The Steering Committee met at the Marriott Wardman Park Hotel, 2660 Woodley Park Road, N.W., Washington, D.C., at 8:00 a.m., Kurt Stange, Chair, presiding.

PRESENT:
KURT STANGE, MD, PhD, Chair
RON BIALEK, MPP, Public Health Foundation
LINDA KINSINGER, MD, MPH, National Center for Health Promotion and Disease Prevention
FRANK LEONE, MD, MS, Penn Lung Center, University of Pennsylvania
SARAH LINDE-FEUCHT, MD, Health Resources and Services Administration
KEITH MASON, MS, National Forum for Heart Disease and Stroke Prevention
JACQUELINE MERRILL, RN, MPH, DNSc
MADELINE NAEGLE, PhD, FAAN, APRN, BC, New York University College of Nursing
SUE PICKENS, MEd, Parkland Health and Hospital Systems
MARY PITTMAN, Dr.P.H., Public Health Institute
AMIR QASEEM, MD, PhD, MHA, FACP, American College of Physicians
SARAH SAMPSEL, MPH, WellPoint
JASON SPANGLER, MD, MPH, Partnership for Prevention
MATT STIEFEL, MPA, Kaiser Permanente
PRESENT(Cont'd):
MICHAEL STOTO, PhD, Georgetown University
ANDREW WEBBER, National Business Coalition on Health

NQF STAFF:

KAREN ADAMS, PhD
HEIDI BOSSLEY, MSN, MBA
HELEN BURSTIN, MD, MPH
KRISTIN CHANDLER, MPH
ANN HAMMERSMITH, JD
NICOLE McELVEEN, MPH
ELISA MUNTHALI, MPH
ROBYN Y. NISHIMI, PhD
KAREN PACE, PhD, RN
REVA WINKLER, MD, MPH

ALSO PRESENT:
MARK ANTMAN, PCPI
MARY BARTON, NCQA
KEVIN BOWMAN, Resolution Health/WellPoint
SEPHEEN BYRON, NCQA
LINDEE CHIN, Active Health Management
KEZIAH COOK, Acumen

DAVID HITTLE, University of Colorado
SARAH LACKNER, Active Health Management
ALLEN LEAVENS, Resolution Health/WellPoint
LISA McGONIGAL, Kidney Care Partners
BANI VIR, Active Health Management
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DR. STANGE: Thank you, everybody who is here. Thank you for people that are on line. Thank you, particularly, to the measures developers who got bumped from yesterday, and we kind of messed up your day today, I am sure.

I am Kurt Stange. I am co-chairing this with Paul Jarris, who is not here, and we have had diminished numbers here, although one new member joining us, but we are going to go forward.

What I would like to do today is try to reflect on our process so far, and help us with planning with the next steps. So if you can indulge me for about five minutes, I would like to go over some stuff, and then open it up for us to discuss our charge a little bit and what the next steps might be, and then we will on to the more instrumental work of doing the updates on the measures.
So I got awakened at 5:00 a.m. by an ambulance this morning. I don't know if anybody else did, and there is something special about those early morning hours. You are between the time when your subconscious has been churning on stuff that we did, like a full day like we had yesterday, and when you are really fully with it.

In that moment, I just reflected back on what we did yesterday, and I was really impressed with how jazzed everybody was, how we came here with a sense of great opportunity in defining and measuring population health, that frankly, this is part of a larger movement. We sense this is an important position in time.

The NQF is uniquely placed to do something important here. I think we all had a shared sense of that. The NQF's unique position, I think we heard, is that what gets measured gets paid attention to with sustained effort, and that the NQF's position as a
framer and a convener could really advance
this larger opportunity and, conversely, that
doing this work, which is new for the NQF,
could actually help to advance the NQF's
relevance in an environment that is changing,
that is moving from individual to community
and populations.

So there really is something
larger going on here. Together yesterday, we
have been really learning about the NQF
process and working together to understand our
charge and to discover this opportunity of
working with the NQF.

As you heard yesterday, Paul and I
are very new, newly appointed as Chairs. As
you saw yesterday, we are working with you to
make sense of an agenda that really had two
very different goals. So what you saw going
on in real time was what we were experiencing
real time, too, which is figuring this out.

I think some of the reason it was
challenging is that we are trying to do very
different things. One, we are trying to frame
a potentially transformative new effort, a new
direction for the NQF that is based on this
Department of Health and Human Services task
order to develop measures of population
health. The NQF really is looking to us to
help develop that and to help frame that.

We are also doing some of the
regular work of the NQF in updating these
measures in their endorsement and maintenance
process. That is what we started to do, a
couple of measures up today. That is
instrumental work that we have to do later on
today, hopefully, in a streamlined way.

So before we get back to that
instrumental work, I would like to just take
a few minutes to first see if we have
consensus on what the transformative
opportunity is, then to make sure that we have
this larger opportunity matched to the unique
position of the NQF and what the Steering
Committee might do, and to develop a plan for
going forward.

So just to summarize -- and I want to have some discussion of this -- what I heard us saying, the opportunity yesterday is to define a frame for developing and using population measures, and then to help the NQF in actually making the call for measures and figuring out what that looks like and, instrumentally, how do you actually measure population health.

I heard three resources that have available to support this. One is the NQF staff. One is the LA Department of Health with Don and Steve, who have been commissioned to do a paper, to do the environmental scan that will help us articulate principles and a framework.

So they are going to help us not reinvent the wheel by looking at what is out there, giving us a framework for thinking about that. Then we have the committee's expertise, wisdom, and volunteers, frankly.
So when we talk in a minute about what we are going to do going forward, we have to think realistically about what we are going to be able to commit to this with that support and how we might get that done.

I thought we did a good start at that yesterday with the three groups that emerged from the discussion. We had the group that Matt led on population health, a framework for measuring population health; the work that Ron did, thinking about what is the scope of that work; and then the group that Sarah led, which is kind of a how-to on evaluating and measuring population health.

So if we combine those three -- combine the framework and scope groups, those actually match pretty well into those actionable opportunities of defining the frame.

So if you put the group that Matt and the group that Ron led yesterday, that is really about defining the frame for developing
and using population measures, and then the
group that Sarah led is really about helping
NQF to make the call for measures, figuring
out what an actual call for measures looks
like and what the how-to of measurement looks
like.

So what I would like us to do is
reflect on both what we see as the actionable
opportunity and then develop a plan for
working forward. That working forward might
involve taking those -- maybe consolidating
those three groups into two. So we have got
that framework group and then the how-to
group. That would be one way to proceed.

So that is a lot of me talking,
but I think we need to revisit the big picture
today, but we have a lot of instrumental work
to do. So I wanted to give us some frame for
discussing that before we dive into the
instrumental work.

So first I would like us just to
see if we have some consensus on what our
actionable opportunity is. Here is my frame
for that. I would like to just open it up.
Does that reflect what you heard and what you
feel or are there other things we should be
thinking about? Ron, Matt?

MR. STIEFEL: I think it looks
good. One piece, I think, that is important
to fit in there somewhere is maybe the piece
that was from the other group of scope, is
what is a population? Actually, there are two
big questions: What is a population, and what
is health?

The "what is a population" one is
pretty significant, and maybe we can come to
a quick consensus about that, but I think it
is pretty fundamental.

DR. STANGE: So what is a
population, and what is health? Then the word
community came up. So I think within
population we will want to think of what is a
community, and how those relate to each other.
So that is going to be a really important part
of the work of that group then. Other thoughts? Helen?

DR. BURSTIN: One additional thought, Kurt -- I think this looks great -- is also just to not forget interweaving in the work that LA is going to be doing. We want to make sure that doesn't feel like it is kind of floating off there. They could, in fact, try to define some of this work and bring it back to the group as one option.

DR. STANGE: Where would you see that fitting in, Helen?

DR. BURSTIN: I think the framework scope model group feels like the right group to maybe also be the interface with LA. Does that sound okay with folks?

DR. STANGE: And these tasks really have to go in parallel. So these can't be groups that go away and work in isolation, and come back. They have got to -- There has got to be some iteration and work together.

Anything else on the charge
opportunity we see here?

DR. KINSINGER: I am just curious -- for Helen -- whether you have done any preliminary looking around at what kinds of measures might be out there, and what does the field look like now, before we have really tried to fine tune it? I was just curious. What is your gestalt about that?

DR. BURSTIN: Yes. Actually, Reva and Kristin and some of others did some really nice work on an environmental scan, and there are actually some very interesting measures, most of which, not surprisingly, come from things like State of the USA, BRFSS, the usual suspects.

I think one of the questions we need to kind of decide first is what are we talking about? We will be happy to share that list. It is part of what -- The LA group is also going to do a broader environmental scan, but it might just be a nice sort of thought piece to get us going, if you would like to
see that work. I thought they did a really nice job.

DR. STANGE: So we are iterating here between getting the big picture and then we need to not reinvent the wheel. So that would be really helpful. Madeline?

DR. NAEGLE: Yes, good morning. I was thinking about some of the comments yesterday about looking beyond our own scope, and I think a good bit of work has been done with WHO and with Canada that combines some of these behavioral health and general health approaches.

