use  
5 for Measure 2776, accountability, transparency,  
6 improvement, progress demonstrated, benefits  
7 outweighed evidence of unintended negative  
8 consequences. Voting Option Number 1 is high,  
9 Voting Option Number 2 is moderate, Option Number  
10 3 is low, and Option Number 4 is insufficient  
11 information.

12 All votes are in. And the voting is  
13 now closed. The results read 11 percent voted  
14 high, 47 percent voted moderate, 16 percent voted  
15 for low, and 26 percent voted for insufficient  
16 information.

17 We are now voting for the overall  
18 suitability for recommendation for endorsement of  
19 Measure 27 --- this should actually be 2777, six,  
20 2776. I'll change that. Option Number 1 is yes,  
21 Option Number 2 is no.

22 Missing one vote. All votes are in,

1 voting is now closed. The results are 58 percent  
2 voted yes, and 42 percent voted no.

3 MS. THEBERGE: Operator, can you open  
4 the lines for public comment please?

5 OPERATOR: Yes ma'am, at this time if  
6 you wanted to make a comment, please press star,  
7 then the number one. There are no public  
8 comments at this time.

9 CO-CHAIR PARTRIDGE: So 2777 and 2778  
10 remain on our plate. And again, this one's a  
11 little awkward.

12 DR. NIEWCZYK: Well, if I can  
13 respectfully ask, you know, we did supply a great  
14 deal of evidence related to reliability and  
15 validity. You know, certainly had we sat here  
16 with, you know, 100 cases or face validity only,  
17 I can understand the outcome. But we not only  
18 had, you know, concurrent validity, but we also  
19 had predictive validity.

20 To see our square values, you know, in  
21 the range that we had, that's highly respectable.  
22 Certainly some published literature, you know,

1 include in our square of 0.17. And it gets  
2 published. So I think I'm confused in terms of  
3 what the committee wanted for reliability and  
4 validity.

5 MEMBER THOMAS: So the last time,  
6 earlier today, there was a discussion about we  
7 have, like, two months to provide additional data  
8 and to try to work with the staff and figure out  
9 whether we can --- some of the, you know, we have  
10 a second meeting and talk. Is that the same  
11 process that would be used in this instance?

12 CO-CHAIR PARTRIDGE: Are you  
13 suggesting you might make a motion to defer  
14 consideration?

15 MEMBER THOMAS: Oh, I wasn't sure that  
16 was the deferral. I thought the deferral was,  
17 like, come back to us and we'll talk ---

18 CO-CHAIR PARTRIDGE: Well, it is.

19 MEMBER THOMAS: -- talk about this  
20 next year.

21 CO-CHAIR PARTRIDGE: It is. As  
22 opposed -- if I'm understanding the discussion

1 earlier correctly, and I may not, so please,  
2 Suzanne and Sarah, stop me. We were really  
3 addressing time frame.

4 If the time frame is pretty  
5 compressed, if we say essentially, during the  
6 public comment period and so on, if there's  
7 additional data you would like to submit, we will  
8 consider it right as part of phase, this ---

9 MEMBER THOMAS: This phase.

10 CO-CHAIR PARTRIDGE: -- this segment  
11 of Phase 3. If you think it would take more time  
12 to make the committee comfortable with a  
13 recommendation to endorse, say up to a year, then  
14 that would be a deferral. Am I right?

15 MEMBER THOMAS: I'm just suggesting  
16 that we heard is this six LTACs, and you said no.  
17 We have data on much more than that. And you do  
18 ---

19 DR. NIEWCZYK: I mean, how much is  
20 enough? Like, I don't know if it's sample size  
21 that you're looking for, you know, certainly I  
22 can pull, you know, data from when we first had

1 an LTAC start collecting.

2 Sometimes what happens is the larger  
3 your database is you have minutiae turn up as  
4 being statistically significant when it's not  
5 clinically meaningful.

6 So in an attempt to counter that we,  
7 you know, we took a sample and we tried to have  
8 the samples equal between settings. Otherwise,  
9 clearly our IRFs would have dominated.

