

Listening Session: Long Term Hospitals, Inpatient Rehabilitation Hospitals and Hospice Programs Quality Reporting

November 15, 2010 1:00 PM ET

Barbara Cebuhar: Welcome, everybody. We are thrilled that you are here today. My name is Barbara Cebuhar. I know that we don't have much time together but appreciate your spending two hours with us to help with the process. Just a couple of introductions. I work for the Office of External Affairs here at CMS, and I am not an expert on this topic. I have other colleagues who are with us today on the phone and also here in person who are far better at this, but I just want to assure you that CMS is in a listen-only mode. We are in the process of gathering data for a rule, so we can't answer any questions. Our job today is to listen to you and your experience and to gather insight into the best way to make a process work here.

So I just was introducing myself and letting folks know that we have got a transcriptionist on the phone. We will be taking notes of the meeting. Those will probably be posted on our Web site at some point. I will let you know where you can find them if there are colleagues who are interested in finding out more. So, once again, CMS is in a listening-only mode. We are not offering comments or thoughts. We are most interested in your feedback.

Under section 3004 of the Affordable Care Act, the Secretary is directed to establish quality reporting programs for the long-term care hospitals, inpatient rehab hospitals and Hospice programs. LTCHs and rehab hospitals and Hospice will be required to submit data on specific quality measures in order to receive their annual payment update. Entities that do not comply will have a reduction in their annual payment update of 2 percentage points. The required measures affecting these payments are to be published no later than October 1, 2012. The Secretary is directed to establish procedures to allow providers to review the data prior to it being publicly available.

CMS envisions the implementation of high priority site-specific and cross-setting quality measures for LTCHs, rehab hospitals and Hospices that are valid, meaningful, feasible to collect, and that address symptom management, patient preferences, and avoidable adverse events.

In facilitating care that is patient centered, it's important to keep in mind the importance of asking if the quality measurements promote better health for the population, better care for individuals, and lower costs through improvement. Thus, do the measures reflect the IOM six Aims for Improvement: reduction in readmissions; improvement in patient safety; increased effectiveness of care; reduction in the causes and risk factors for ill health, both physical and emotional; risk factors; patient centeredness, timeliness and efficiency of care. Through the listening sessions, CMS is seeking to understand your experience with quality measures and how that experience can inform that goals for the measures outlined above.

Proposed measures must also meet the implementation requirements that are stipulated by the Affordable Care Act section 3004 which stipulates that these quality measures be made available by 2012. Reporting on these measures is

anticipated to begin in fiscal year 2013. For fiscal year 2014 and each subsequent year, failure to submit required quality data shall result in a 2% reduction to the annual payment update.

This listening session is the first step in the process of obtaining your input. There will be a special open door forum held on December 16th from 1:00 to 3:00 p.m. Eastern time that will include an opportunity for a larger group to attend and for us to seek your input. You are also encouraged to submit additional ideas that you aren't able to express today to an e-mail address established for this purpose. Let me give it to you. It's LIHQRP@rti.org. We have a set of questions to put before you and are looking forward to hearing from you about the work that you've been doing in the development and collection of quality measures.

Just some housekeeping issues so we can run an orderly meeting. If you do have a response, if you could just please turn your card on its side, and I'll recognize people in order. Also, if you could please, there is a transcriptionist on the phone. Please indicate your name when you first start talking. And if you could speak loudly, that would help.

Of the quality measures that you are currently using in your setting, which would you suggest as most meaningful to report? Are they process, structural, or outcome measures?

Margaret?

Margaret Crane: Basically we report both to our database for LTCHs and to the state on these measures and they're significant because they impact a huge number of our patients, and that's both infection control outcome measures and infection control process measures. The infection control outcome measures are our central line infections, our urinary tract infections, and ventilator-assisted pneumonias. In addition, we report to the state outcome measures for C. difficile infections, VRE and MRSA bloodstream infections. And then one process measure to the state on infections, and that's our central line insertion (inaudible). We report those. Those are mandatory reports that we go through NHSN which we report to those and they have to submit (inaudible).

Barbara Cebuhar: Great. Thank you.

Margaret Crane: We are also weaning centers where we do ventilator outcome weaning, both time and rate.

Barbara Cebuhar: That's very helpful. Thank you. Do you identify them as process, structural, or outcome measures?

Margaret Crane: (inaudible) Outcome.

Barbara Cebuhar: Thank you. Anyone else? Quality measures that you're currently working with? Carol?

Carol Spence: Yes. This is Carol Spence. We have several, but the one that is most widely used right now is our family evaluation of Hospice care. It is a post-death survey that is sent to the family caregivers who then fill it out and mail it-- primarily mail-- it's a mail survey. It has numerous items on it. The core-- what we call the core items, because there are some that are optional. There are around 40 questions. Some of those are screener questions however. They're not all, you know, indicator questions. We currently do not have a composite for those. Each question on the survey is its own separate, you know, quality indicator. And the Hospices use those to determine what they should work on for their performance

improvement program. And the vast majority of the ones that we want them to focus on for quality-- as quality indicators-- are outcome measures on that. This is not truly a proxy measure. I just want to emphasize that this survey measures the perception of quality of care of that family caregiver. Some of the questions on there do ask about the care the patient received, but because it is highly important in Hospice that the family and the caregiver be considered a unit of care, there are many questions on there that actually pertain to the interaction of the Hospice staff with the caregiver and the interventions that were aimed at the caregiver. So it is mixed, and as I said, we do recognize that for things like symptom management on there, it is the caregivers perception of the, you know, care that the patient received.

That measure happens to be NQF endorsed currently. The other NQF-endorsed measure that we have is what we call a comfortable dying measure which looks at-- for the patient's that were in pain (inaudible) patients of Hospice, was their pain brought to a comfortable level within 48 hours of admission. That also is an outcome measure, and the data for that are collected by the Hospices and then reported back to us, and we do national report for the Hospices then to compare their results.

Barbara Cebuhar: That's great. Thank you very much.

Marsha?

Marsha Nelson: Yeah. I'd like to follow on Carol. Marsha Nelson, American Hospice Foundation. Because we developed and have been testing a Hospice report card which uses a number of the measures Carol-- or a number of the items Carol was describing from the family evaluation of Hospice care, we chose that for the first generation because the survey is NQF endorsed, and there were a few things to choose from, so those items make up the bulk, though not all, of the measures that we look at in the report card, and we've been testing them with about 150 Hospices. And I just wanted to comment, of the ones we've looked at, and it's certainly not all 40, we have 10 categories, but we have four that have shown particularly large variation which I think would lend them some value potentially in distinguishing among Hospices. Those are information for family caregivers, particularly the composite measure of satisfaction with communication, availability of Hospice staff measured by responsiveness on evenings and weekends, overall quality measured by the percentage of families who rate patient care as excellent.

The interesting thing, there's another measure that we looked at also, which was the willingness to recommend Hospice. And we found very little, almost no variation if I recall correctly, it was two or three points on that one, and what we took from it is that there is a general high level of satisfaction with Hospice, and people are ready to recommend it even when they have problems with individual components of care. And then finally, an item that looked at emotional and spiritual support. We based this on a composite measure of support of the family coming from emotional and spiritual sources. So we had only a couple of measures that showed very little variation, but these were the ones that showed the greatest amount.

Barbara Cebuhar: Great. Thank you very much. Jeff Lycan, then Paul, and then Suzanne.

Jeff Lycan: Hi. Jeff Lycan with the Ohio Hospice and Palliative Care Organization. We've developed a tool which I would say has kind of all three pieces. But I'll talk first just about the outcome measures which, I think, Carol has eluded to as well somewhat. We have a pain unacceptable level that we use which is pretty germane to the NQF question that's been approved. We also developed a pain

for nonverbal and nonresponsive patients using the PAINAD tool as the guide. A couple of other outcome measures that we have that we look at are falls, medication administration, as well as, I think, a couple of process pieces with advance directives and medication reconciliation.

The other part of the tool though as we've developed that I would say is more structural in the sense that it's a quarterly-based tool. We currently have about 75 Hospice programs in Ohio, a few in West Virginia, a few in Michigan, and some other folks that are interested in participating, but we report quarterly to those folks. And part of that was to develop a structural tool that they could take and be timely enough that they could use it to make improvement versus getting something that comes out yearly or annually, that way, and having difficulty then in relating it to what they're doing at that period of time. So that's been part of the structural piece that's been very important.

The other structural questions are demographic-type information that we use then as we look at that and compare it to the outcome measures that we're gathering. The other part of that currently, we also have a general inpatient tool that we're using for our Hospice inpatient facility, but focusing on a general inpatient level of care using some of the same outcome measures as we're doing that. But in Ohio we have about 35 inpatient facilities for Hospice-specific care, so we developed that tool to help them benchmark amongst themselves as well.

Barbara Cebuhar: And that's reported quarterly?

Jeff Lycan: Those are reported-- those are reported quarterly as well. They have one group of annual measures which are things like percent of RN-- percent of staff that are certified-- nationally certified, physicians that are nationally certified, turnover ratios and some measures like that that are probably more structural measures that the Hospices can benchmark and compare themselves.

Barbara Cebuhar: That's great. Thank you. Paul?

Paul Dongilli: I won't repeat some of the other things that folks have said knowing that, you know, we too take a look at more of the medical outcome kind of indicators such as Margaret said. Then we also try to balance that with measures of functional outcome and discharge disposition and roll those kind of all together from a perspective of, are we effective, do we do what it is we say we're going to do? Keep people safe, get them home, or to a less intense setting.

And we look at some more operational kind of indicators and a way to measure, are we efficient, do we do those things, but do we do it in a way that is cost effective? We recognize that there's also some limitation in those areas and are trying to actively explore more measures that are holistic in nature using World Health Organization ICF model as a way to maybe standardize around that and look at all dimensions of a person's life, you know, whether we're truly effective. And then follow up in terms of following patients post discharge to see are they maintaining gains or improvement that they've made to show that what we're doing is long lasting. Is it the best experience it can possibly be?