It would be good to take a look at that. Not all of it is so helpful, but certainly, we are all talking about the social determinants work, and that has already proved very helpful, and there are some materials that, I think, might enlighten us a little bit by just getting out of the box and thinking maybe how their approaches might articulate with our system or not.
DR. STANGE: I think we are transitioning in our conversation into the how-to, and that is a really important point that we want to start with, what is out there. We want to -- We started yesterday with the NQF existing measures and thinking about how those might relate to population, and that is one task that will keep going forward.

The other thing we are doing is starting with what is the larger picture and then coming back to the NQF's role. So what Madeline is talking about is having a broad enough scope for that, that we look internationally as well as nationally, where other countries have, frankly, been thinking with a population perspective for a lot longer than we have.

MR. STIEFEL: And would that fall into Sarah's category of looking at how we articulate and define the measures? I think that is a really -- I mean, the European Union has done some great work on population health
measurement as well.

DR. BURSTIN: Is that okay, Sarah?

DR. STANGE: And then one thing we have to do is make sure there is communication with the NQF staff and with the people that are charged -- LA Department of Health are charged with doing this work, so that we can -- so the volunteers here aren't spending all their time doing the searches and the framing and finding what is out there, but can take advantage of that other work.

DR. STIEFEL: That is just a question I have, because obviously, that -- we are kind of doing the same thing as LA. So how does that relationship work?

DR. WINKLER: Well, I think what we are envisioning going forward is the work groups that you all have sort of being sort of the thinkers, bringing the ideas. We can schedule conference calls with your group, staff and the folks from LA. You guys can pose the ideas. We can do the work.
DR. BURSTIN: And some of the LA work is actually quite distinctive. They will do the broad environmental scan, for example, of population health measures, nothing that these work groups are doing.

I think what we clearly need to figure out is some of the definitional work, I think, is very overlapping, and some of the model work is very overlapping, which is why I think those two aspects we should -- and I suspect they would welcome having a group to sort of ping ideas off of.

DR. STANGE: So we don't have the full group here. We don't have our co-chair here. So we don't have to get this all locked in for what we are going to do for the next year, but we do need to think about some next steps.

So one thing is that we are going to give feedback on the draft paper. We have already given feedback on the draft paper and on the draft outline that Helen shared with us
yesterday about the how to measure this stuff based on what the NQF is already doing.

If people have other things they want to contribute, they can certainly email that to Elisa. We will get other drafts of that, and we will have a chance to do feedback on that, but the other question is next steps.

Is the next step to have a conference call among these two groups, and we will have to then have an electronic process for people to figure out which group they want to be in initially, because there are people that aren't here. Is that a reasonable next step? Okay.

Other next steps that we should capture while we are all here together?

MS. SAMPSEL: I just wanted to make sure on the how-to group that we will get everybody's feedback from the criteria that you shared, Helen, so everybody understands that is part of the assignment, is to give the criteria feedback, so we can filter that into
our work.

DR. STANGE: Right. These groups really -- their charges dictate so much. We can't have an isolated process. I think you are exactly right. So anything that is shared with one group should probably be at least cc'ed to the others, because that is going to be -- If we are working from different background materials, we are going to have a hard time getting the common language.

Other next steps? Personally, that helps me to relax, because that seems like it is the transformative opportunity that got us all jazzed yesterday. I was very impressed with how people immediately switched gears and dove into the measures update process. I was shocked at how people did that.

If we keep going at that same rate -- Obviously, we have got three days of work, but what Reva told me in a holding my head in my hand way on the one phone call we had
preparing for this beforehand, was don't worry, the first measure takes a lot of time, and we really worked through the process.

DR. BURSTIN: And hour and a half, every time.

DR. STANGE: Oh, good, because that is probably what Reva said. I heard half-hour.

DR. BURSTIN: No, an hour and a half.

DR. STANGE: Oh, that is good. Okay. Oh, so we are in the norm. So I ask one thing, is that don't have to vote on every aspect of it. We did need to, I think, do that, and I think we needed to vote on every aspect of it so we know what we are doing, because the global yes/no question is based on having met those criteria, and particularly the initial no go importance criteria, but then all the instrumental criteria about how things are measured and all those other factors.
So we do need to think about that,
but we do have the opportunity to just vote
yes/no on each measure.

What I would suggest is that we
begin the framing comments by either the
person from the group who is assigned or the
measure developer. If we have those try to be
as succinct as possible, not so much working
through every criteria, but since we are
updating measures that are already pretty well
established -- all of them, I think -- what is
new? It was helpful yesterday to know that
these were preliminarily approved, the two
measures we discussed yesterday. That seemed
like a helpful frame.

The two people who discussed
yesterday, I thought, did a nice job of just
saying what is new, what is important; but if
we can just have that be the frame -- Tell us
from your careful look at it, what do we
really need to pay attention to, and we can
start the discussion with that, and just make
sure everybody has a chance to bring up
anything about the other criteria -- I think
we will be able to go through this pretty
quickly.

Reva, what do you want to say
about the process?

DR. BURSTIN: We also want to
invite our two new members -- welcome, say hi.

DR. STANGE: Yes.

DR. WINKLER: Amir and Mary.

DR. STANGE: Okay. Amir,
yesterday we introduced ourselves briefly and
did disclosures of any conflict of interest.
So if you want to start, and then, Mary, if
you could do the same thing, that would be
great. And welcome.

DR. QASEEM: Good morning,
everyone. Amir Qaseem. I am Director of
Clinical Policy at the American College of
Physicians. Sorry I couldn't be here
yesterday. I had to run another meeting.

In case of disclosures, I don't
have any financial conflicts of interest.

Non-financial, I am on various boards. I
don't know. Do you want me to disclose those?

Off the top of my head, I am on some CDC
committees, on IOM Guideline International
Network, but they are all non-financial
conflicts of interest.

DR. PITTMAN: Good morning,
everyone. Mary Pittman, President of the
Public Health Institute in California. I am
sorry I couldn't be with you yesterday. I
had my board meeting.

I have no financial conflicts of
interest and, same as Amir, serve on a number
of boards in areas where they do look at
indicators.

DR. STANGE: Reva, do you want to
pick us up with the next thing?

DR. WINKLER: All right. Just to
recap yesterday, we started on a group of
influenza immunization measures. We did do
two of them. Based on the availability of our
measure developers, we are going to start with measure 226, influenza immunization in the ESRD population.

This is from the Kidney Care Quality Alliance, and this is the percentage of end stage renal disease patients age six months or older receiving hemodialysis or peritoneal dialysis during the time frame from October 1 or when the influenza vaccine became available to March 31st who either received, were offered and declined, or were determined to have medical contraindications to the influenza vaccine.

So Lisa McGonigal, I think, is on the line from the developer. Any intro comments, Lisa?

DR. McGONIGAL: Yes, I will just take a couple of seconds. Can you hear me okay?

DR. WINKLER: You are a little soft. If you can bring it up.

DR. McGONIGAL: Is that better?
DR. WINKLER: Better.

DR. McGONIGAL: Great. Good morning, I am Lisa McGonigal from Kidney Care Quality Alliance, which is an alliance of patient advocates, health care professionals, care providers, and purchasers, all convened by Kidney Care Partners to develop performance measures for end stage renal disease care.

We are pleased to have submitted information for our influenza immunization of the ESRD population, which is a facility level measure. Again, I would like to provide a little background information on the measure.

The KCQA measure has been field tested at 53 dialysis facilities across the United States on a total of 1,115 ESRD patients, and has been demonstrated as reliable, valid, and feasible, and we have included detailed testing results in the measure submission form that you received from NQF.

The measure was endorsed by NQF in
2008, and it is included among the Centers for Medicare and Medicaid Service Phase 3 clinical performance measures which are slated for use by CMS in its Crown Web Dialysis Facility Data Repository when it becomes functional.

The underlying rationale for the measure is to ensure that all ESRD patients aged six months and older who do not have an underlying medical contraindication receive an annual influenza vaccination, as is consistent with the current clinical guidelines released by the CDC's Advisory Committee on Immunization Practices and the American Academy of Pediatrics, and the major is also consistent with the Healthy People 2020 goal to immunize 90 percent or greater of high risk individuals against the flu.

Unfortunately, however, evidence indicates that the U.S. continues to fall far short of these longstanding and well established recommendations and goals. According to the most recent data from the
United States Renal Data System, less than 63 percent of all ESRD patients received a flu vaccine in 2008.

We would like additionally point out that the measure is completely harmonized with the NQF's Influenza Immunization Standard Measure specifications that I heard you discussing a bit yesterday.

Finally, we assert that a separate measure addressing influenza immunization status specifically in the ESRD patient population is imperative, given the need for the specifications to explicitly stress that only inactivated virus should be used in this population, and also to reflect the fact that ESRD patients receive routine medical care in a unique manner and setting -- that is, within the dialysis facility.