10 So if you took a look at, you know,  
11 the submission files, they're all roughly 5,000  
12 patient counts. Of course, when you have 800 and  
13 some-odd subscribers in IRFs, there's going to be  
14 more variability of those numbers of facilities  
15 versus LTACs. We may have a smaller pool, but  
16 nonetheless, there were more than six. So if  
17 it's just a larger sample you want, that could  
18 easily be done.

19 MS. SAMPSEL: So, Peter, your question  
20 is a process question as well. And so basically  
21 what happens, there were a number. So gap was  
22 consensus not reached, reliability, validity, and

1       then use, usability and overall.

2               And so it does go back to the process  
3       of, you know -- and I think what Paulette's  
4       trying to find out from all of you all is what do  
5       you want to see.

6               You know, they don't have to provide  
7       all their data. I mean, we know if health plans  
8       test they probably test in three health plans.  
9       So kind of, you know, what are those things? And  
10      I think that's what we'd like to draw out. Right  
11      now, what are those things that, in this eight  
12      week period, UDSMR could bring back to you.

13              Because you will re-vote after public  
14      comment on these measures. Did I, is that what  
15      you're looking for?

16              DR. NIEWCZYK: Absolutely. And it's  
17      just, I've been involved in this process for  
18      quite some time, not only for our measures but,  
19      you know, I've been on the line for other  
20      measures under consideration.

21              And it seems to be a great deal of  
22      variability between what's submitted for



1 measures. So sometimes the committee is  
2 perfectly fine with, you know, one setting, you  
3 know, a handful of -- and other times it's -- so  
4 if there's some consistency in terms of what you  
5 want, you know, we'll try to provide that.

6 MEMBER BRIGHT: Really briefly, I  
7 think one criteria that really weighed in for me  
8 was the fact that this is a new setting for this,  
9 okay.

10 So I think that, to some degree, what  
11 you're getting from the committee is a sense of,  
12 yes, give us a little more data. Because this is  
13 a setting that hasn't done this really. And it's  
14 really great that you have such a robust data  
15 set.

16 But you're talking about a data set of  
17 organizations that already have resources and a  
18 focus on this. And we're talking about trying to  
19 pass a measure that could be applied to settings  
20 that aren't doing this at all or definitely  
21 aren't doing it well.

22 So I guess, just speaking for myself,

1 I feel okay with saying could we see some other  
2 examples, just prove to us that it's not just six  
3 facilities. But that's really it. And the  
4 newness of the setting was really my litmus test.

5 CO-CHAIR PARTRIDGE: Lisa and then  
6 Sherrie.

7 MEMBER SUTER: So for gap and for  
8 usability, the information that would be really  
9 helpful to me would be looking at facility level  
10 distribution of results and some information  
11 about the data that goes back to facilities.

12 I know we heard from Samuel that  
13 there's a lot of comparative data, but a little  
14 bit more information about that, which it sounds  
15 like would be pretty easy to pull together, I  
16 think would be very helpful from my ---

17 DR. NIEWCZYK: Thank you.

18 CO-CHAIR PARTRIDGE: Sherrie?

19 MEMBER KAPLAN: Yes. Full disclosure,  
20 I'm on the National Advisory Committee for  
21 Physician Compare. And all of these issues are  
22 being raised at the, you know, how do you measure

1 physician level performance, and how do you  
2 discriminate, and at what level should you  
3 discriminate.

4 And there's a fairly robust literature  
5 out there at the physician level which is  
6 applicable for this unit of comparison. It's a  
7 unit being compared. And the issue of intraclass  
8 correlation coefficients comes up there. And  
9 there's fairly generalized estimation equation.  
10 So there's a fairly robust literature out there.

11 So the kind of facility level  
12 comparisons that we were looking for in the  
13 reliability, and then validity at the facility  
14 level for discriminant validity between  
15 facilities, which is what you want if you're  
16 going to be the facility, and you're going to  
17 either be inappropriately or unfairly compared to  
18 folks with different, either sample size  
19 distributions or --- you really -- this is not a  
20 trivial issue anymore.