Barbara Cebuhar: Great. Thank you. Suzanne, then Carolyn, then Margaret.

Suzanne Snyder (ph): Okay. This is Suzanne Snyder. We are looking at very similar items to the medical pieces and the functional items. Some of the medical ones that I don't think that I heard were things like venous thromboembolism, measuring incidents of that, hospital acquired, present on admission, looking at falls, particularly falls with injury. I come from the inpatient rehab setting, and part of what we do is try

to mobilize the patient and get them moving, so inherent in that is the risk of fall, so we try to minimize injury and really particularly measure injury of falls.

The litany of different, you know, MRSA, VRE, some catheter-associated urinary tract infections is one thing we monitor pretty closely. Trying to look also, we serve a large spinal-cord injury population, and so I think we'll probably get into this a little bit, and every time I speak I'll probably say something about it, but we feel like that population is especially high risk for urinary tract infection and kind of needs to be looked at a little bit differently and treated a little bit differently.

Also, in addition to some patient satisfaction and some functional measures, which we qualify some of the efficiency measures for function, we have to be really careful with how we use and how we look at them, because using them with kind of the wrong motivations can sometimes steer the care of the patients in a direction that might not be best for the patient. Some unintended consequences of what we focus on.

And we also, just to kind of explain my role, I-- we have my facility, and I think it's-- I'm pretty sure most people who come from facilities could say we measure more things that you can shake a stick at, but we also have kind of a collaborative. We formed a patient safety organization, and within that patient safety organization, we work with some other inpatient rehab facilities, and we have kind of six or seven key indicators in there that it's just been very valuable to each of those participants to share. And a lot of those are the medical management pieces, restraint use, volume of code blues, rapid response team, those sorts of things, because that might be more of a facility-level, but those are things that we kind of self-selected as really important.

Barbara Cebuhar: And you report them how often?

Suzanne Snyder: Those are quarterly.

Barbara Cebuhar: Quarterly also. Okay. Thanks very much. Carolyn?

Carolyn Zollar: Thank you Barbara. We at AMRPA have been working on quality issues for at least-- for about a year now, and I just wanted to say that, in doing so, our-- we've raised the question, and pulling back a little bit from talking about the different measures at this point, we talk about an approach that we've actually framed, I think with your first question, of structural measure and outcomes. We find that in doing that (inaudible) We have a caution though when doing this, and that is when you're looking at process measures, is to make sure that-- one, that there's (inaudible) measures, two, that it doesn't pose a burden without reason, and then three, that maybe looking at quickly trying to pick up measures right now that (inaudible) a process measure but not focus on a lot of process measures and consider them for later development. We've come to this from a framework of very, very specific principles we're looking at, our promotion of really safety and preventing illness, promoting goal achievement, approaching value and benefit, (inaudible) providing innovative care, promoting and ensuring (inaudible), and promoting access and making sure (inaudible). Again, saying the kind of-- before we talk about improvement (inaudible) the key issue of not creating conducive new behaviors that result in failure to provide access particularly for the difficult populations that are representative of today, which I think are some of the most difficult (inaudible). We had reporting criteria that we looked at also with the direction from IOM (inaudible) adverse events but also trying to (inaudible) to create good events or positive outcomes as well as looking at the effect of (inaudible). To be added into the mix of considerations as you move forward for talking about specific measures.

Barbara Cebuhar: Thank you very much. Margaret, and then Dr. Callister.

Margaret Crane: Before I talked about the California mandatory reporting (inaudible) as much as possible if we already have reporting in our states that there is some consistency between the federal and state reporting between what we report, the definitions and things that we don't have to be reporting two or three different items, like ventilator-assisted pneumonia has a different definition, so consistency would be helpful there. But I also wanted to report the long-term care hospital industry has a couple of databases. And one of the databases is-- that I would like to speak to on behalf of the National Association of Long-Term Hospitals, we have both outcome measures-- they're all quality measures, but we call them patient safety measures, we call some process measures, operational measures, and some others very similar to what I mentioned before, that hit most of our major issues in the LTCH care, one of them being respiratory with weaning rates, but we also look at mortality rates, we do look at functional status, we look at where we send the patients on to the next level of care, we look at some of the many inpatient rehabs in terms of risk and patient safety, fall rate, we look at some process measures, both ventilator bundle and central line bundle.

And the only pitch I'm going to make there is if we have a process measure and an outcome measure, make sure our process measures and outcome measures are-- there should be evidence-based literature that when we choose to do something with it, whatever the process is, that there's some evidence that it actually has some impact, because a lot of these databases, you know, you report some outcomes and you report process, but there's not necessarily a correlation. Then operational measures, we can do things like cost and financial pictures too, and there's a whole list of materials that we have to share. But they are collected by that 50 or 60 different LTCHs, and we benchmark against ourselves, we benchmark against other LTCHs, and we could do it either by aggregate or we can do it by individual DOT so it's pretty well done. And we've been doing this for a long time to make sure that we are collecting the right data and the right quality data.

Barbara Cebuhar: That's very helpful. Thank you very much. Dr. Callister, then Marco, then Cathy.

Dr. Brian Callister: Well, Margaret gave me a nice segue into some things I wanted to hit with regard to ensuring not only quality and access, but that we're measuring the things that allow us to move those agenda items which is really what it's about forward. We have to be very careful that we don't spend so much time looking at measures that are out there that are easy to get our arms around if they don't give us the outcome data that we need in order to process patients to where they need to be. For instance, the NALTH database which is very robust which you just heard about has a lot of great outcome measures in there, and there are also some measures in there that you're all familiar with that we all collect that for our purposes, you know, some of them will have to be removed for your purposes, I would think, because they won't be entirely useful in getting to that endpoint, just as you said, process and structure getting to outcome.

Good example, and we measure this of course, look at crude mortality. If it's not risk adjusted in a long-term care hospital, it's meaningless. And to follow that unadjusted for risk, you would select out across the nation for people to take less sick patients for long-term care hospitals because they don't want their mortality rates to be high. I quite often will sit in front of a group of doctors and say your mortality rate is too low. You're not taking sick enough patients. To a lay person, they'd say, what? They know I really mean that. Let's look at the acuity. If your mortality is really, really low, you may not be taking sick enough patients in what's meant to be a system for complex care.

Now, there are some process measures out there that you can piggyback with, and I think we'll all agree, do equate to adequate outcome measurements, but they're indirect, and that would be your ventilator bundle and your bloodstream infection outcomes with your central line bundle. Those are good, and they're indirect, but then we get to things like vent weaning. That seems very straightforward. I tell you, I've seen more ways of measuring vent weaning than you can shake a stick at. They're not consistent across this land. And if we don't recognize that, that's not going to be a useful measure because somebody-- you know, what is a successful vent wean? Is it 72 hours, or 96 hours? It is seven days? It is discharged off the vent? All of those questions need to be answered because I'll tell you, on these relatively simplistic measures that look to be straightforward and true, it's not necessarily so in those areas.

With that being said, one measure I really like that we're trying to work on through LifeCare, my hospital group, and ALTHA is one that's a relatively new measure, as an example, it's unplanned transfers back to the short-term acute care hospital from long-term. It's not NQF endorsed yet. We just started measuring it the last three quarters, so there's a ways to go on this. But for instance, if you just look at acute care discharges as a total, how do you tease out the emergent discharges in the middle of the night at 2:00 a.m., which is really what we're trying to avoid, versus the preplanned third-stage flat procedure that is set up ahead of time and is very appropriate. You can't tease that out if you just look at acute discharges as a total. You've got to break out unplanned. So that's one example, not meant to be all encompassing, but I think we need to recognize in this group, there are certain things that may be a great measure for Hospice or rehab, not so much for LTCH, and there are certain measures that may be useful to all of them. And I think we need to look at where the subsets intersect and where they don't.

And then, last but not least, we talked about different measures we've heard or not heard yet. I haven't heard anybody talk about incidents of nosocomial pressure ulcers. I think that's a pretty good one that's consistent at least on a short-term acute care and an LTCH level. But once again, you have to be careful about how it's defined. If you look around this country, half the people measure it per discharge, half report it as per thousand patient days. To get apples and apples, I would argue you need to look at per thousand patient days or you're not really-- you can't compare across groups.

So are they perfect? No, but if you get enough of these indirect measures and look at really the advantages and disadvantages of each as you work to guess what, access for those patients that truly need this level of care, to benefit them or give them a chance for improvement in an efficient, cost-effective way. And that's how I think you ought to break it down.

Barbara Cebuhar: Thank you very much. That's very helpful. Marco?

Marco Villagrana: Great. Thank you. I'd like to piggyback-- Rather than speak directly to the specific measures, I'd like to piggyback onto what some folks have said and think about, as we move forward, developing measures for the-- in these settings, to think about a framework, you know, for looking at the measures.

One of the things the Joint Commission has started to do, and again, our measures do not follow this framework yet, but I think what we're doing, what we're undertaking now, is looking at each individual measure in different settings started with the hospital setting because that's our biggest program, and that's where we (inaudible) measures that we've been collecting, is to look at whether measures meet-- or different criteria which are present, and Dr. Callister has

talked about this accountability. And a couple of these folks have already mentioned.

One is the level of evidence, whether there is strong evidence that the pure process, the processes associated or linked to the improved outcome. That's the first criteria. The second criteria is whether or not the evidence-based care process is actually delivered. And then three, whether there are the least number of intervening variables between the care process and outcome. And then finally, looking at what a couple other folks have mentioned too, looking at unintended adverse consequences and whether the measure has the opposite, little or not effect, or little or no chance of inducing an unintended adverse consequence to the patient.