The specifications from the other flu measures being considered here today won't and don't translate to this population, because they are either intended for specific
populations, such as health care workers or home health patients, or they are the wrong level of analysis, the physician level, to allow for an accurate and effective assessment of the care provided to ESRD patients.

KCQA would like to thank the Population Health and Prevention Steering Committee and NQF for your consideration of this measure, and we welcome any questions either now or after your deliberations.

DR. WINKLER: Thank you, Lisa. I just want to point out to the committee that the four members of the Work Group have done preliminary evaluations of this measure. They are upon the screen. I think it is close enough we can see them.

Amir, you were the primary reviewer for this one, and what comments do you have?

DR. STANGE: And, Amir, just imagine that you were here yesterday, and we did discuss the generic things that relate to
influenza immunization, both about the
importance of it and about some of the
challenges of measuring the evidence. So just
imagine that we have already done that. Is
there anything additionally unique about this?

DR. QASEEM: I am sure you
probably already discussed most of the issues
here. So a brief overview: These are pretty
established measures. We already know what
needs to be done, what doesn't need to be
done.

One thing I do want to voice, and
I am sure you already discussed this, is --
and that relates to the harmonization of
measures, and I am sure you had extensive
conversation, but I don't think we can all say
enough about it.

What I am struggling with is what
is this measure adding to the value? I think
the KCQA rep just mentioned the imperative
need to have an influenza vaccination measure
for ESRD population, but I am not really aware
of any evidence that shows that to have a population specific measure for this population is going to lead to increasing vaccination rates in any way or it is going to change physicians' behavior in terms of when it comes to flu vaccination.

So essentially, with influenza ones, what I am struggling is why can't we just have a measure -- and I know there is some good measures out there. For example, PCPI has a really good measure that you give vaccination to everyone who is over six years of age after March 31st.

If you have a measure something of similar nature, that will cover the ESRD population. That is sort of a feel for what I had, was that what exactly is this measure adding, and I know I am not really sure if it is beyond the scope of this committee or not or if we are supposed to even talk about that or not.

Then in the meantime, if we can
move toward the direction of harmonization, at least have the numerator and dominator statement start feeling a little similar. You can have it specifically for ESRD population, but at least they should start reading what the other statements are talking about.

Again, all of you are involved in performance measurement. It feels like -- You remember what the guidelines used to be, and we have a little bit reined them in, in terms of -- Of course, there is no harmonization still there, but I am just not seeing what is this measure adding.

DR. STANGE: That is a real important measure. We discussed it yesterday, but I don't think resolved it enough. Can we park that until we have done all these immunization measures or at least the influenza ones, and address that question, is there something more that could be done; and then the other thing we will do at the end is we will reflect on these. We will say, is
There anything that informs our larger
discussion.

So, Jackie, then Matt.

MS. MERRILL: I think that this is
the only special population that still remains
out of this general thing. So all the other
high risk populations have been folded into
the general. So the argument would really be
why is this the only one that is excluded.

DR. STANGE: So we should discuss
it now then.

DR. WINKLER: Just one comment to
Amir, something we discussed yesterday was
harmonization and NQF's previous efforts
around harmonization. If you can believe,
three years ago we had 16 measures for
influenza, and the way that harmonization was
approached was to create a sort of a standard
set of specifications that reflected the
guidelines.

Those specifications are generally
to have numerator categories of vaccinated,
declined, and contraindications computed and reported separately in the numerator and in the denominator as broad a population as possible.

So the exclusions were not taken out of the denominator, and this measure actually does conform to that. Three years ago, that was really established at NQF with everyone being aware and advised and notified that this was the direction we were moving.

So this is how we are trying to pull everybody in alignment. So I just wanted you to be aware, because we did talk about that a bit yesterday.

DR. QASEEM: And I think that is very helpful, but is it a fair question to ask that what value is this measure adding?

MS. MERRILL: I actually agree with that. It is a very small population. It is in the thousands of people. So, really, I mean, what does it hurt to have a special measure by this special group? I don't know
if there is any downside to it, but it just
seems completely unnecessary.

If it is this particular group
trying to keep tabs on its membership and --
I don't really know what NQF's position is on
things like that.

DR. STANGE: So that is a question
for Reva and Helen. How do we take this
concern forward?

DR. WINKLER: A couple of things.
I think there are a couple of things to
consider. When you look at other measures,
the question is who could pick up this
population as an alternative, and this is a
facility level measure. As opposed to some of
the others, the level of analysis may not
apply.

So it can get into the devil is in
the details. I think, keeping that as an
overlying question is definitely something for
the group to consider. You may need us to do
a little bit more looking into the details for
you before you can make a final consideration.

DR. QASEEM: And I think that will be very helpful, because to get the data on this specific population, I think you can extract that from -- even at the facility level, if you are just looking at the ESRD population. You can extract the data and get that information. Am I wrong? I just don't see. Why can't you get that information from -- even if you have the population broader statement, you can still extract the information. I get information about my diabetic patients or any of the population.

DR. WINKLER: Can we at least just -- From the criteria we have for the measure as it is, putting that question aside, do you feel that the measure meets the criteria for importance? Is there an opportunity for improvement in this population, and is the evidence solid?

DR. QASEEM: Sure. I think, definitely, and I think it is -- That is the
one question I struggle. I agree with Jacqueline about that in terms of impact. I think it is a small population, but if you just look at that specific population, the impact will be there, but in the broad scheme of things, you are talking about a very small population over there.

In looking at the opportunity for improvement, what the measure developer actually presented, if I understood the numbers correctly, it seemed like there was already reasonably good rate that was there, to begin with, and maybe I didn't really interpret the numbers correctly.

In terms of evidence, again as I was talking to Kurt this morning, influenza is a well established measure. I mean, I am not going to contest anything when it comes through. That reliability was good over there. Validity, I wasn't really too convinced, and I gave it, I believe, a moderate, the next to high. I think it was
moderate, but generally -- Am I supposed to go
over like this, or not?

DR. STANGE: So just as a model

for how we might get through these, it sounds

like we have -- Does anyone have any

disagreement about importance, and it sounds

like we have strong -- good evidence, enough,
certainly, to approve, with the concern about

maybe combining down the road. Any

disagreement with that? Madeline?

DR. NAEGLE: I don't have a
disagreement with that. I heard something

that you mentioned I want to just follow up

on, and that was that you felt that physician

behavior might not change.

I think that fits under usability

and feasibility, but it also raises the

question about why do this, if it is going to

impact a small number of people, and it might

not be implemented anyway.

DR. McGONIGAL: May I speak to

that? We know that-- There is a strong
indication that the measure will be widely implemented. As far as why it is separating off the ESRD population, it is to do with the fact that they receive their service in facilities. So we would like to look at a facility level measure, and that is how the measure is being used by CROWNWeb and CMS as well.

DR. QASEEM: The final question I was going to ask Rita and Helen is: Of course, looking at all these different, separate criteria, you can give it high, moderate, and it seems to be a good, well developed measure. But then the struggle comes in, and I don't know how we are supposed to talk about it when it comes to final endorsement for the issues I that raised

What the criteria was does not address the things that I am talking about.

DR. WINKLER: typically, what we want to do is look at the criteria for the measure independently, and if it meets all the
criteria and then, looking at the group of measures, ask the question you are asking.

So we kind of need to do this first, to be sure that -- because, for instance, if it failed one of the criteria, it would be off the table, and there is no need for any further discussion. So we need to establish, and everybody is comfortable, that it meets the criteria.

Then the subsequent question is, is it a necessary addition or not. It is a perfectly appropriate discussion to have, but we do want to establish that it meets all the criteria up front.

DR. STANGE: Is anyone not ready to vote on whether it meets the criteria?

MR. STIEFEL: It is hard to separate out the two issues. If there is a family of measures with exactly the same numerator and just different specifications, different cuts for the denominator, on what basis would we vote differently about all of
these criteria? The other thing is why wouldn't there be 1,000 of these? I mean you could do it for every imaginable subset of the population. You could say influenza immunization is important.

DR. BURSTIN: Simply to respond to it -- and I think you are right. What we have seen already is, for example, many of the physician level measures have been consolidated. There was one for COPD. There was one for many, many different conditions. That has now gone away, to the credit of the developers.

I think the only difference in some ways about the ESRD measure is actually the data source, that it is built into CROWNWeb. It is done at dialysis facilities. So that, I think, is more of a harmonization, and they harmonize to standard specifications. So the question is, is it really a competing measure or is it harmonized, and that is acceptable? I think that is one of
the questions that is still not completely clear.

DR. STANGE: But it sounds like the mechanism we have for going forward with this would be to approve the measure if we feel it meets the criteria, and then ask you to do additional work on looking at both the logistics and the politics of getting it combined or harmonized.

DR. WINKLER: Kristin, can you go forward to the voting slide that asks about the summary: Does it meet the criteria for endorsement? There it is.

So as you can see, the question is: Does it meet the criteria for endorsement. That is sort of the first step, and then we can continue having this other conversation about, in the big picture, how does it relate to all the other measures?

So this is our first one. Amir, there should be a little vote -- You got it. Okay. Thank you. All right. You have to
point it at Kristin's computer over here, but
if everybody is ready to vote, go ahead.