21 And it brings up the issue of  
22 usability as well. Because if CMS is going to

1       then begin to use these for, you know, penalizing  
2       people or incenting people, in one way or  
3       another, for meeting or not meeting these  
4       benchmarks, then the standard goes up.

5               And so I think that's what NQF right  
6       now, Sarah, unless I'm wrong, is dealing with.

7       There is some changing in the uses of these  
8       measures now and the potential uses of these  
9       measures, even though we're supposed to be  
10      agnostic to use, that's starting to move the  
11      psychometric properties that we're going to be  
12      expecting from these measures.

13             So I'm still struggling with the issue  
14      of what's fair to hold developers accountable  
15      for. Because the Betty Crocker of how to do this  
16      is in the literature. It's not like we dreamed  
17      it all up in this committee. There's a fair  
18      amount out there that would be useful and helpful  
19      in how to actually do this.

20             The question is whether it's fair  
21      right now to hold measure developers accountable  
22      for meeting the requirement if, in fact, the

1 guidance hasn't been clear enough. That's what  
2 I'm struggling with.

3 CO-CHAIR PARTRIDGE: I think you have  
4 heard several of these measures that it would be,  
5 it would perhaps raise the comfort level of a  
6 number of members if we had the distribution data  
7 that Lisa Suter asked for. And you were nodding,  
8 which suggests to me that perhaps that's --

9 DR. NIEWCZYK: That's definitely  
10 possible. Yes, absolutely.

11 CO-CHAIR PARTRIDGE: -- possible. So  
12 that would be a suggestion that I would also  
13 support.

14 MEMBER KAPLAN: And the intraclass  
15 correlation coefficients at the facility level in  
16 the way we were talking about, not the way it was  
17 done.

18 MEMBER THOMAS: Can NQF staff provide  
19 some technical assistance or communication with  
20 them in order to run that data?

21 MS. SAMPSEL: No. We won't run the  
22 data for them.

1                   MEMBER THOMAS: No, no, no. Not to  
2 run it, but TA, technical assistance to do it the  
3 right way.

4                   CO-CHAIR STILLE: Yes. We're going to  
5 work with Sherrie on that.

6                   MEMBER THOMAS: Yes, okay.

7                   MEMBER MELILLO: Yes. I would like to  
8 see the training manual to see what the burden  
9 would be to those staff who are coming at these  
10 measures new, how complicated is it.

11                   You know, what's the realistic  
12 expectation that, within an organization, they're  
13 going to be able to use this material to actually  
14 score the FIM in a consistent manner as the IRFs  
15 are currently scoring it. In addition, I would  
16 love to see a sample size of at least 30  
17 facilities.

18                   DR. NIEWCZYK: So is that, like, a  
19 rule? I mean, because I just see that that there  
20 are some different rules for different  
21 submissions.

22                   It seems, you know, like, nowhere did

1       it ask to show any training materials or anything  
2       like that. Had it asked for that, we would've  
3       absolutely included it. I just want to be held  
4       to the same standards that everybody else is  
5       being held to.

6               MS. SAMPSEL: Well, but I could say,  
7       within Phase 1 with the CAHPS measures, the  
8       question about how CAHPS was administered and all  
9       of these similar questions on CAHPS do come up.

10              So, I mean, we don't -- do we have CMS  
11       bring their 500 page volume? No. But some of  
12       these questions do come to feasibility,  
13       usability, and use. And I think you're hearing  
14       more of this, at least that's what I'm picking  
15       up, because these are new to the LTACs. So I do  
16       think this is a fair question.

17              DR. NIEWCZYK: And, you know, we'd be  
18       happy to provide it. I'm just, I want as much  
19       clarity as possible so we can get you what you  
20       want.

21              MEMBER MELILLO: My level of concern  
22       is that you mentioned this is a cross cutting

1       measure for use with the IMPACT Act which then  
2       becomes a compliance related measure and also,  
3       potentially, a payment related measure. And so  
4       because of that, I think it's critical, it's  
5       right.

6                   CO-CHAIR PARTRIDGE: I just tested  
7       this script with the lady to my left. The  
8       question before us is on 2777 and 2778, the two  
9       remaining measures for the UDSMR team and us.