Again, we're just at the beginning of doing this at the Joint Commission, but again, I think one of the priorities of our organization is to ensure that while there may not be as many measures out there, they may not be the easiest measures to identify right now, or we do not (inaudible) measures out there that will meet this criteria. I think it's important that we start to move in a direction of identifying very meaningful measures of processes that lead to outcomes so that they are more meaningful so that folks aren't just collecting 30 or 40 different measures and understanding that different settings and different providers will collect different things that also impact them and inform their own processes. But certainly from our perspective, as an accreditor, we're looking to just identify the measures that meet these four criteria. It may not be as many as we're currently collecting or could be collecting right now, but I think that's the direction we'd like to move in. I would urge that, as you consider moving towards this deadline, that you consider that as well.

Barbara Cebuhar: Thank you. Cathy Ellis, then Dr. Gans.

Cathy Ellis: My comment that I'd like to make-- I'm with an inpatient rehab setting-- is regarding the question of measures that are most meaningful and around the concept of patient-centered. And in our setting, we do measure patient experience and then we look into those data to see what the key drivers are for overall patient satisfaction with their experience. So that's just one suggestion of looking at the key drivers. Often the key driver is treated with dignity and respect to-- by a specific caregiver or overall patient satisfaction experience data. The other comment is just, other people have said this, is to look at hospital-acquired pressure ulcers, and I would echo the need for defining the measure for hospital-acquired pressure ulcers because there is so much variability in that area.

Barbara Cebuhar: Thank you. Dr. Gans, then Dr. Clohan.

Dr. Bruce Gans: Thank you. Bruce Gans from Kessler Institute and the AMRPA. I guess I'd like to go back to, why did you ask that question to begin with in terms of whether-- of how we measure process, outcome, and structure, because I think that the preliminary question to be asked is, what are you trying to measure? What are you trying to achieve by collecting information? And then, once you have a clear fix as to why you want to collect data from all of these different settings in a consistent way, it would be obvious whether some of those questions you're trying to answer would be best served by process elements or outcome elements or structural elements. So, for instance, we all know that you can have a perfect process with a dreadful outcome, and so you want-- and so the question is, what is the value? What are the data going to be used for? What purpose will be applied? Or in the framework that Carolyn mentioned, that we've been thinking in AMRPA and in my other organization is, well-- and again, largely based also in the IOM notion, certainly people should have a right to expect that a safe environment where you're less likely to have something bad done to you

deliberately in the hospital setting or in a Hospice setting or in the long-term acute care hospital setting.

So as we're having adverse events, this should be very low, there should be few and far between. So while that would be something reasonable to measure, it would be a very poor total-- totality of things to measure because it sort of-- it's a basic, it's a given. You want it to be there, but it's likely to not-- it doesn't count. Bad things happen. As Carolyn mentioned, one of the things we like to promote is where you've got a purpose, where you're trying to achieve something in the setting, then trying to measure how you accomplish those good things, whether it's not only creating those decubitus ulcers, but how about healing the decubitus ulcer and achieving a positive outcome. Having pain management, having-- There a variety of things that become the purpose for this day. Surviving, having a comfortable death, those may be the purposes. So identifying the purpose of the organization and then measuring the success or lack of that.

Closely aligned with achieving positive outcomes, in rehab in particular, is achieving functional goals and achieving functional expectations, because we admit people for very specific reasons to accomplish certain kinds of performance they attach to, whether-- And it's not always the patient's performance, it's sometimes family's performance that we're trying to work on so that the patient can go home and be safe and have outcomes that are appropriate. And an even more sophisticated way of thinking about all of these things is, can you do those things and achieve positive outcomes in an effective and in an efficient way. Are you being effective and using resources wisely and minimally but appropriately? So some form of measurement of this aspect is missing because you do seem to be a reasonable thing to look at to try and evaluate the setting of care. And then, a very important notion is we may do these great things for people, but if they don't perceive them to have been great things, were they? So the questions of the perception of patient, the perception of family members. We talk about that in satisfaction, some (inaudible) score and measures of what I refer to as ability, but again, some measure of how the customers view the work that we've done would seem to be a reasonable thing to try and describe by setting and system of care.

And then the last thing I would point out is the best way to gain the assistance to get good scores is to be very selective in who you don't take care of. And so a notion that we think ought to be high and centered is access to care, social justice, making sure that there are not unintended consequences of the things you choose to measure that drive people who need it the most out of the system because they're too high a risk for me to take rather than so much of a need for them to try to get the medical care. So I would encourage thinking about all of those attributes. And then, by the way, you might find out that for one thing a process measure is going to deal up another thing you have to measure, something else (inaudible).

Barbara Cebuhar: Thank you Dr. Gans. Dr. Clohan, and then I think what we need to do is move to the next question. So I appreciate everybody's time.

Dr. Dexanne Clohan: Thanks. I'm Dexanne Clohan with HealthSouth, and we have inpatient rehabilitation hospitals and long-term acute care hospitals, but for the moment, for this question, let me put on my hat thinking of inpatient rehabilitation hospitals. And you talked about structure, process or outcomes measures, and I may be restating the obvious, but in the inpatient rehab community, we've used the measure-- functional independence measure, FIM, that many people-- everyone in our industry is familiar with. And then the others are-- And I've scratched my head over the years when the rest of the world was focusing on, oh, we're stuck with process measures because we can't really get to outcomes

measures. I've always been saying like, am I just deluding myself or don't we have outcome measures? And so I think in the rehab environment we're very proud of the fact that we have developed and used very consistently with a very strict methodology, a systemic way of measuring people's function. And what to briefly point-- in thinking of the purpose of what you do, if we look at our patients in the simplest way, we take either people whose impairments are so significant and illnesses are so severe that they require an inpatient setting for rehabilitation.

So the two things that we go after as logical measures for that is to improve their functional outcome, which is traditionally measured with this functional independence measure, and then to try to return them to a community living setting as a demonstration that they have achieved an outcome that allows them to regain some level of independence, at least perhaps within the family structure.

So the advantage, I know Margaret Crane has mentioned, is if you're going to have performance measures and some are already required in some settings, it makes sense to try to parlay that so we're not making more reporting requirements than are necessary. So we, and everyone else in the inpatient rehab industry, have used the FIM score, so I just wanted to say that I think it is a functional measure. And also, we put a lot of weight, as does CMS even in its payment structure, in trying to get people back home again as an ultimate proof of what we've done.

All that said, I'd also reiterate Dr. Gans' point which is that we need to be extraordinarily careful that we don't select performance measures that make it desirable to avoid certain patients and that in our zeal to promote quality that we not pawn access.

Barbara Cebuhar: Thank you very much everyone. Which of the measures would you suggest be selected for the quality reporting program to drive quality improvement, and why?

Which of the quality measures would you suggest be selected for the quality reporting program to drive quality improvement, and why?

We've probably touched on a number of the ideas. So does anybody have--?
Dr. Clohan?

Dr. Dexanne Clohan: I will say, if we can find a measure that-- to be achieved, requires process and structural-- good process and structural things to happen, then maybe you've hit the bonanza. It may not be perfect in that regard, but one attribute about it, in my mind, is if you're looking at this sort of final common pathway, how much functional improvement has the patient achieved? In order to achieve that, there are lots of things you tinker with in the system, your patient education program. Now, you could-- I mean, you could design a measure specifically around how good a job are you doing with patient education or measures specifically around, you know, any of a hundred different other topics. But to the extent that all those process things have to be right to get the final outcome of improved functional performance, I would say there's an advantage towards going for the performance measure that's the highest on the-- sort of an evolutionary hierarchy.

Barbara Cebuhar: Okay. Jeff Lycan, and then Tom Buckingham.

Jeff Lycan: I think if you ask that question (inaudible) around end-of-life care, I think outcome measures are one of the most important, and yet I also think that there's a functional way to measure that that we don't routinely think about. And I think, if I pronounce it right, Mr. (inaudible) talked a little bit about the International

Classification of Functioning which is a broad tool from the World Health Organization that not only looks at structure and functional outcomes, but it's broad enough to also go deeper into environmental, communications, relationships, and things like that, and I think when we look at what's a positive death, we look more holistically at family and patient and that whole process, and yet I don't really see that we have things that we really talk about in our industry that really ultimately hit what the main outcome is. And I see us building processes around all of those measured care pieces, which even though they can be successful, they may not attribute to the thing that we're trying to achieve. And in some way, I guess in my perspective, I think, that outcome measure is the ultimate piece. But we probably all have our own ultimate piece we want to get to in a sense, and it's up to us if it's a good death.

Barbara Cebuhar: Thanks. Tom Buckingham, then Jim Prister.

Tom Buckingham: Tom Buckingham, Select Medical. I think your question is on what should we begin reporting with. I think, additionally, I'd like to recommend that we pick some measure of patient perception of care. If we don't provide a perceived value to the customer of our services, it might not be a good or bad idea, but we have the best MRI picture or whether we cause certain errors. But we happen to use the AHRQ tool with the HCHAPS, a patient satisfaction tool. We have 22 questions. And we, as Dr. Gans mentioned, use questions 21 and 22 about recommend-- willingness to make recommendations, that promote measure, as kind of a summary of, you know, did you get enough information on your pain medication or about your procedures. But in the end, would you ever come back? Would you ever send a family member back to this setting? I think you're going to do something immediately for the public in the guise of healthcare reform, we might want to say-- and we think you think it's the right thing to do.

On a second category of measures, unlike the first, although its not a very good measure, help comes to all. But way back when, (inaudible) a concept of first, do no harm. I think as hospitals we all keep track of how many errors do we do to patients, whether it was falls or hospital-acquired infections or wounds or things of that sort, and we all-- probably those are the best definitions we have. You know, NHSN, the CDC, have some up with great definitions and we adapt them for how to determine when you've given that patient a VRE or an MRSA or C. diff or something. It's easy to count, it gets us in the habit of reporting to CMS or wherever it might be collected. And it certainly meets that first test, the first try not to do harm to your patients. And then-- I think, as the industry grows, we get good at reporting much like the hospital compare database started with eight measures and then went up to 50-some, we might think similarly in our segments and we start with a smaller number and then grow over time as we get more sophisticated and adjusting to counting similarly. (inaudible)

Barbara Cebuhar: Thank you. Jim Prister, Carolyn Zollar, and Dr. Gans.