Does it meet the criteria for endorsement? It is not -- Okay, do you want
to take a hand vote, which is the old way?

DR. STANGE: Shall we try it again, Kristin?

DR. WINKLER: Want to try it again, Kristin.

DR. STANGE: Let's give Kristin a minute to look at that. Should we do a hand vote. All those in favor that it meets the criteria, raise your hand. Okay. Anyone opposed? Jackie, were you opposing?

MS. MERRILL: Yes, I am opposing.

DR. STANGE: So Reva and Helen, help us with what is the next step to get this --

DR. McGONIGAL: I'm sorry. May I ask what the outcome of the vote was?

DR. WINKLER: Oh, okay. Yes, 11; No, one.
DR. McGONIGAL: I'm sorry, again?

DR. WINKLER: Yes, 11; No, one.

So the next measure we want to look at --

MR. MASON: I think, to Amir's point, and to Matt's point, how many resources does it take to continually go back and ask people for more information or get more information or put it somewhere else? If you had, to Matt's point, 1,000 of these, and that is an hour each, that is a thousand person-hours work. So if we continue to approve very small subsets of measures, you are going to have thousands of hours of work to do, in general, setting a precedent.

DR. BURSTIN: And to be clear, since three years ago, as Reva pointed out, we have worked with the developers and eliminated almost all of the condition specific ones. Again, this is somewhat unique because of the facility level measurement and building it into CROWNWeb is the database that dialysis
facilities use.

So I think it is more of a data source issue, I think, than necessarily a data slide, but I think it is certainly something we can come back to when you finish the other immunization measures, to see if we think there is still a competing measure issue.

DR. STANGE: So I think the committee is -- At least I am not clear on how we act on this concern. So there is this concern.

DR. BURSTIN: The way you act on it is we will finish the review of all the related measures, and at the end, our fifth criteria is you then take the measures that you think met the criteria for endorsement, and we then do a competing or a best in class assessment, and it is at that point -- We just don't want you go through an exercise with measures until they have passed.

Once they have passed, we will have you do that assessment, and at that point
we can have a discussion of whether or not you think this measure is really best in class, does it add value, or is time to somehow bring it into the other measures.

DR. STANGE: And that will be at the end of the immunizations. So we are still doing yesterday's work. So let's try to get through yesterday's work here, so we can get to today's agenda.

DR. WINKLER: The next measure we will look at is 1659, which is the from CMS. It is inpatient hospital based measure: Inpatients aged six months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge, if indicated.

In this measure, I don't believe we have a representative from the measure developer. This is a hospital level measure. This measure essentially is a new measure that was created on the recommendations from the
work NQF has done previously.

Previously, CMS had a measure for the patients with pneumonia in the hospital, and the question was why just pneumonia patients; why not everybody? So the recommendation was to expand this to all hospitalized patients, and essentially that is what they did.

So it is new only in that the denominator is much more expanded, but essentially measuring immunization status on all hospitalized patients rather than just the narrow subset.

So who was the -- Jason, I think you were the reviewer for this one. Where did he go? Oh, okay. So perhaps -- I didn't realize he wasn't here. I think perhaps we will then switch to another one.

Do we have the folks from NCQA on the line? Oh, they here? Great. You are in my blind spot. Then great.

Let's look at the measure 39 from
NCQA. We have the measure developers in the room. This is flu shots for adults aged 50 and older. This measure represents the percentage of adults aged 50 and older who received an influenza vaccine within the measurement period within the respected age stratified CAHPS surveys.

This measure is only reported by age group stratification. The terms -- and it uses the terms FSA and FSO. FSA is the rolling average of percentage of members 50 through 64 years of age. FSO is 65 years and older.

So as we do have the measure developers --

DR. SPANGLER: I am back, too.

DR. WINKLER: Okay. Well, we will get back to you. Why don't we go ahead with this measure. Did anybody from NCQA want --

MS. BYRON: Good morning,

everyone. I am Sepheen Byron, the Director of Performance Measurement at NCQA, to give a
little intro about this measure.

This is actually two measures. The FSA and FSO are abbreviations for the measure names. So it is Flu Shot for Adults, and it is Flu Shot for Older Adults, and they are both collected via CAHPS survey. One is the CAHPS for Plan OH, and then the other one is the Medicare CAHPS for the 65 and older groups.

So these measures focus on the age groups that originally were the targets for flu shots, according to a Advisory Committee for Immunization Practices, part of the CDC, the ACIP recommendations, and they are longstanding HEDIS measures, and we actually just presented this yesterday to our committee on Performance Measurement -- sounds like September is a really busy time for people -- and the measures were approved for continuation in HEDIS with no changes.

Happy to answer any specific questions you have about the measures.
DR. WINKLER: Linda?

DR. KINSINGER: Thanks. As was said, this is a longstanding measure. It is pretty straightforward. I don't think there are really any issues with it. I think it meets all the criteria.

You know, it gets into the discussion of whether it is overlapping with other measures, but I think -- Does it meet the criteria? I would say, absolutely, yes, it certainly does.

DR. WINKLER: Just to point out that the summary from the Work Group is up there. I guess the one question that makes this measure different is that it is a survey measure.

DR. KINSINGER: It is.

DR. WINKLER: And so I guess that, I think, different from other measures that tend to use medical record sources -- I think that is a discussion point that the committee would want to consider, the pros and cons of
that.

DR. KINSINGER: And maybe I could just say, since the recommendation has changed now to a universal recommendation over age six months, I guess that would be a question as to whether the age range is appropriate any longer. So I would look to you for a question for that.

MS. BYRON: So on the survey measure, the reason it is a survey measure is because we understand that these are health plan level measures, and relying solely on administrative data and codes would not be helpful, because people are getting flu shots from all sorts of places that don't record it. You know, they get it at Costco and CVS and Wal-Mart. So that is why it is a survey measure.

In regard to the age group, we are aware that the recommendation has been expanded. Our typical policy for HEDIS is to give the industry a little bit of time before
we implement changes to vaccines. So

typically, we wait about three years before we

put them into HEDIS to give the industry some
time to adjust to new vaccinations.

This is something that is on our

plate to look at expanding the age ranges.

For now, it is as is, but will be in the queue

for -- It would be considered almost like
development of a new measure, but we are

aware, and we don't think it would be a

problem.

DR. STANGE: Sarah?

MS. SAMPSEL: I promise to behave.

I think it is important to note, though, that

immunization is already captured in HEDIS,

flue immunization for children, and is it in

the adolescent one as well, or not yet?

MS. BYRON: It is. We actually

just added -- We have an immunization for

adolescents measure and, in fact, we just

added an HPV immunization measure that is

brand new for this year in HEDIS.
MS. SAMPSEL: Okay. So I just thought I saw it, because we have been talking about the full age band.

MS. BYRON: It is just captured differently in those different populations for HEDIS is important to note. So we are really just almost talking about 18 to 50 that would be reevaluated.

MS. SAMPSEL: Okay.

DR. STANGE: So it sounds like we have the same concern about maybe combining or harmonizing on this, but given that, any additional concerns about this before we vote?

DR. WINKLER: One thing I brought up. You said that the level of analysis for this could be the clinician or group practice or the individual clinician, and I guess, how do you see this being implemented in an individual physician practice, given that it is a survey measure?

MS. BYRON: Well, I think that we marked any level of measurement that could be
applicable, and it would really rely on them administering a CAHPS survey.

The specifications -- they are available, and I know that there is some work with PCMH to implement different surveys. So we thought it was applicable in that sense.

DR. BURSTIN: So this is part of which CAHPS survey?

MS. BYRON: It is the CAHPS 4.0H and also Medicare CAHPS for the 65 and older.

DR. BURSTIN: And it will also be brought into the Patient Centered Medical Home, you think, as well?

MS. BYRON: We -- I have to say, I don't know a ton about the Patient Centered Medical Home, but I know that there is some work to consider different measures that would be applicable for that.

DR. QASEEM: So your numerator statement is to number of patients in the denominator who responded yes to the question?

MS. BYRON: Yes.
DR. QASEEM: And then your

denominator is the number of members who
responded yes or no to the question?

MS. BYRON: Right. So it is

actually the denominator that you turned the
correct age and that you actually answered the
question. So it is just the way the CAHPS
survey is set up. You answer yes or no, and
then you take the people answered yes as
numerator compliant. I know it is a little
confusing.

DR. WINKLER: So just to clarify,

so people who did not answer the question are-

MS. BYRON: Put in according to
the way the CAHPS --

DR. WINKLER: Do you have any idea
how often that happens?

MS. BYRON: I could get that
information but, no, I don't.

DR. QASEEM: That is definitely --

It is an important point you raise, Reva.
MS. BYRON: I could look into that and see if we can pull that information, but this is -- as we know, it is a longstanding CAHPS measure, and it is the way that the CAHPS survey is set up. It is not an NCQA -- The CAHPS survey is not made by NCQA, but we made the measure for the CAHPS survey.

DR. WINKLER: Any other discussion?