10                   What is the comfort level with this  
11       committee about going through all evidence gap,  
12       reliability, validity, feasibility, usability,  
13       and overall, for each of those two remaining  
14       measures as opposed to doing what we have done  
15       earlier, and saying we believe the results for  
16       each of those two would be the same as with this  
17       2776?

18                   And we need only take the overall  
19       recommendation for endorsement vote, just on that  
20       issue, comfort level, I'm sorry, not for  
21       developers. Lisa? Anybody have heart failure if  
22       we did it that way? Sure.



1 DR. CLOHAN: Is there a need to go  
2 ahead and record votes for the two? Or if the  
3 committee is moving toward just collecting some  
4 more information, might you want to just leave  
5 those other two unaddressed for the moment and  
6 get that information back.

7 CO-CHAIR PARTRIDGE: I believe as a  
8 process question, in order to allow it to go  
9 forward for public comment, we need to take the  
10 recommendation vote. Am I right?

11 MS. SAMPSEL: Yes. It's also  
12 consistent with what we did for the rest of day  
13 this morning. So I think we should still do  
14 that, realizing that, you know, it still may be  
15 consensus not reached. But I think as a process,  
16 correct, we do need to do that.

17 MEMBER THOMAS: Similar enough  
18 measures that we can assume that --

19 MS. SAMPSEL: Yes. And in fact, we  
20 did this in Phase 2 as well. We carried, even in  
21 the report, we carried the discussions forward in  
22 the report of saying we had similar discussions.

1 These were the highlights of the discussions.

2 CO-CHAIR PARTRIDGE: Okay. So Desi?

3 MS. QUINNONEZ: So we are voting for  
4 the overall suitability for recommendation for  
5 endorsement for Measure 2777. Option 1 is yes,  
6 and Option 2 is no. Voting is now open.

7 Looking for three more votes. All  
8 votes are in, and voting is now closed. The  
9 results are 47 percent votes yes and 53 percent  
10 for no.

11 We're voting now for the overall  
12 suitability for recommendation for endorsement of  
13 Measure Number 2778. Option Number 1 is yes,  
14 Option Number 2 is no. Looking for two more  
15 votes, one.

16 MS. THEBERGE: Deb, we need your vote.  
17 Thank you.

18 MS. QUINNONEZ: Okay, all votes are  
19 in, and voting is now closed. The results are 37  
20 percent voted yes, and 63 percent voted no.

21 MS. SAMPSEL: So this one fails.

22 There's a public comment that we

1 missed.

2 MS. THEBERGE: Operator, can you open  
3 the line for a public comment please?

4 OPERATOR: Yes, ma'am. At this time  
5 to make a comment, please press star then the  
6 number one. We do have a comment from Deanna  
7 Hayes.

8 DR. HAYES: Hi, this is Deanna with  
9 Focus on Therapeutic Outcomes. I want to thank  
10 you for the opportunity to observe this. These  
11 were some great conversations and things that  
12 were really thought provoking to me.

13 I was unclear with 2769 and why it was  
14 passed when it did not appear to meet the  
15 standards for being a performance measure. I  
16 think you probably just addressed this in your  
17 most recent comments. But my request for comment  
18 was submitted prior to your last discussion. But  
19 I was still unclear about 2769 itself, because it  
20 was passed.

21 MS. SAMPSEL: Actually, Deanna, 2769  
22 was -- hold on a minute. You know, so they were

1 different measures. I mean, from my  
2 understanding from the committee, and this is  
3 just my interpretation, is those first three  
4 measures were the SNF measures where they have  
5 been in longer use.

6 And there was more data provided  
7 where, with the LTAC measures which were the last  
8 three that were not recommended, as of right now  
9 consensus was not reached. But that was a  
10 difference in voting.

11 DR. HAYES: What I heard in the  
12 discussion was a committee member described  
13 concerns, and it didn't sound like they were  
14 resolved. It sounds like the data is there, and  
15 it's available to demonstrate validity and  
16 reliability for performance. It's just a matter  
17 of continuing to work together to find the right  
18 analysis.