Jim Prister: Thank you. I know we're not supposed to ask questions, but I think your question really stimulates sort of a-- something that we have to do and step back. Because you indicated what indicator would be best, and if you're asking across all three different settings, I think you would have a very difficult time if there is one single indicator or two indicators across all three different settings. I think the populations that we're dealing with are so diverse. Some are very small populations, some are very geographically spread out, some are within hospitals, free-standing areas. There are a lot of complexities in the providers that deliver the services among all three settings.

I know from an LTCH perspective, we have not always necessarily agreed on what the appropriate indicators are, but I think that there is an opportunity to look

at it if you're thinking about at least from those silos. If you're looking at it across the silos, I think that there is very little information or evidence today that would be available to say that that would be one indicator that would be accurate in all three different and distinct arenas.

I think the other challenge that's out there, and I'm not sure if you're asking for challenges or not, but you asked the question, and not having any feedback from you is-- So I think of the challenges, the-- You're hearing it. It really is focused on patients and it should really be patient-centered. I think part of this is also there are a lot of different types of organizations, not just around this table, but across the country. Our small to large, have ability to gather data. I think one of the things that we've seen is that the-- sort of the reliability of the indicators, whether-- whatever measure it is. The more that it can be standardized, which you heard already, the better off it will be. The more that it can be driven by specific points of data, whether it's in information systems, which some of us have, many of us don't, the human error going into these measures can be substantive. And that is something that is a challenge that I think, as you look at those indicators, that you're contemplating is going to have to be dealt with.

I don't have any answers for that question that you asked on question number two, though.

Barbara Cebuhar: Great. Thank you. Carolyn Zollar?

Carolyn Zollar: Thank you, Barbara. I know many of (inaudible) I would again suggest that your question is to pull back and have the word measure, I think was the last word in your question, put in an asterisks. And then we consider-- before we were talking about very specific measures which also consider that any measure-- the whole issue, the whole area needs to move around several general considerations. Again, one is risk adjustment, and that there's risk adjustment in toto to be (inaudible) measure. And again, it's so that you can get everything done in a measurement (inaudible) so that you can also make sure you're not walking into the negative, but we have mentioned earlier (inaudible) any measure with a behavior that results in the measure assures that there is (inaudible) payment sense. But it could also be used in a quality sense (inaudible). So I would put a whole bunch of (inaudible) about risk adjustment (inaudible). And at the same time (inaudible) not precise times right now and that when we would tiptoe into looking at rehab hospitalizations and long-term care hospitalizations (inaudible) And number two is-- some have alluded to, is that the best extent possible, we all want to look at evidence (inaudible). Again, looking sometimes in these arenas, there may not be a bunch of literature on measures as used in these arenas that would make a reasonable person feel comfortable. So I guess the (inaudible) but I would suggest a master (inaudible) measures looking at evidence, and then after that, if there isn't (inaudible). Look at a number of measures, many of which have been mentioned. Those include falls with injuries (inaudible) it doesn't need to be tweaked to meet demand. Second one would be (inaudible). In looking also (inaudible) looking at the issue of pain and how facilities (inaudible) about measuring pain or (inaudible). The issue of DVTs and pulmonary embolisms (inaudible) at this point in time, and there are again some considerations there about (inaudible) is that every patient or is it, you know, just some patients who get those and some not.

Look closely at the issue of readmission quickly. Database (inaudible) readmissions by inpatient rehab patients (inaudible) acute care (inaudible). Raise the question (inaudible) raised earlier about-- what about the planned readmission (inaudible) the definition of readmission ought to include, in my opinion, (inaudible). Also what you're (inaudible) with the potential for creating a negative (inaudible) who are rewarded (inaudible) discharge to community. What

do you do in terms of a good care and quality of life improvements for patients who may not be discharged to the community (inaudible) social deficits , so it has nothing to do with their functional (inaudible) it has to do with the family (inaudible) taking Grandma home. They've changed their minds. And so we would suggest that as people might look at discharge (inaudible) reasonable measures, but we have a conversation about the nuances. Something we talked about in looking at discharge data, did you meet the expectations for discharge (inaudible). Pressure ulcers is another one that might be a process measure that we could (inaudible). Our group has looked at a lot of process-- pressure ulcer measures, and we haven't fallen in love yet with one of them. (inaudible) Finally, the whole question of function obtained is critical in our arena, and we think that there are a number of (inaudible) characteristics any such measure could meet, and I'd be happy to submit these (inaudible) right now. We've looked at all the existing measures and had (inaudible) some change for a healing effect. A fabulous job (inaudible) fabulous job (inaudible) and it won't show on any measure.

Barbara Cebuhar: Dr. Gans, Paul, then Marsha, and then Beth.

Dr. Bruce Gans: So I'd like to again bring back the notion of, if the question is how to establish a quality reporting culture, as opposed to receiving just great measures of quality, then I think that's a slightly different question, and it prompts me to describe some attributes of the quality measures that you might want to consider to kind of shape behavior in the field as opposed to measuring performance in the field. I would think about, first of all, picking measures that have a low burden of response quality so the facilities will be able to do them with relative expectations. Identifying measures that are likely to be familiar to the facility because they may already be reporting it so that it's something that is familiar and also have some assurance that it can perceive value, so if the measures that are being asked are relevant in the eyes of providers, they're going to be more likely to be actually reported and reported well. And if they have all-- they're all selected to be meaningful in terms of patients, that not only an external reporting collection organization is interested in, but that the provider him or herself is interested in having so that they have these-- can do something with it themselves. (inaudible) available for internal use as well as for external monitoring and thus more intrinsic value and would contribute to substantial quality of care so that the data and knowledge being captured were of (inaudible) to the providers who are reporting. So I would suggest that one of the things that you might think about doing is find out what information people routinely capture. You're getting some sense of it from this conversation, but you could do that in a much more systemic way, collect evidence about what is a commonly reported measure in the various setting and try to think of things that have credibility and high frequency of use anyway. This would increase the probability of this process being successful, measures are likely to be less ambiguous. And that's another issue. The measurement itself may be highly ambiguous and hard to measure consistently and reliably (inaudible) and you get better compliance and then it's the start of a step towards (inaudible).

Barbara Cebuhar: Thank you. Paul?

Paul Dongilli: I work at an organization, the (inaudible) Rehabilitation Hospital, that has both an acute rehab and a long-term care hospital area. We belong to AMRPA, we belong to NALTH, we don't have ties back to a Hospice provider. But as I hear Jeff Lycan speak, I think that we have some things in common in terms of looking at a framework. I noted you're asking for specific things, and you want those measures, and I can understand that when there's a bit of urgency and limited time that you want the measures, but I think that (inaudible) looking to pull these three levels of care together, and we're all going to have a different perspective.

But I think that if you have a common framework, and I guess this is my-- another plug for the ICF and the World Health Organization framework.

I think that those areas could apply across all settings, and as you look at disease, impairment, activity limitation, and participation restriction, that you can almost sort from the things we're talking about today into those areas. You don't want to cause harm, don't want to cause any other disease for someone. Impairment aspect, you look at the medical area, improving pulmonary function by getting off the ventilator, improving skin function by improving a wound. All of that is there, and as you move into activity limitations, you get the whole array of function. And then finally, from a participation standpoint, that might get some of the discharge disposition areas, interim concerns. (inaudible) may go home, you all know that there are some people who go home who are isolated, who become depressed, who then run into a whole host of problems, and those-- and that individual did not have a good outcome even though, I mean, we say they went home and it was great. They may go to a certain nursing facility which has increased socialization for them, maintains their diet, and they have a very good quality of life. So as we look at what is meaningful from a participation perspective, that may vary by individuals served. So I hope we don't lose sight of the framework. That we somehow have to have a framework that connects all of this, that then integrates all of the measures. And, you know, the ICF, I think, might provide us that framework. And so if we could look at the measures in conjunction with the framework.

And then finally, the things that we all talk about, standardization, risk adjusted, you know, assuring access. I think those are-- not that they're given, but they need to be given. (inaudible) the problem would be, I think, the framework. So if we could balance what we do with a framework, I think that would be good.

Barbara Cebuhar: Great. Thank you very much. Marsha?

Marsha Nelson: A few things. First of all, just from the point of view of specifics. We feel very strongly that there needs to be an experience of care component in the measures that are adjusted-- that are chosen for reporting. Jeff talked about the notion of a good death, and that is the ultimate goal in Hospice. How do you really measure that? Well, you can't dismiss how the family comes out of that experience. And Carol mentioned earlier that the family evaluation of Hospice care is not simply a proxy measure administered after death, information from the family or caregiver, it-- because the family is part of the unit of care, and what they take from that experience is pretty critical. They can't go back and do it over, and it has a strong relationship to what the patient experienced for all of us who have ever sat at the bedside of a loved one. You don't need a lot of evidence of that. So we would push strongly for an experience of care component. The family evaluation of Hospice care is not universally used. It is NQF-endorsed. It is, I think, the most broadly used survey tool of its kind. I think, Carol, it's about a third of Hospices or more now that are using it.

We'd also push for-- I mean, although you can eventually, I'm sure NHPCO will come up with a composite score for the survey tool. I think there are important components in it for people to take away. A couple of things to look at, I think, when we're considering measures, are-- one critical thing, what do people who are going to be using those measures really want to know and need to know? As a prelude to (inaudible) we did some focus group work and found out some things that I think people wouldn't be surprised by, but there are things that people want to know when they're selecting a Hospice.

People who-- and we looked at people who had no experience with Hospice and we looked at people who had experience with Hospice-- for people who had no

experiences, they learned about the services of Hospice. The whole notion of a care plan and coordination of care really struck a cord with them. For people who had Hospice experience, one thing that emerged was the importance of the bereavement services that they experienced afterward, and it's not yet endorsed by NQF, but the NHPCO has put forward an evaluation of bereavement services experience survey that is starting to be used by more and more Hospices. And that was an important component that people who had prior experience really wanted to know about.