MR. STIEFEL: So when we get to harmonization -- Well, I don't know if it is an issue now or when we get to harmonization, but it is -- That is different from that rule you just described about making sure that we are handling the measures in the same way.

DR. WINKLER: Again, I think the first question is does it meet the individual criteria? Is there an opportunity for improvement, given the data that was presented? Is it consistent with the evidence? Does the measure have sufficient reliability, validity in the way that it is
This one is different, and it is a survey measure. So I think there are different questions you may ask in terms of reliability/validity. Similarly, for usability and feasibility.

So I think, you know, you do want to look at the various criteria in terms of the characteristics and specification of this particular measure initially, and then we will look to the harmonization issue.

MR. STIEFEL: So if this particular measure leaves out that piece of the denominator that we feel is important in the other measures, is that -- are we assessing that as part of the criteria or are we assessing that later?

DR. WINKLER: I think that is -- Since you are talking about the specifications of the particular measure, that is part of scientific acceptability, and I think it is part of the criteria.
DR. STANGE: So Matt and Amir, do you want to -- one step further before we vote. Do you want to talk about that? Linda?

DR. KINSINGER: I think you could make a judgment as to whether that makes it moderate versus high in terms of its validity, which is, I think, where that would come in. I guess I wouldn't see that as bumping it down to a low, but it is a judgment call.

DR. QASEEM: Can you give us just a feel for in terms of how many people you are talking about, because that will affect the -- I mean, that can have a major impact or a small impact. The range is so broad. I don't have a call in terms of the population, if it is really going to do what it is supposed to be doing. Not everyone is being included, and we may need more information, I think. Is it possible to get a feel for it at least?

MS. BYRON: I can look into getting that information maybe by the end of the meeting. I can see if we can get that
information, but I am not sure how quickly we can get it, to be honest.

DR. BURSTIN: I think it would be helpful to actually state the specific concern about the denominator, just so we are all on the same page. I am not sure we are all --

DR. KINSINGER: My understanding is the question has to do with the percent of people who respond to the question. So if there is a large number of people who don't answer the question at all, they drop out of both the numerator and the denominator, and does that skew it in some way.

You would have to assume that people non-randomly drop that question, and maybe that is true, but I don't know.

DR. BURSTIN: I guess that is the question. I mean, it is part of a larger CAHPS survey. I am not sure I have any priors to think that you would answer that question differentially in CAHPS sampling, and assessments have been shown to be valid and
So I guess, for me, it is more of the vehicle of CAHPS, which we know about. I am not sure I can differentially up front think of a reason why you would answer that question differently.

MS. SAMPSEL: So in my history, the way that those CAHPS measures are developed on behalf of NCQA when they insert is, first of all, they go through the validity testing of is this a valid measure to begin with.

That is more of a face validity which, we have already talked about, is important in influenza immunization. But then the actual testing goes through a number of focus groups, and then actual administration for a number of years to ensure that the question isn't answered any differently than any other CAHPS question.

So if we believe in the overall reliability and validity of CAHPS which, I
think, AHRQ does -- Mary, I don't know if you have any insight on CAHPS at all, but there is no reason to believe that this question is any different or that we are losing a lot of people in the denominator.

MS. MERRILL: But do they mention how they deal with the missing observations?

How do you deal with the missing observations in the analysis?

MS. BYRON: And again -- and I am sorry, I am not as well versed on the CAHPS survey, but I would have to get some information on that. But to me, that is a CAHPS vehicle issue versus a measure specific issue.

DR. STANGE: So my sense is we should vote on the information that we have and your judgment about -- really, this is for -- really, this is for any information by self-report is the issue that has been raised. So just using your judgment about the tradeoffs between that and between other
measures that would have the missing data from people getting the immunization and other sources, just using your best judgment about that, let's go ahead and vote on this.

I think we can vote on the whole thing. I think we have consensus on the importance. I think we have enough consensus on the rest, and the vote really will be about that. So let's do the overall vote.

DR. WINKLER: Is everybody ready to vote? Yes, 11; No, one.

DR. STANGE: Thank you.

DR. WINKLER: Thank you, Sepheen.

Mark, are you guys ready? Okay.

The next measure is measure 041 from PCPI. This is the percentage of patients aged six months and older seen for a visit between October 1 and the end of February who receive an influenza immunization or patient reported previous receipt of an influenza immunization.

Linda, I think this is yours also, and we have Mark Antman from PCPI here to talk
about the measure, and the summary of the Work
Group evaluations is up. Mark, did you want
to make a couple of introductory comments?

DR. ANTMAN: Yes, thanks, Reva.

Good morning, everyone, and thanks for the
opportunity to present this measure.

Again, this is the influenza
immunization measure from PCPI. This measure
has been endorsed by NQF since 2009, and it is
a clinician level measure, as I think you
probably already noted.

The measure, again as I think you
have probably already noted, does include all
patients six months and older, and so it is,
therefore, consistent with the ACIP -- the
updated ACIP recommendation from 2010, which
I know you have already discussed.

We documented, we believe, ample
data related to the importance of the measure,
the importance of the topic in the measure.
I think importance has been discussed by this
committee quite a bit already. So I won't go
into those details.

The measure has been tested, and I can refer you to the measure evaluation form and the data that you have available to you, which we believe documents reliability, validity, and feasibility of the measure. We also had a low exception rate, exclusion or exception rate, which I believe you will have noted in our results.

If I may, I will take a minute to talk about what I think may be somewhat unique features of the measure, anticipating some of the discussion of the committee; or, Reva, would you prefer to go with the reviewers' analysis first?

DR. WINKLER: Go ahead.

DR. ANTMAN: Okay, thank you. I already said that the measure has a low exception or exclusion rate. This measure does allow for exceptions. It allows for patient level medical reason or system level exceptions, as you have probably noted in the
information in our submission.

The reason for the system level exceptions is related in part to the time frame provided for the measure. You have no doubt already noted that the time frame for immunization or for physician documentation that an influenza immunization was received is October 1 to the end of February.

I know this committee has already discussed a good bit the standard time frame for your immunization measures, and I recognize that this is not in full agreement with the time frame that has been discussed or the standardized time frame.

The reason for that -- One reason for that is that the Work Group felt that the intent of the measure is to capture the bulk of activity in medical practice. Given that vaccine is, as I think you have already discussed, frequently available now early in the season or before the season, but it is sometimes not available, depending on the
year, until sometime in September.

    Our Work Group was concerned that
it would be necessary to exclude a lot of
patients from the measure if they went with
the time frame of September through February
or September through March.

    So the feeling was, let's capture
the bulk of activity from October 1 to the end
of February, and there is a system level or a
system reason exception provided so that, if
a vaccine is not available, then the clinician
can exclude a patient from the measure.

    Additionally, our clinical leaders
for the Work Group also referred me to the
details of the ACIP recommendation, which note
that when vaccine is in limited supply,
vaccination efforts are intended to focus on
delivering vaccination to the high priority
populations or the populations at greatest
risk of influenza, and that is another intent
of the use of the system level exclusion.

    I think I will stop there, and see
if there are any questions after the review.

         DR. KINSINGER: So my question
gets to the end time of your time frame, which
is end of February. Why not extend it to the
end of March like the other measures are?

         DR. ANTMAN: Right. This was also
discussed by our group, and I think the
feeling was that, by the end of February, the
bulk of the flu season will have passed. Most
immunizations will have already been given.
Vaccine at that point may be running low, and
physicians will still use the remainder of
their vaccine supply, but again the feeling
was that it would be burdensome to ask
physicians to use that exception for a lot of
patients either before the season or nearing
the end of the season, if for one reason or
another they needed to exclude the patient
from the measure.

         So again, the Work Group
recognized that, by choosing October 1 through
the end of February, they were somewhat in
conflict with the time frame chosen by NQF and
by other developers, but the intent was,
because this is a clinician level measure and
because the intent was to capture the bulk of
activity in the ambulatory setting, they chose
to focus on, again, October 1 through the end
of February and allow for clinicians to except
or exclude patients as needed either before
the very beginning of the season or near the
end of the season.

DR. KINSINGER: Maybe I don't
understand how this measure works. Who
responds? Who provides the data? Are you
saying that physicians actually have to go
through their charts to --

MS. MERRILL: Yes. They are just
saying that, if they run out of vaccine, then
they have to exclude all their patients. That
is more work for them, but I don't see how you
can go against what recommendations are coming
from another body.

DR. ANTMAN: So let me see if I
can respond to that, and I do have -- I believe I have a couple of colleagues on the line who are welcome to chime in, if they wish. I am sorry. Can you --

DR. KINSINGER: Explain very, very briefly how this whole process works in terms of responding. It sounds like you are talking about the burden on physicians to exclude their patients. If they are making -- How does this measure work, just so I understand that?

DR. ANTMAN: Okay. It is a clinician level measure, and the intent is for physicians to document either that they provided the influenza immunization to the patient or document that the patient, in the language of the measure we said who received an influenza immunization or a patient reported previous receipt of an immunization.