19 MS. SAMPSEL: Right. And so during  
20 these next few weeks, NQF staff will work with  
21 UDSMR, and they will provide that additional data  
22 that was not submitted. And therefore, the

1 committee will re-vote.

2 DR. HAYES: Thank you.

3 OPERATOR: And at this time there are  
4 no public comments.

5 CO-CHAIR PARTRIDGE: Peter.

6 MEMBER THOMAS: But on the third  
7 measure of the LTACs that just failed, can we  
8 assume that that was an accurate vote? I mean,  
9 there were a couple instances today when it  
10 wasn't accurate. Why would it have changed? We  
11 didn't discuss anything differently.

12 MS. SAMPSEL: We can definitely re-  
13 vote that one. I mean, I have the same  
14 questions. I mean, if anybody changed their vote  
15 between the two, you know, I guess, does somebody  
16 want to explain, or do people want to re-vote?

17 MEMBER THOMAS: I'd like to re-vote.

18 CO-CHAIR PARTRIDGE: Okay, let's re-  
19 vote.

20 MEMBER THOMAS: Only because we've had  
21 this happen a few times today. And I just don't  
22 know why it would have changed.

1 MS. QUINNONEZ: Okay. We are  
2 reopening the vote for overall suitability for  
3 endorsement of Measure 2778. Option 1 is yes,  
4 Option 2 is no. All votes are in, and voting is  
5 now closed. Thirty-nine percent voted yes, and  
6 61 percent voted no.

7 MEMBER THOMAS: What does that mean?

8 MS. SAMPSEL: Well, it still means  
9 that UDSMR has the opportunity to bring data back  
10 to us, and we'll re-vote after ---

11 MEMBER THOMAS: Okay. Fair enough,  
12 fair enough.

13 MS. SAMPSEL: -- public comment. It's  
14 the same results.

15 CO-CHAIR PARTRIDGE: Any further  
16 comments or discussions? If not, I'm going to  
17 excuse our USMDR people. We've put you through a  
18 difficult afternoon. And I'm afraid you're still  
19 going to have to work with us.

20 And dinner is at 6:00. I know we lose  
21 some of you, because you have other obligations.  
22 But those of us who are going to be going for

1 dinner, I look forward to that in 40 minutes.

2 But otherwise, we're adjourned for the day.

3 Tomorrow morning we begin at, all  
4 right, 8:30 again. Breakfast at 8. We will try,  
5 and again, we had some pretty interesting  
6 discussions today. We will try to have some time  
7 for us to think back over the day and a half  
8 before we leave.

9 And one note, we have to leave at  
10 1:30, I promise you. Because I have committed to  
11 my husband that I will leave by 1:30. Chris can  
12 take over but --

13 CO-CHAIR STILLE: Okay, that's fine.

14 CO-CHAIR PARTRIDGE: -- this half of  
15 the Chair will be home, but do think of some of  
16 the kinds of questions that have been raised  
17 today, some of the things that Sherrie said about  
18 what is it that their current algorithms dictate  
19 that maybe we can't change, but we might want to  
20 recommend be rethought, particularly with regard  
21 to PRO-PMs and anything else that, particularly  
22 from our new members, as you've hit this process

1 for the first time. How can we do it better,  
2 make it work better for all of us? Otherwise --

3 MEMBER THOMAS: I just want to say  
4 that in comparison to the last two times that  
5 I've done this, the staff briefings on this were  
6 unbelievably helpful. And I just really  
7 appreciate that.

8 (Applause.)

9 MS. THEBERGE: So the restaurant is at  
10 16th and K, 1600 K Street. And some folks may  
11 wish to go back to their hotel and so if you want  
12 to just meet us there. And it's called P.J.  
13 Clarke's.

14 (Whereupon, the above-entitled matter  
15 went off the record at 5:23 p.m.)  
16  
17  
18  
19  
20  
21  
22



A			
<b>a.m.</b> 1:9 5:2 124:21,22	<b>accurate</b> 346:16 349:11	348:12 389:7 390:7	293:22
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