Certainly things that I mentioned earlier that showed significant variation would be important to think about. But if we're also talking about measures that can help people ascertain or compare across settings, and that by the way came up repeatedly in our focus group work, people who understood Hospice less well than many other settings wanted to understand how they compared to each other. Because when it gets to the end of life, they have a choice. There's nursing home care, there's home health care, there's acute hospital care, and there's Hospice care, and they don't fully understand the differences. In looking for places where measures may intersect, and some of them will be less distinguishing among Hospices, some of the pain measures for example, the treatment with dignity measures, didn't show a lot of variation among-- between Hospices, but I think potentially might show substantial variation across settings and be meaningful to people. So I think we have to think about that component as well.

Barbara Cebuhar: Great. Thank you. If everyone would please introduce yourself each time you talk, I would really appreciate it. It helps with the transcription. So thank you. Beth Feldpush?

Beth Feldpush: Hi. Beth Feldpush with the American Hospital Association. Certainly our members provide services across the wide continuum of both acute care. I just wanted to offer a few comments today to share our perspective on reporting since we have, for the acute care hospital setting, been reporting on quality measures now for about seven years. Maybe we could share some lessons learned in the hopes that they can add to the conversation and be a message for the developing of a reporting program for the other settings.

A few things that we have learned. Firstly is that measures should really be consensus based. In the acute care setting, how the hospital (inaudible) because, as mentioned, this represents a broad group of stakeholders, but it is a really big thing bringing everybody around the table together, not only the provider groups, but purchasers, consumer groups, other provider organizations such as physicians and nurses. Just really kind of has garnered the forces together to one national set of acute care hospital quality measures. So bringing your stakeholders together throughout consensus has been very important.

And the next step beyond that is willingness to put the lead focus on evidence-based measures, or what measures are going to affect evidence-based care processes. We know from experience that it-- really to get the clinician to buy into the measures. To get it across to caregivers, the physicians and nurses, that these measures matter, and they should be striving for them. We have to have good measures in order to do that. So really focusing on measures that assess good evidence-based care processes and get the clinicians behind the measures and make everybody kind of moving towards the same shared goals.

Thirdly, I would say that the issue of field testing has shown to be very important for us so it's as great (inaudible) measure as you could craft sitting in your office or in visiting your one facility until we get out and really test them among a wide variety of providers. There are always going to be things that need to be

tweaked and readjusted. So I think that's sort of the way this conversation started with everybody outlining the measures that they are currently using, I would suggest the CMS could look at those measures that are already in widespread use because in a sense that field testing has already been done for you and the measures have already been accepted in those settings.

And then lastly, I just wanted to say, we have also seen tremendous expense implementing measures, and something that you referred to as measure sets, that is several measures grouped around one topic. We started out looking at measures around heart attack care-- care for heart attack patients, heart failure patients and pneumonia patients, and we have found that sets of measures around a certain topic really have several benefits. One is your broader picture of the care you're providing for the patient, so it allows providers to dig down a little deeper into those areas and in working with those patients. But it also lessens-- actually lessens the burden for providers to attach to that data because, what we have found is, say for our heart attack measures, there might be a central set of 15 main elements that are collected on every single heart attack patient. Those key elements are necessary for calculating all of the measures that have been set. Beyond that, each specific measure itself might only have one or two specific additional data elements so we're looking at-- I mean, you're looking at maybe 20 data elements across a set of five measures as opposed to 20 main elements for this particular measure and that measure. So really kind of thinking along the lines of, are there such topics, whether it's certain infection control measures or pressure ulcers, falls, around which there's a specific measure set. That has shown to be tremendously effective both for provider improvement as well as reducing the burden of data collection.

Barbara Cebuhar: Thank you. Mr. Chiplin and then Dr. Callister.

Alfred Chiplin: I'm Alfred Chiplin with the Center for Medicare Advocacy. Our major concerns in the measures arena are in the area of trying to have something that measures due process, what kind of notice people get about their rights when care is either denied, reduced or terminated, or they have to move from one care setting to the other, what kinds of information they are provided about those transitions and the coordination that goes with that. I see these as things that are first of all process measures that have a substantive component as you look into what are the elements that you provide to the patient drill down. Those are the overarching concerns that I would see impacting all of these arenas.

Barbara Cebuhar: Thank you very much. Dr. Callister?

Dr. Brian Callister: In listening to the discussion and the difficulty in separating specifics among the groups that are here, yet recognizing the need for a consensus in the post short-term acute care setting, it makes me think that what we may have to look at is something where we have a broader boat of measure sets, to steal from Beth down here, or maybe the subsets a little bit different across the groups.

So you brought up at the beginning of the day structure, process, outcome. My little categories-- I know those are the common ones-- but I tend to divide them into clinician, into outcome, prevent bad things, which is, you know, patient safety and quality assurance, and then what I call the "touchy-feely", which is just as important as anything, which is satisfaction. And as well as known, perception becomes reality as we've seen all over the country, that when patient and physician satisfaction, for that matter, goes up, quality measures tend to go with it. I don't know if that's a cause or an effect or not, but they do tend to go hand-in-hand.

With that being said, you take something, and to piggyback off a little bit what Jim said, I mean, we're looking at mortality in an LTCH versus mortality in a rehab. And some of these outcome measures, to start with that first set, include mortality. In rehab it's awful, in LTCH it's a relative term, and in Hospice it's a good thing. So I mean, starting right out of the gate there, we have a separation, but it doesn't mean we can't start with something. So you went from Bruce, it can be a consensus-driven outcome measure that maybe is specific for Hospice but fulfills this general set that you're after with regard to the whole grouping in the post-acute world. And maybe it's a little different one. Maybe it is FIM scores in rehab, but I can tell you, in the LTCH setting, where you're going to be looking for improvement, we might be looking for somebody not to deteriorate. So the benefit may be that they just don't get worse or they don't die. But again, back to the need for risk adjusted, in such specific measures that count across different areas, within the same room mean very, very different things.

A short-term acute care transfer rate, as an example, could be useful but for different reasons in all of these areas and would have to be defined, I think, differently in all areas. If you have inpatient Hospices in your neighborhood, short-term acute care transfer may be pretty low. But if you don't maybe that is a good measure to follow. I know you guys work very hard to prevent that. In the rehab setting, again, it's going to be critical to prevent the planned transfers as it is in the LTCH setting. So that's just an example.

If you get into the process measures, or what I call the-- more the prevent-bad-things measures, I think that actually is the easiest thing to get the evidence-based science behind. Whether it's ventilator pneumonia or bloodstream infections, I think we're all comfortable with those, and it's a matter of picking ones you feel best reflect the areas that we represent. But I think that's going to be the least difficult of the three categories.

The third category is that patient satisfaction, and even physician satisfaction, area, and, I mean, that's an arena we could get into things like your due process. How did they handle your transfer between these different levels of care? How did you feel about it? And that's going to be very different, again, among those subsets.

To kind of put that all together, I think we can get general categories, but I think early on recognizing that you're going to have to have some specific differences in even basic measures among these groups will keep you from driving patients into this homogeneous middle ground where everybody's care is worse because you've created incentives for people not to be in the right place where they have the specialized care that they need.

Barbara Cebuhar: Thank you. Carol, and then Margaret, we're going to have to go on to the next question. So I'm sure you'll have some input. Carol?

Carol Spence: Carol Spence from NHPCO. That was a wonderful segue to what I wanted to say, actually. Although I am going to differ with you a little bit in that going back to symptom management, patient preference and adverse events as your three primary categories. I think that there are different areas of overlap for these three provider settings among those three.

I think it's probably greatest under that patient preference piece and also, I just-- where I really want to emphasize is the need and the probably lack thereof for measures that look at psychosocial spiritual care. What I believe these three patient populations that we all deal with have in common is that they all are looking at tremendous change. You can look at it-- you could put it under the framework of loss, perhaps, and helping them deal with that, cope with that, all of

us are involved in patient and family support for each and every one of these populations. Therefore I think that patient preference, plus if I can lump psychosocial spiritual in that category, is where we have the most common ground. And yet those are the types of measures, I think, that are probably neglected the most and really need to be built up. So maybe for this first step, not sure.

Then there are also the ones that are common, I think, across almost all settings. The being treated with respect, the communication issues, the continuity issues with transfers, too, and that speaks to what Marsha was saying in terms of people. We really need to be able to be meaningful if we're talking public reporting. People, you know, need to be able to look at what they already know and know what's going to happen for these settings that they are somewhat less familiar with probably in terms of what goes on.

Symptom management, we've got a middle ground there. Everybody is dealing with symptoms, they're not always quite the same symptoms, but certainly I could see where process measures-- you've got to do an assessment before you can do an intervention, so maybe common ground there. But there's where we may be having a larger category of measures such as specifics. And I think that's probably even more true though with the adverse events. In Hospice, for example, pressure ulcers is prevention. Healing, not going to happen. And for a lot of these patients, functional status, it's not going to improve, even maintaining. Quality of life, that's another issue, and if there's a way to take safety, quality of life, under the same umbrella, there we've got common ground. But I would say patient-- the Hospice patient population, when it comes to adverse events, probably is-- got more unique access to it and in the context that you need to look at safety within Hospice perhaps than the other two.

Barbara Cebuhar: Great. Thank you very much. Which processes of caring and programatic monitoring have been effective in improving the quality of care in your facilities? I don't know if people can get specific with this or not, but I think we've touched on a number of items.

But which processes of caring and programatic monitoring have been effective in improving the quality of care in your facilities? Margaret?

Margaret Crane: I think it's all of the above that we talked about. And if I can get my point in that I was trying to make, I do think there are a lot of common things, commonality, among (inaudible) But each site at this point in time (inaudible) still have differences. And we want to make sure that whatever we're measuring has the most impact. We don't want to measure just to measure. So we really need to look at things (inaudible) LTCH, which everybody knows, and trying to get a commonality of what we do can be difficult. But in terms of looking at overall DRGs or programs, there are certain things like respiratory weaning (inaudible) wound care, and its basically complexities in breaking that down in order to make sure that we're hitting the most significant things. And that would be weaning and wound care. So looking at what's the most significant impact upon our patient population at each location, trying to make sure they're each (inaudible) where they're all the same at the top and they will all impact the population within each one of those arenas, and then where they have to be different because it's going to impact that population most significantly.