DR. KINSINGER: How were patients chosen to be reported on?

DR. ANTMAN: The denominator to
the measure is basically all patients with an
ambulatory visit within the time frame of the
measure, between October 1st and the end of
February.

MS. SAMPSEL: But, Mark, isn't
this deployed at this point through PQRI?

DR. ANTMAN: I'm sorry?

MS. SAMPSEL: Isn't it deployed
through PQRI? Isn't that where you data is
from?

DR. ANTMAN: Hopefully, not
uniquely through PQRI, but yes, Sarah, it has
been in PQRI since 2008, I believe.

MS. SAMPSEL: So there is not an
understanding of what that means, and I think
that is what Linda would like an explanation
of, is how that works for PQRI and they
actually do that.

DR. ANTMAN: That is fine. I can
do that. I choose not to focus exclusively on
PQRI or PQRS, because we hope the measure is
being used elsewhere, but PQRI, or PQRS as it
is called now, is the Physician Quality Reporting System of CMS where physicians report on measures for which patients, more or less automatically, appear in their denominator based on the denominator specifications.

In this case, in the case of this measure, again the denominator of the measure is all patients aged six months and older seen for a visit between October 1 and the end of February. Consequently, all patients with an ambulatory visit code automatically wind up in physician's denominator, and they are, therefore, asked to report to the PQRS program on all of those patients.

To do so, they either have to indicate that they provided the flu shot or that the patient indicates that they have already received the immunization, and the patient can -- and that can include either having received it, as we have indicated in a definition of the measure, that they either
received it from another provider or that same
provider in a visit prior to October 1st. So
that also accommodates the possibility that
the patient was vaccinated before October 1st.

DR. STANG: Can I raise a larger
issue? My understanding is that this concern
was brought up three years ago, and so what --
We are saying, okay, things like this, they
are about harmonizing about the population.
Here it is harmonizing the dates.

If that has been brought up
before, and nothing has happened, do we need
to disapprove this now or what do we -- or do
we say please go back, please see if you can
harmonize this with the others again, and give
another three years to do that?

DR. BURSTIN: This is a somewhat
unique situation, because the last time NQF
did this there was a standard set of
standardized specifications that were put
forward that the developers did it to meet.
I think it is difficult to agree to a
different set of specifications, and I guess
I will curious, Linda, with your role in ACIP,
if the ACIP says it is through March, I am not
sure that simply cutting it off in February is
logical unless there is evidence to give us
how much of additional burden it would be for
a measured based on CPT-2 code. I just think
it is a question.

So I think it is very appropriate
for now, given the fact this is three years
later from the last time we did this.

MS. MERRILL: Is there value
having that data when vaccine is in short
supply than if it is a lot of exclusions in
that month of March? Is that valuable data to
have?

DR. WINKLER: Does the data exist?

MS. MERRILL: Well, if that is
included in the statement, then they must
exclude their patients for cause, which is not
having vaccine, if it is in the denominator
statement. Is that not correct?
DR. ANTMAN: So all of those patients are counted in the denominator, and the intent in all PCPI measures with exceptions or exclusions is that those excepted or excluded patients be counted separately. So that data is available. It is recorded.

DR. WINKLER: Mark, just to clarify, your exclusions are in the denominator. Correct? So they are subtracted from your denominator population, which is another difference from what we are seeing in the other measures.

DR. QASEEM: I was going to bring the same issue. I think that -- Wouldn't it be better to have the numerator that talks about that who received the vaccination assessed and offered vaccination but declined or assessed and couldn't get a vaccine then because of contraindications? Shouldn't that go into the numerator statement rather than denominator? That may help, and the
denominator should be everyone who should be getting the vaccination, because you have done it the other way around. It is a process measure, and in a process measure these things should go in the numerator rather than denominator.

DR. ANTMAN: I think we are saying the same thing in different ways, Amir. So the patients are -- Yes, all patients are in the denominator. The only patients for whom the exceptions are counted are those patients who did not receive -- for whom there wasn't a numerator hit. In other words, those patients for whom the vaccine was not received.

So the intent is that the patients are counted in the denominator, but the intent is to not capture any false exclusions. In other words, if a patient did receive the vaccine but an exclusion was also recorded, that, we think, would be a false exclusion.

So they are within the
denominator, but the intent is to only count
them as exceptions if they indeed were not
counted in the numerator.

DR. QASEEM: Correct, but the
intent is to assess that, right?

DR. ANTMAN: Absolutely.

DR. QASEEM: So that is what I am
saying. Don't you think that belongs in the
numerator, though, because you need to assess
them. Denominator is always going to be
whoever needs to get the vaccine. Numerator
is what you are supposed to be doing.

Again, as I said, going back to
the process measure, and if you are already
putting them in the denominator, to the
exclusions -- What you are asking physicians
to do is they should be assessing the patients
to get the vaccine. I mean, the end result
might be the same, but the point is a process
measure should have the assessment in the
numerator.

DR. ANTMAN: Yes, I agree, and so
-- Well, let's go back to the PQRS methodology, since as was pointed out, that is the bulk of the use of the measure currently.

In the PQRS methodology, patients who are counted in the numerator and the patients who are excluded are all counted within the -- as patients for whom the measure was met, essentially. So they are counted, but I am trying to emphasize that we ask that they be counted separately as exceptions so that it truly represents who received vaccine and who didn't receive vaccine. But, yes, they are counted along with the numerator to give a true picture of to what extent the intent of the measure was met.

DR. STANGE: I think we have raised a concern here. My understanding is this concern was raised three years ago. I don't think it is the job of this committee to actually fix it now, and I really am concerned about us -- We are not even coming close to getting through our agenda.
So when we consider our vote on this one, one option that I would like us to consider that a No vote might mean would be asking for more information about how this might be harmonized with other existing measures, and that is both about the time frame issue, about the end of the time frame, and about the exclusion criteria, and then whether that is done in the denominator or the numerator.

So I don't think we are going to solve that here, but at least I think we have raised that as a concern. So when we are doing the vote, one thing that a No vote -- or I guess we could vote on that explicitly -- would be yes, no and return with more information before a vote is actually done. Is that a reasonable thing to vote on?

Okay. So could I have a shown of hands if you would like to have more information about how this could be harmonized on those two issues before a vote is taken?
Raise your hands, and keep them up, please. Eight.

DR. BURSTIN: Eight yeses. Noes? And the No is that you think it is good to go or you have concerns beyond that?

DR. KINSINGER: I am just not sure. I mean, I think we have heard the explanation. I am not sure that going back and asking them to explain it to us again is going to get us anywhere. It seems like we've got what we got, and I would say we should vote up or down on that, but that is just my thought.

DR. QASEEM: Just to add to that, because just following what we have been doing all morning, the question on the table is does it meet NQF criteria. I am having -- That is what I am evaluating this for, I think, to answer that question. Otherwise, I may have to go back and revote on all the rest of the measures from this morning.

DR. STANGE: Let's just vote Yes
or No on endorsement and go from there.

DR. QASEEM: I think we vote for

it.

DR. ANTMAN: May I ask, before you
take that vote, I do believe I have colleagues
on the phone. Can we ask if they have
anything else that they can add to this
discussion?

DR. STANGE: yes, but we really

need to respect the need for us to move on

with the agenda.

DR. ANTMAN: That is fine.

Unfortunately, our clinical expert was
available yesterday afternoon, but neither of
them were available this morning.

DR. STANGE: I am not sure if

there is more information that would fix this
at this point. It is a concern that was
raised three years ago. So I am not sure it
is an information issue at this point. We
trust your expertise.

DR. WINKLER: Everybody ready to
vote? Okay. Four Yes; 8 No.

All right. Our last immunization measure -- we go back to Jason -- is measure 1659, immunization for hospitalized patients, and we don't have a measure developer representative.

This is a measure for inpatients aged six months and older discharged during October, November, December, January, February or March who were screened for influenza vaccine status and vaccinated prior to discharge, if indicated.

Let me find the -- I do have the summary of the Work Group up on the screen. Did we lose Jason again? Is anybody from CMS or FMQ on the line, just to double-check? Where did Jason go? This is the last flu immunization.

I was going to say, we have the results from the Work Group. This is a measure that essentially is a revision of a previous measure that CMS had used with
immunization of pneumonia patients as part of
their whole hospital quality reporting system,
and again three years ago when we were going
through this whole exercise, it was why just
pneumonia patients; why not everybody in the
hospital.

So they have come back to us with
the broadened measure. I think that, if we
look at the Work Group summary, it was felt to
have high impact. The performance gap was
there. I don't have the data right in front
of me, although what they report on in the
submission is just the subset of the pneumonia
population. Oh, here it is. The gap is
small. Currently, it is at 92 percent.

This is, again, this subset they
tested on, which was only the pneumonia
population, not the entire general hospital
population, which quite possibly might be
different. Again, it is an opportunity for
intervention.

The quality -- The evidence is the
same evidence. It is all about flu immunization. So is there anybody -- Comments, particularly from the other Work Group members who looked at the measure? Thoughts? You need to use your microphone, Jackie.