Having said that, looking at (inaudible) in terms of what we've been doing. Obviously, we're a weaning center, so we have spent years collecting weaning data and trying to improve and putting in new protocols and watching we do and getting research on that. And we have been able to improve our weaning outcomes. We're at 60%, but you have to realize, our type of patients, that

they're the top 10% of the most difficult to wean coming from acute care hospitals.

Focusing on the infection-control data and benchmarking, because in California we get benchmarked against acute-care hospitals, so non-LTCH hospitals for the most part, except for the Kindred Center there. That has been significant and working with collaborative groups, the patient safety organization groups and the patient safety collaboratives, and there's a tremendous push in all of the areas between UTI, basically almost nonexistent, UTIs are dropping, central lines are dropping, because we're using the central line process measures that are there. And just knowing about wound care and watching what's going on. We hate to say it, but the carrot is a stick. We've been collecting wound-care data on our patients for 15 years, and just on the bed population alone, 42 to 60% of the patients that were admitted from the acute-care hospital in ICU coming to our hospital, had stage 2 or above wounds. It's dropping significantly. Why? Because pay for performance is coming in. It's now down in the 20s. So everybody in the state is working very hard, and we've been working very hard, to keep our wound-care population down because we know what's coming. We hate to say it's the carrot or the stick, but it was actually the stick that got everybody going on the ventilator and wound care. But the advance admissions on wounds are dropping significantly now. But we've been working hard about getting beds, and we've used essential therapy to keep those down, and we've made improvements in all weaning, infection control and wounds with a tremendous amount of attention in all of those areas.

Barbara Cebuhar: Thank you very much. Suzanne Synder?

Suzanne Synder: Just going back to the question, and maybe I'm not understanding it, or maybe I'm over thinking it, but the processes of care and the programs of care that are routinely provided in inpatient rehab tend to be structured around the diagnoses of the patient. We, in our facilities, have a spinal-cord injury program management team. And so while the facility might be looking at certain quality indicators, that program management team focused on spinal-cord injury might have a different approach to try to reduce adverse events in that population.

So just without getting into too many specifics, I guess the point that would be relevant here is that even within these measures, as we're talking about trying to gain consensus and to have measures that might reflect all three settings at once, I don't think we can lose sight of the fact that even within that, when you're simplifying that, you might be losing, again, some of those key bubbles around the types of patient that will be very important to maintain quality in those speciality populations that are out there. So not to silo us, but to say this type of patient might require a certain type of view or a certain type of approach.

Also, just one other thing about-- and it's not tremendously patient-centered at all-- but speaking about different facilities and different locations and comparing apples to apples, we have within my hospital-- we're a multi-campus hospital-- we have a free-standing inpatient rehab right next to an acute-care hospital, we have a unit inside another acute-care hospital, and then we've got another free-standing that's 13 miles away from the nearest acute-care hospital. And the variations in things like readmissions that we see and even the variations in the types of adverse events that come up, tend to be driven by things like, how willing are we to send this very sick patient to a facility that's 13 miles away from the nearest acute-care facility? So we'll see different trending even within our own three facilities, our own standardized care that we try to deliver, just because of the location of the facility. And I don't know-- I would imagine there's a similar effect for free-standing LTCHs. I don't know very much about Hospice care to

speaking on that, but just a word of caution, again, about when we're reporting and trying to compare ourselves across settings.

Barbara Cebuhar: Great. Thank you. Dr. Gans, then Cathy Ellis, then Tom Buckingham.

Dr. Bruce Gans: Again, if I understand the question, what it made me think about is, of course, the process improvement activities that we all engage in, and our organization certainly uses plan-do-care-check-act cycle, the PAT process improvement methodology (inaudible). Somebody for some reason decides there's a problem, somebody perceived the different data from clinical experience amalgamation and then there's a consensus that the problem exists, and we charter a process improvement team, and specific individuals are charged to do a whole bunch of stuff, collect data, understand it, flowchart the activity, introduce change, and to measure the outcome. It's very clear that we're-- very clear we've had dramatic success in dropping our fall rates, dramatic success in reducing our use of restraints, dramatic increase in the number of medication errors because we decided we weren't reporting them accurately and then so you have good robust reporting and can start fixing medication errors.

So the actual outcome varies upon what your intent is with the process. So there's constant surveillance inside an organization for things that are going on, activities, identifications of things that may warrant use of a process of improvement methodology to achieve change. At the same time, you can think of a hospital or an (inaudible) organization as a juggler with lots of plates spinning on sticks, and we're constantly moving from one plate to the next one. And I have this suspicion that when we focus on these things over here, they clearly get better, but I wonder what's happening to these other things over here that we have them stop giving particular attention to. So you do have to be careful about where you direct peoples' attention, and it may be directed away from other things that are also important.

And the issues change dramatically from setting to setting. It's not unlike Suzanne, Kessler is a three-hospital hospital with three specific separate buildings, and they're about 30 miles apart, but they're a single Medicare provider. We have the same efforts to standardizing the processes of care, single medical staff, lots is the same, but there are very unique distinct differences in the building. And one building may have a problem with a process that another building doesn't have the same problem with, you know, everything will not be the same. So there's a lot of local variation and even within a given building, there may be local variation unit to unit or program to program. So there can be lots of variability.

The last thing I'll just say about the process of improvement. I'm by nature an optimist, but I'm also a realist and I'm starting to wonder how much of what we do in process improvement is not simply a great example of the Hawthorne effect going into reality. Sometimes I think it doesn't matter what we do as long as we're focusing and paying attention to it. It doesn't matter whether we're using this model or that model, whether we use this data or that data, but essentially the process of paying attention and shining a light on the assembly line. I think you change the activity level. So I think there's probably some intrinsic good, but when you're shining a light over here, you may be making it darker over there. So you do have to have caution about that.

Barbara Cebuhar: Thank you. Cathy Ellis, Tom Buckingham, Kevin Gibson, and then we need to get to the next question. So thank you.

Cathy Ellis: I'm also at an inpatient rehab facility, the National Rehab Hospital. And the processes that (inaudible) monitoring-- are you monitoring that have resulted in

improving the quality of care are largely in medication reconciliation, medication administration, prevention of falls, reduction of restraints, prevention of hospital-acquired pressure ulcers and reducing the number of MRSA and VRE infections through monitoring handwashing.

Again, I would echo what Dr. Gans was saying, that our programs include stroke, brain injury, spinal-cord injury, repeated cardiac, DVT, when we became the most effective. When those data were shared with the caregivers closest to the patient. And the corrective action plan came through those individuals. In fact, we experienced frustration until we got to that point. And then because of the highly varied and individualized needs of people depending on their diagnosis, their age, their psychosocial situation, insurance, oh a bunch of factors, we were actually able to see good improvement when we got to-- closer to the caregiver level. We also need to (inaudible) this very strong tradition in the future.

Barbara Cebuhar: Great. Thank you. Tom Buckingham?

Tom Buckingham: To respond to something Suzanne commented on, maybe I missed that when (inaudible) but I thought I heard her say that we're trying to maybe possibly come up with a common set of quality indicators, and I would advocate, at least for this first step, that that not be a consideration. I think process and outcomes particularly, maybe the adverse events and error rates where you want to keep those down, but if you think about just the degree of medical intervention. I mean, by definition, if you move to Hospice, you've ceased all aggressive medical treatments. For a rehab, they have to be somewhat medically stable or they don't get admitted. On the other hand, we're over here taking the most aggressive of medical intervention patients. Same thing with outcomes. I mean, if the hospital achieves its goals as designed, the patient expires. In rehab I imagine the rates are very low, and in ours they are somewhat moderate, but again, taking into account the risk adjustment, I find it very difficult for the very first set of measures for us to come up with a unified field theory of, you know, the world that really these very disparate settings for post-acute services could have the same first five or eight quality definitions. I hope that's not the intent of putting us in the same room together.

Barbara Cebuhar: Got it. Thank you. Kevin?

Kevin Gibson: Kevin Gibson from UDSMR – University of Buffalo. One of the things our organization has done for the past two years is look at program effectiveness, program improvement, whether the things that we've developed recently (inaudible). We have roughly 70 to 75% of the inpatient rehab facilities. What we've done, using the FIM instrument at the core, is to develop a program of (inaudible) where we're ranking all of our, you know, 150 subscribers or so from the highest performance facility to the not so highest, and at the core is the FIM instrument which all the rehab facilities have (inaudible). Also, some of the other models, the model itself also is looking at what are the goals of an inpatient rehab, looking at discharge rates into the community, so how efficient and effective our subscribers are that (inaudible) as well as looking at discharge rates back to acute care as a not so good (inaudible). So that's one of the things we're working on with our subscribers is looking at best practices and looking at the FIM instrument.

Barbara Cebuhar: Thank you very much. To you and your organization, what are the key elements of a quality reporting program for LTCH, rehab hospitals, and Hospice?

To you and your organization, what are the key elements of a quality reporting program for LTCH, rehab hospitals, and Hospice? Suzanne?

Suzanne Snyder: The key elements that just come-- jump right into my mind, and again I'm not sure if this is what you're looking for, but from the facility's perspective, the key is our ability to benchmark. You know, to measure where we are and see where we need to improve relative to our peers-- or where we can-- where there's room for improvement relative to our peers, hopefully in an apples-to-apples kind of comparison because we have historically been compared to acute care, like I'm sure LTCHs have as well, on the measures, and there's just-- sometimes there's no way that we're ever going to be at that level just because of the nature of what we do.

What jumped into my mind secondly was we want to-- key would be the things that are meaningful to the patient, to the person that we're serving, and that what's measuring and what we're trying to improve is something that's important to them and that they can understand.

Barbara Cebuhar: Dr. Gans, then Mr. Chiplin.

Dr. Bruce Gans: Key elements of quality reporting that came to my mind were really capturing relevant data accurately. The second thing is analyzing those data well. And third is acting on the analysis of those data to make changes. Like the PDCA cycle that that's exactly the issue. The fourth thing is changing what we measure over time and not being locked into the same things over and over, achieving 100% success and continuing to measure the same 100% success over and over and over again. And the last thing is reporting and making ourselves accountable to the various stakeholders. The ways you quality report for employees that are written for the intent that the employees will be able to understand it in their context. The ways you report to consumers (inaudible). The ways you technical report or program things, ways you quality report for a board leadership. So we have different audiences which those data need to be presented to in the right way so that the emphasis and the language can be available, and it gives us that-- more of a sense of being responsible and transparent to our various stakeholders.

Barbara Cebuhar: Thank you. Alfred Chiplin, then Beth Feldpush, Cathy Ellis, and Dr. Callister.

Alfred Chiplin: This is Alfred Chiplin from the Center for Medicare Advocacy. What we see really is on the end of dealing with patients when things go wrong in these various care settings. And the primary issues of concern are lack of information about what happened, why it happened, what kinds of options there are for correction, and what kinds of information, and how timely it is provided about community-based options. So it's that constellation of things that, in my view, that if you could get some real hands on with measuring how that's handled would be really critical.

Barbara Cebuhar: Thank you. Beth Feldpush, and Cathy Ellis, Dr. Callister, then Carolyn Zollar.

Beth Feldpush: Thanks. Again, just a few things that we've learned from the acute-care hospital reporting program. Data validation has been considered very important by the providers, because we want to make sure that we are able to accurately compare hospitals. So we actually do have a data validation program that we recently changed what we send out into our reporting program. But it might be a good structure to base one on to be set (inaudible) but clearly data validation is important. On the second half of that, if you have a process for validating data and assessing whether the providers are capturing data accurately, then you also need to use an appeals process so that if somebody is told the data they submit does not match or is not accurate that there is a structure and a process in place to appeal that decision. We also have one of those in place for acute-care hospitals, and that has worked well for us as well.

Barbara Cebuhar: Thank you. Cathy Ellis?

Cathy Ellis: To answer the question from Suzanne, just a few points that I have. The umbrella vantage point is I'm currently the Chair on the Board of CARF, the Commission on Accreditation of Rehabilitation Facilities and what we actually do is accredit health and human services programs in a very large (inaudible). So the umbrella format for key elements of quality reporting are well articulated within the CARF accreditation standards particularly under the (inaudible) for excellence standards. And then individualized, as it pertains to the various CARF accreditation standards for individual programs. At the National Rehab Hospital, some of our most key elements, which certainly fall under the CARF accreditation standards, are patient input to the process. We do a three-month followup, we do very specific questions in some of our followups on patient participation in community as a very important indicator. We also so a survey on patient experience and patient experience data being a key element. And the person served is at the center of all of the CARF accreditation standards. The other important piece I think we've been repeating is validity of data. That's a very key element and it is an ongoing process. Identification of the data source and constant clarification of the data.

Barbara Cebuhar: Thank you. Dr. Callister, then Carolyn, and then we'll go to the next question.

Dr. Callister: I have a little acronym I've used for this for a while, EVAC, Education, Validation, Action and Communication. And it starts out on the boots-on-the-ground level with the education of the individual quality people at individual facilities. Most of the rollout problems we've seen in data gathering, you can usually trace down to either an under educated or under trained individual who is kind of left floating out there to try to roll stuff together. Then you have the educated leadership at a much more advanced level trying to figure out why the data isn't valid or why there are issues, and it comes back full circle to, you know, once you have chosen, at a leadership level, with education and proper reasoning based on evidence and what outcomes you really are hoping to gather, that you properly educate the people on the ground floor. And I think that's a place where we still have so much variability and not much communication or education.

Then you kept the validation part, which I won't beat that into the ground. I think we all recognize and have heard it four times from four people how critical it is, but you'll have a lot easier time validating good data if you start out getting good data from more people.

The next thing is action. And you heard before, measuring 100% success for three or four years in a row, who gives a darn? You've got to be able to turn around and, number one, put in an action plan, or issues that are new or are ongoing quality improvement disasters, and have the guts to take away the inertia of continuing to measure those things that really either are already taken care of or you've realized over time they don't matter. There are things that we struggle to improve on where somewhere during the course of our improvement we realize that maybe that measure isn't as meaningful as we thought, but we're so caught up with trying to improve it, we don't drop it out. So I think that's really key.

And then the last one, communication, and that goes hand-in-hand with education and really goes back to your question three. The interdisciplinary team approach that at the LTCH level we've learned from our rehab brothers and our Hospice sisters, I think is something that can't be underestimated or undervalued with regard to how much it has improved quality, by sitting down at the table and hearing from multiple disciplines on a regular basis about what's going on. I can

tell you, as a physician on the front line, there certainly has been a tremendous difference in how I approach patients. And the (inaudible) I have for approaching them anew every week after hearing that input. So I think that's something to really focus on. The whole team needs to hear, not just one or two people, what these measures are.

Barbara Cebuhar: Thank you. Carolyn?

Carolyn Zollar: (inaudible) wanted to reiterate something that we talked about before (inaudible) and it also be meaningful and understandable for the patient and provider. Meaningful for both and understandable, the success rate of getting it recorded and being able to (inaudible) accurately (inaudible) and being able to use it in a reasonable manner (inaudible). As well as making sure that (inaudible) promote those more positive outcomes.

Barbara Cebuhar: Great. Thank you very much. The next question is, do your measures meet the NQF rating criteria?

Do your measures meet the NQF rating criteria? (inaudible) I don't have the rating criteria in hand. Sorry. Dr. Clohan?

Dr. Dexanne Clohan: Is it evidence-based? Is there readiness in the field to adopt it? Can it be measured accurately? Is it useful? Would it actually yield improvement?

And I think this goes back to a point Carolyn made earlier and that colleague who finds it showing in an actual journal article that has to do with parachutes, that there really are no double-blind controlled tests to demonstrate that, you know, wearing a parachute is actually better than not wearing a parachute should your plane crash. But I think most of us around the table would say, you know, I'm going with the parachute.

And so I think there is concern, at least in my mind, in the three areas that we're talking about here, Hospice, LTCH, and inpatient rehab. Our research base hasn't always been the same as some of our colleagues. And sometimes we get a little down on ourselves about that, but then I remind myself, you know, if we really held their piece to the same fire that our pieces are being held to, I think we'd discover, you know, there's not a lot of randomized controlled trials of whether surgery versus lemon juice is better for appendicitis. I mean, really, you know, you watch a while, some people die, you start operating, but you don't do the controlled randomized trials on that for very long.

So I think one concern I have with the NQF process is, I admire the process, I've been involved in it myself and served on panels, and our organization is a proud member of NQF, so in no way am I trying to undercut the importance of their measure endorsement, but you could find yourself with a potential measure that would be very logical that experts in the field would reach almost unanimity on, but it would be hard to get it through the process because of the lack of the evidence basis. So I think perhaps there is a role for maybe convening some consensus panels or doing something that could create something that would meet that metric for the evidence basis without necessarily demanding that it be a more traditional type of research.

Barbara Cebuhar: Thank you. Carol Spence?

Carol Spence: Carol Spence, NHPCO. I think very quickly those four areas are-- the first one is important, because if it doesn't meet importance and they don't consider it. So the other three then, the scientific acceptability, usability, feasibility. But I can't give you what all the various little permutations or criteria are under the four. I

totally agree. Evidence-- hard evidence-based in terms of trials is definitely lacking. Consensus however, I think is there. I mean, for palliative and end-of-life care, at least at NQF there's a framework that has been, you know, agreed upon.

So the first-- back to our very first question, refer to measures that we discussed for Hospice, the family evaluation and the comfortable dying, do have currently NQF endorsement. And as Marsha mentioned though, NHPCO has other measures that we have not yet sought, but they don't quite-- you know, there's-- we have a bereavement is another survey that's after the end of bereavement services. Again, it's a client satisfaction, although I'd rather-- I much prefer evaluation of care to satisfaction because we don't ever ask-- use that word satisfaction in any of the questions. But we also have-- looking at taking a 360 approach, we also have a staff satisfaction, you know, survey that is used and that we have both individual Hospice reporting and national-level reporting. And we've got a patient evaluation in development currently. So we are going down that route. I agree NQF may not be perfect in its selection, but it's what we've got now.

And also, with the family evaluation, currently there is grant money out around the University in collaboration with NHPCO with looking at a major revision-- or actually enhancement addition to that measure. Keeping in mind, this is something we haven't-- I'm just going to throw one right now quickly because we haven't talked about it before-- Hospice covers numerous settings, so there's facility-based Hospice, there's Hospice alone, there's Hospice in nursing homes, there's Hospice in assisted care, and there's-- primarily though, it's still Hospice at home, and coming up with measures just even for Hospice that work across all their settings is a challenge.

Barbara Cebuhar: Margaret Crane and then we go to the next question. Thank you.

Margaret Crane: Well, I'm speaking on behalf of our (inaudible) LTCH database. We have looked at the NQF measures and we probably would be able to get some of our measures approved based on the fact that there are many measures in the NQF database that are similar, like an example is DVT, except it's for a specific population of perinatal and so we would have to go through a different population. In talking to them, we could probably use much of the data that they have in terms of the DVT and just justify it for our population. In other areas we haven't, because as Dr. Callister stated with weaning, there is no consensus on a definition of weaning. What evidence-- what is the best weaning (inaudible) weaning rate? Everybody has a definition of when the patient is weaned differently. So some of these things we have to build some consensus and do some research probably before we could go, but some of the things in here are already in the database, they're just for a different population within NQF. But we haven't gone through the process yet of trying to get them approved but could.

Barbara Cebuhar: Great. Thank you. Carolyn, we have about 10 minutes, so I think I'm going to wrap up with the-- do you have concerns or considerations that you would like to share with CMS regarding the development of a quality reporting program for these settings?