MS. MERRILL: When we had our subgroup immunization group phone call, this was the measure we used as our example. So we all have looked at this measure. Few of us bothered to actually review on paper, but we all looked at it.

DR. WINKLER: And these are the issues. Anything else that you recall, Amir?

DR. BURSTIN: Did the measure meet the full set of standard specifications here?

DR. WINKLER: Yes. That was one thing that I had hoped to be able to clarify, because it is interesting the way the specs are presented. The numerator is stratified, and so rather than write it in the numerator specs as the three different categories, they
give us the combined, but then write it as
stratified for those subsets.

So it is just an interesting way
of presenting it. I think we ultimately end
up in the same place. I would have liked to
have confirmed that with CMS, but that has
been difficult to accomplish, and Jason has
returned. Not a problem.

I was trying to substitute for you
for the hospital measure. You will do a much
better job.

DR. STANGE: Actually, Jason, we
have heard that this is actually the measure
that your group discussed and that there
weren't any particular concerns about meeting
criteria. Anything you want to add to that?

DR. SPANGLER: I will just add a
few things. Reva, did you mention about the
previous measure? This is an extension from
a previous measure. Oh, okay.

There are only two concerns I had,
actually, about this measure. One is that in
the validity testing, when they talk about face validity, I am not sure that the face validity was systematically assessed. They just say that there is a group of national experts, but there is no other information about who they are, what their expertise is, where a lot of the other measures have those details. So that was one concern that I had.

Then I had one other. This is one that actually listed the other measures that are related. That was mentioned yesterday, or competing. So they actually listed all the other measures that related to that.

I thought there was one other thing, but I can't find it right now. But otherwise, those are the main -- I guess the one main issue that I had.

DR. STANGE: Madeline?

DR. BURSTIN: Does it match the -- I see it matches the timeline, Jason, of the standard specifications. How do they address -- just because we had those previous
discussions about the numerator exclusions.

Can you clearly see that in the measure? Reva was mentioning while you were out that you had done some stratification, but I just want to confirm it actually meets the standard specs.

    DR. SPANGLER: Yes, I thought it did. They actually had a pretty -- I thought, a pretty well detailed description of inclusion and exclusion.

    DR. WINKLER: I think the only thing, Helen, that is -- It isn't totally clear. When you look at the stratification, if you look under 2(a)1.10, the stratification details, you do see those categories, and they convert them to a pass, pass, pass, pass, and the issue would really be whether they are computed or reported separately. That is a clarification that would be useful to try and get from CMS. I mean that the measure is constructed that they certainly could do it. The question is will they do it that way.

    DR. BURSTIN: I am just confused.
So it is stratification, meaning we should be able to see the proportion who offered and declined the vaccine. That is the key issue from the standard specifications that Reva and Karen went over yesterday. We want to be able to see how often they were offered and declined, because we know that is pretty mutable, depending on the way the clinical team can be -- We just want to confirm that it is, in fact, something you can see as a numerator strata.

MS. SAMPSEL: Right. If they converting it all to Pass, we wouldn't be able to see the differences.

DR. BURSTIN: That is my question.

MS. SAMPSEL: Okay, yes, that is what I thought.

DR. SPANGLER: Sorry. I did find it. The one other concern I had was about usability. In looking at the public reporting aspect of it as well as the quality improvement, they used PN7, which is -- and we
had this discussion, I think, on the phone.

It is a very small subset of actually the --
of the entire population that they would be
looking at, and I am not sure that is the best
reporting to be used.

So there was a question about
additional explanation. Is that the only kind
of program they would use or population set
that they would use when it comes to public
reporting, because there seems to be -- The
much larger population would not be reported
on and would not be used for quality
improvement.

DR. WINKLER: Jason, I think this
represents the transformation from what they
did previously with just the pneumonia
patients, and now that this measure is
available more broadly, they would change the
implementation to the broader population.

DR. SPANGLER: Okay.

DR. WINKLER: It is just that is
what their experience is.
DR. BURSTIN: This is an example where they stop the slicing and dicing by condition. They actually included children. I think that was extraordinary.

DR. STANGE: Ready to vote?

DR. WINKLER: Yes, 12; No, one.

DR. BURSTIN: Reva, I just did confirm, it is actually in the numerator, those strata. So that should take care of it.

DR. STANGE: Good. So thank you for your careful attention and persistence on the immunization measures for influenza.

DR. WINKLER: The question is: At this point, out of the six measures that were put before you, one is about health care personnel, which may be looked at differently, and the other five you voted to approve four of the five.

The question is now would be the appropriate time to have that discussion about the global measure or the further harmonization or further consolidation about
the measures.

So of this group, you feel that meeting the criteria, you feel for the one for hospitals, the one for home health, the one for dialysis facilities, and the survey measure that becomes part of the CAHPS survey. So those are the four recommended so far.

Do you want to talk about possibly further consolidating those measures. Are they different enough?

DR. STANGE: So, really, you should give us some frame for this. How do you act on this? What can we do to help you to act in a way that is helpful? We will talk about what should be done, but give us what the end game is, so we know how to frame our discussion.

DR. WINKLER: I think that -- In a perfect world, I think everybody has voiced the idea that one measure that could be applied all over the place would be ideal. However, we are not there yet, and there are
logistical issues, real world issues about data sources, collection methodologies,
programs that they are implemented in, and the way the measures are implemented that may not be surmountable to force us into a global measure at this time.

The question is: Is that where we are? Is there somewhere else we can push this?

DR. STANGE: What do you do then? You go and talk to the measure developers, and you cajole them to try to come up with a consolidated measure, and you have the threat of not approving next time? Is that what happens, or what happens? So we can go back and undo the approvals based on this issue. Is that it?

DR. BURSTIN: So, basically, you have -- For the ones you have approved, they now need to go through the head to head comparison, and I guess the question would be -- sounds like the ones you want are the ones
that are outstanding as potentially being one
that people thought might be -- could be
consumed under others. So I guess we should
finish that discussion. We would go back to
the developer and see if there are any options
to pull it in.

I think the only issue that we
will be challenging is the data source issue,
because currently the data are collected in
dialysis facilities in a different way. So I
guess one question would be: Is harmonization
enough? They have harmonized to the standard
specifications.

I don't know that they can
harmonize further in terms of moving into the
same data source.

DR. STANGE: So I guess the renal
disease -- whether they should be a separate
category, but there is also having different
measures for different age groups. Is that
also something that we are talking about
harmonizing?
DR. SPANGLER: Reva, can you repeat the ones that we --

DR. WINKLER: The measure for inpatient hospital, the measure for home health, the measure for ESRD, and then the NCQA survey measure for patients over 50 that is stratified into 50-64 and over 65; and then realize that in the background also we have two measures appropriate for nursing homes.

DR. SPANGLER: So except for the last one, it is all based on location.

DR. WINKLER: Correct, and each of those locations has a different data source.

DR. NAEGLE: I guess I am thinking about this in a real world way. So I am wondering if harmonization is possible at this time, given the difficulties with the disparate data sources. That is one.

Then also thinking about level of both consumer and provider awareness, compliance. Maybe I am wondering if sort of this state of the science of utilization of
these immunizations is where we can harmonize this and have -- begin to approach as good an outcome as we would if we leave them separately. Is that clear? Do you understand?

DR. BURSTIN: The measures are harmonized. The issue we are really talking about today is: Is a separate measure going to exist or should it be subsumed under another measure? They are harmonized.

DR. NAEGLE: Consolidating. So if we consolidate, does that mean that there is the possibility that some of these discrete groups which these are written to target might not be included for real world issues?

DR. STANGE: Matt, and then Jackie.

DR. McGONIGAL: I think that the dialysis care patients would likely be excluded, and they are a particularly vulnerable population. Their data will be collected through CROWNWeb by CMS, and if you
try to incorporate them into a broader measure, it is likely that they will get missed.

MR. STIEFEL: This is just another potential assignment for Sarah. So this is the population health group, and almost all of these are patient health measures, and I think -- So when we look at the criteria for this group, I think we ought to be looking at how would a population health measure for flu vaccine be different than these patient focused measures. I think we might come up with different criteria from the population perspective.

MS. MERRILL: what about the double counting issue? In other words, if we have all these different measures and someone says, okay, I ant to get a picture of how this immunization is in the population, and I have six different measures; and if I more or less look at those six different measures, am I going to get some true sense of what is going
on or is the ambulatory care setting going to
count some of the dialysis people? Is it
going to give a false picture of what actually
is the state of the population in terms of
this immunization?

DR. BURSTIN: I don't think so,
because it is a fairly unique group who are
picked up in dialysis facilities. They could
be admitted. They could have home health.
They could --

MS. MERRILL: So they excluded
from the ambulatory care measure, because the
ambulatory physician may see their dialysis
patient for a visit and then count them, and
they are already counted in the ESRD data.

DR. BURSTIN: It is not a
prevalence sample.

MS. MERRILL: No, it is not.

MR. STIEFEL: You can't add these
up to get a population.