Do you have concerns or considerations that you would like to share with CMS? I know you've been sharing a lot of them, so if you could repeat them, that would be helpful. Suzanne Snyder?

Suzanne Snyder: Key to first and foremost to my mind is that I know in the inpatient rehab community when quality measures come out, it might be, you know, paper reporting, but in the back of our minds, it's paper performance. And so anything

that comes out, facilities are going to strive, they're going to use their well-honed process improvement strategies, and they're going to try to improve and reduce adverse events and improve their outcomes. And I don't think maliciously anyone is going to try to game the system, but I think that it could potentially happen because well-intentioned people get very focused on black and white and might lose a little bit of the big picture. And there is a chance, a significant chance, that what comes out could have impact on access to care. And key, and very important to myself, and I know to the American Medical Rehab Providers Association, and I would think all inpatient rehab providers, is that those really-- the patients who are very debilitated, very sick and high risk for us to take because their chance for having adverse event, we don't want to prevent access to care to those really needy people who need inpatient rehab.

Barbara Cebuhar: Thank you. Marsha Nelson, Dr. Callister, Jeff Lycan, then Jim Prister. And, I'm sorry, Carolyn.

Marsha Nelson: Marsha Nelson, American Hospice Foundation. Just one very quick point that I haven't heard made that's a little bit outside everything we've talked about, and that's jumping ahead to public reporting. One thing we have in our focus group research, Hospice is a very misunderstood level of care. There are widespread misconceptions. There's lack of understanding. Some people think they know a little, and it gets distorted. In order for any quality reporting program to have meaningful impact and to enable consumers to meaningfully choose among Hospices and ultimately perhaps among different choices of care for end of life, there does need to be an educational component associated with what's put out. With that in mind, we developed one that's part of our report card format, and did some cognitive testing on it, and actually we had to go through three rounds of revisions before people sort of got it because of the basic misconception that Hospice is a place where you go to die. So I just wanted to make a pitch for whatever program CMS goes forth with, whichever measures are ultimately chosen, that there be some educational context provided to consumers so they can make use of that.

Barbara Cebuhar: Thank you. Dr. Callister?

Dr. Brian Callister: Well, when I first think about concerns, I think about all the struggles we're under as a society with limited resources. And I'll tell you that, as a basic premise, the most cost effective thing you could do is let all our patients die. Now, if we agree that that's probably not a good thing from a social justice, let alone your own family and your mother would probably not like that too well, we need to step back a little bit and make sure that we really do come back to the social justice side of things. And say, as we look at a quality reporting system, does this really address access to specialized care? Where we not only look at a potential improvement, but we need to look at the word benefit, not from the perspective you're used to using it, but the word benefit from the perspective of, is there a quality of life issue, a satisfaction issue, some other issue that has a measurable sign of improvement, we can get our arms around, or a measurable sign of-- and again I'll use the term benefit, I know it's out of context for some people in this room-- whether it be at the Hospice level or a functional improvement level with rehab level or, in our case, the LTCH level. And that's sometimes very, very difficult, due to the complexity, to get our arms around. But I can tell you, it's worth the effort so we don't get back to premise one.

Barbara Cebuhar: Great. Thank you. Jeff Lycan, Jim Prister, Carolyn Zollar, Marco, and Dr. Gans.

Jeff Lycan: Jeff Lycan, Ohio Hospice and Palliative Care Organization. You know, the one thing, even with your last question I kept coming-- I keep thinking about is just how important patient-centered care is. And I think, a lot of times, as we try to

look at or measure that, those fall more-- some of those things fall more in the behavioral side of science, and they might not meet the traditional medical evidence-based practice type of guideline, and that we don't lose that. And I think even as we talk about social justice and the benefit of that and quality of life-- those things sometimes are hard to measure. And that we just-- as we go down this road, that we don't forget those things because they're so hard to measure, and just pick up the things that we can measure that, while they have a medical impact, they may not have an overall quality of life piece. And I think we all build with those quality of life issues in our arenas because of the impact to the change in the patient environment. And I guess that would be my biggest concern.

Barbara Cebuhar: Great. Thank you. Jim Prister?

Jim Prister: Jim Prister with RML in Chicago. I think what you will hear and have seen today is that there really is an eagerness to be involved in the process to address all three different arenas. I think that's a great first step that we're taking. I would suggest though that it shouldn't be driven by the payment issue or concern that's out there, that the 2% drop in payment at some point in the future shouldn't be driving this. It should be driven because of the benefits that we would be able to achieve for our patients, whether they're Medicare patients or other (inaudible) that are out there in our setting. I would suggest that there is a strong perspective that's given that there should be consistency across all the payers. Not just on the definitions of the measures that are out there, but if we're going to do something for Medicare, let's make sure that it's the same thing that we do for Medicaid. If we can do the same thing for all of the different payers that are out there, it would become a much better benefit for us on this end of the equation.

Let's also make sure that we're not just reporting for the sake of reporting. Again, just to re-emphasize what a number of other people have said. I think there's one perspective that hasn't been clearly identified, is that many of the organizations that would be involved in this post acute are small organizations. The burden on those organizations to measure, quantify, report, submit data, follow up, could be astronomical. And if we burden an organization under a score of measures that have to be submitted, it could really be a very difficult burden financially and operationally to many of those organizations.

I would also suggest that at some point we have to bring the physicians to this. Physician practice in these settings is varied. Not only are there variances in what we do, but if we can bring physicians in along with us, not as a separate, but if we can bring them in along with us, it would be very beneficial I think to the entire process. And then lastly is just the patient satisfaction piece, because there really does have to be a patient satisfaction component of this. And that might be an easier one that, you know, we could all say is in terms of a recreation or some sort of other-- and we don't have that. You know, the short-term hospitals have the HCUP requirements, but we don't have that. That would be a standardization that I think could be done fairly quickly across all three different settings. I think the phrasing and the terminology may be different, but whether it's the patient's family's perspective in the Hospice to the events that that patient perceived in an inpatient rehab or (inaudible).

Barbara Cebuhar: Thank you very much. Carolyn and then Dr. Gans.

Carolyn Zollar: I want to go back to (inaudible) earlier that might (inaudible) be a consideration in developing (inaudible). I am echoing what Suzanne said again by key underlying factors of avoiding and (inaudible) adverse behavior (inaudible) access. (inaudible) keep the focus on patient care, again it makes sense (inaudible) both get them involved in the collection of information, but it also gets them going back

outside and (inaudible) development of patient education or consumer education about what the measures are, how they're supposed to make sense and how they're being used. (inaudible)

Barbara Cebuhar: Dr. Gans and then Marco Villagrana.

Dr. Bruce Gans: I'd like to just focus on a couple of different things that we haven't talked about, and that's an ongoing process for continuing to do this quality reporting. And I'd like to suggest a couple of things. First of all, I think it's great that you're having this (inaudible) opportunity, and I think this is an example of how you can gain information from various stakeholders by convening such conferences. My personal recommendation is that you plan to continue this kind of a mechanism as this program evolves and matures, and whether you can memorialize them in some formal way by a standing technical panel, whatever you can do to periodically reconvene meaningful input and review to help structure and guide the program.

One voice isn't around this table and that's truly the voice of the consumer, and I'd like to suggest that somehow there be (inaudible) additional considerations (inaudible). Because there's a huge difference in the view of the consumer from, like your advocacy perspective, and the view of the consumer who represents the disability community. So it's not all the same. Just as we're not the same as providers, consumers are not all the same, and more varied input would be helpful.

The last thing I would suggest is that we keep talking about evidence-based medicine as the new standard. I'd like to recommend that we somehow have a standard of evidence-based selection of elements to be measured. That whatever quality measures are chosen, you hold yourself to. Because it has to meet a threshold of meaningfulness or reasonableness, whether it's consensus, whether it's because there's evidence that justifies it in some other way. But I do think at times it's the whole (inaudible) of evidence-based policy making in that they regulation as well as evidence-based practice, and we can all learn from those things (inaudible).

Barbara Cebuhar: Thank you. Marco?

Marco Villagrana: That was the perfect segue. I really just want to reiterate that, you know, again, that we should strive to the extent possible to give any measures that have the strongest evidence of a relationship to desired outcomes that we're looking for. Again, balancing meaningfulness and burden and reasonableness and all that. And we look forward to continuing the discussion. I also like that idea.

One thing that I'd like to touch on that was mentioned earlier is the idea of measures depending on the different settings. I think the populations are so different, one thing we're finding from our experience on the acute-care side is that the measures on the acute-care hospital side aren't necessarily the best measures to use for LTCHs and the rehabilitation hospitals. And so I think one of the things that we're looking at over the next year is to develop not only individual accreditation standards that are specific to long-term care hospitals and rehabilitation facilities but also to develop measures as well. I would urge that you take into account the population served, their needs and the setting when you're developing measures. And maybe at the onset you can't develop a common set of measures.

Barbara Cebuhar: And Carolyn gets the last word.

Carolyn Zollar: No, no. I'm sorry. I didn't put it down.

Barbara Cebuhar: Alright. Okay. I just want to make sure that folks know how much we really appreciate everyone taking the time and the effort-- and making the effort to come here today. This has been very instructional to all of us here at CMS. I know that-- I'm sorry. Dr. Clohan?

Dr. Dexanne Clohan: This is just going to be a process question. I know you've mentioned there will be a broader listening group in December. If we should think of something specific that we wish we brought up today, are you interested in, like if we've developed a greater (inaudible) measures that we use internally, would you like-- ?

Barbara Cebuhar: We would love to see them. Anything that you all didn't get a chance to talk about, I was going to make sure that you knew the-- I'm sorry-- the e-mail address just in case you didn't take it down. It's LIHQRP@rti.org. Send anything there that you think would be instructional to us and useful for the considerations. So we-- Once again, many thanks to all of you for making the effort to be here today. This has been most helpful, and we do appreciate your time. Thank you.