MS. MERRILL: Yes, you can't add
them up, but when you are looking at the four
of them -- the six of them as a composite, is it going to give you something realistic, a realistic environment scan, so to speak, or they are just totally not comparable?

DR. STANGE: No. So that is Matt's charge to Sarah's group.

DR. BURSTIN: And as I mentioned, there is an item on BRFSS that asks flue vaccine immunization. It is a regular thing, but again you then can't -- The problem with our current Federal data systems as well is you then can't take that data and stratify it down to look at hospital, provider or dialysis level performance.

So it is really the conflict of the performance of the individual entities within the health care system. But, no, you cannot take these and get a global assessment.

DR. QASEEM: So just back to the harmonization issue, in terms of why folks -- everyone needs to develop their own performance measures, would it be possible for
NQF at least to somehow harmonize what goes into numerator and denominator statement, because even of those four measures, you are seeing the differences.

I know you said that they are harmonized, and I am not entirely convinced, Helen, that their measures are really harmonized. In consolidation, we may be a little bit far away from consolidating these measures. I think that is not going to happen, but at least if we can agree on even for the subset of population, ESRD or whatever it is there, at least we have what goes into the numerator and what is excluded and what is not excluded, and right now there is so much variation just seeing across all these.

I am going to bring it up when we talk about pneumococcal vaccination. I mean, there are patients in hospitals that, if you are not really sure someone has been vaccinated, you vaccinate. People are getting double vaccinated, and there are a lot of
patients that are going to come down the road.

At least, I have to say that if we can just have harmonized what goes into what we are measuring, and I think that is what I am struggling with, that might be a good start.

DR. WINKLER: Amir, that was the purpose of the standard specifications, was the agreement on what should go in the numerator and the denominator. So that is really a fundamental part of what we are doing, is looking at the measures to see how well they meet that, because that is what everybody is standardizing to.

Certainly, there are logistical and philosophical issues in getting at alignment. I think you are seeing the result of it. These measures -- that was one of the assessments you all were making, was how well did it line up.

DR. QASEEM: But in looking at these four measures that we have approved
today, am I the only one or are you all seeing the differences across these? Then in that case, is it possible for us to send them back to these folks and say that they may not -- Either they are not meeting your criteria or maybe your criteria is not clear enough. There is something missing.

DR. WINKLER: I think the thing we would need to do is really take a look in detail, and this is something staff can do, to really tease out what those are, those differences are; because it looks like they are -- The big things seem to be there, but perhaps it is the small things that we are now able to -- which is a huge step forward, frankly, in this whole process, if we are looking at the little things and not the big things.

So we could certainly do that and see exactly the degree of issues you guys are identifying, and see what we can do by just pointing those out, and bring it back to you.
DR. STANGÉ: Before we do that, can I just ask if Amir's summarization is the feeling of the group, that because of the differences in the populations and the data sources, that we are not quite ready to recommend a consolidated measure across all immunization measures, but that after you have done the big chunk work on the numerator and denomination issue that there is some further work done for harmonization, and that we are going to ask you to do more work on that and report back, and then probably work with the developers. Is that a consensus?

So is there anything else to discuss then? Jackie?

MS. MERRILL: Well, part of it is -- and I am sure these forms are very onerous for the developers to put out, and I understand that the forms have changed during this period. So some of them have submitted one form and then it has been put into another form. So fields are not filled out.
That makes our work much, much harder, and sometimes it is not actually harmonization of the criteria. It is the language they use to describe it. So they need to use the same language all the time. If that is what they mean, that is what they need to write.

So if it is like anybody who was seen, it means they were seen, and they were screened, and they received it, if they needed it. That needs to be explicitly stated. So it is like sloppy language is being put in the thing; and, I'm sorry, I would hate to have to fill out these forms, but they really should meet a standard for a sort of language that is the same across categories.

MR. STIEFEL: Just to strongly endorse the recommendation, Reva, I wasn't clear if when you said it is the responsibility of this group to look at that. If it is the responsibility of this group to look at consistency of numerator
specifications as we are going through each measure or if that is after we looked at them all. I thought it was after we looked at them all.

DR. WINKLER: You were doing it --

You were kind of doing two things, but during the course of your evaluation of each measure you were also considering within the specifications how well they met that standard, because that had been an up-front expectation for the measures. But now Amir and Jackie are pointing out that, even if we've got the big things, there are still a lot of little things.

So that is a next step that we can see if we can get further harmonization on.

MR. STIEFEL: Which criterion applies to how well it meets the standard?

DR. WINKLER: It is probably a combination of scientific acceptability, because you are looking at the specifications as well as the competing related measures.
issue.

DR. BURSTIN: Sometimes settings of care have different language. I think the key thing is that the spirit is there. We cannot mandate that the exact language be used on every single one. Hospitals are inherently very different than ambulatory facilities, but I understand the spirit of it.

DR. STANGE: Keith?

MR. MASON: My question is: Once endorsed, what is incentive for any of these developers to change it within the next three years or just wait until three years? If you go back to them and say, hey, we want you to standardize this, they will say, well, it is going to come up in three years. Is there any incentive for them to actually change, once we have endorsed?

DR. BURSTIN: You won't endorse it.

MR. MASON: Well, we have endorsed them already. Right?
DR. BURSTIN: No, you have not. You have only said they have met the conditions for consideration -- that they have met the criteria. They have the fifth criteria as the key one, which is about harmonization and competing measures. So, no, you have actually not approved them for endorsement yet.

DR. WINKLER: And also remember that you only recommend them to the rest of the process anyway. So we are still in the early stages.

DR. STANGE: So we have not approved one, and we have apparently not endorsed the others, and we are not going to endorse them then until more information --

DR. BURSTIN: Just in terms of the wording of this, since many of you are new:

So your role as a Steering Committee is to approve -- or to recommend the measures to move forward. They go out for comment. They go through all the various channels to follow.
At this point you have not recommended one move forward, although I suspect we will probably hear from the developer on that one as well, and then you have now -- The others you think have met criteria will come back to you with additional analyses to see if it satisfies your concerns about harmonization and competing measures that fit the criteria.

CHAIRMAN STANGE: Then you will make a final recommendation on those measures, whether they should move forward.

DR. STANGE: Is there any other discussion about the influenza measures before we take a break -- or before, actually, I guess, open it up to public comment? We need to do that and then take a break. Amir?

DR. QASEEM: So just on the process, Helen, so essentially it is going to go back to the developers and then now they are going to come back, all the discussions we had over here about harmonization in terms of numerator and denominator. At that point, we
are going to deal with it again.

DR. BURSTIN: Again, the question is -- I think we may actually be able to just do a staff analysis of a side by side, shoot that back to you, see if you think there are additional issues, if we need to back to them. You know, I don't want to keep pinging them, if we don't need to.

DR. STANGE: Rufus, can you open up the lines, please, for anyone who has been listening in and wishes to comment.

OPERATOR: And if anyone on the phone line would like to ask a question, please formally press the star key followed by the digit 1 on your Touchtone telephone.

If you are on a speakerphone, please make sure that your Mute button is disengaged so that your signal can reach our equipment. Again, that is *1 to as a question.

We have no questions on our roster at this time.
DR. STANGE: Rufus, would you record my voice mail, a message for me, please?

Anybody in the room wish to comment?

So we have now caught up with our agenda for the end of yesterday. Why don't we take a 10-minute break, and then come back, and we will start talking about some of the screening measures.

(Whereupon, the above-entitled matter went off the record at 9:52 a.m. and resumed at 10:04 a.m.)

DR. STANGE: We are going to start up again here, and we are going to try to do a process where we take what we have learned about the process of doing this and use that to not do a gloss but to not spend time discussing things that we already have consensus on.

So when the measure developers are presenting things, if you could really focus
on just the important context we need for the
discussion. People that are doing the primary
introduction of a measure, if you could focus,
please, on what are the areas that we need to
particularly focus our energy on. We don't
have to go through all the different criteria,
but where do you think we should focus our
efforts, if you can prime the pump of our
discussion, that would be very helpful.

We are going to begin with
colorectal cancer, and if people can take
their seats, I really would appreciate it. We
will begin with colorectal cancer, and Sarah
is going to introduce it. Reva, do you have
any framing comments?

DR. WINKLER: Dr. Medows is not
able to be with us today, and she was the lead
discussant on the first two measures for
cervical cancer. So what we are going to do
is just juggle the agenda just a little bit to
get folks oriented to these types of clinical
screening measures.
So we are going to start off with the first measure, 34, which is colorectal cancer screening, the percentage of members 50 to 75 years of age who had appropriate screening for colorectal cancer.

This again is a measure from NCQA and, Sepheen, I don't know if you wanted to have one or two sentences just to intro just briefly, please.

MS. BYRON: All right. This is an NCQA HEDIS measure. It is another longstanding measure. It was actually reevaluated about three years ago or maybe it was two years ago, and we made sure to align with the U.S. Preventive Services Task Force.

So it looks to see that members received a colorectal cancer screening, and what counts as screening is a colonoscopy, flexible sigmoidoscopy -- sorry, that was FOBT, thank you -- and the age groups are also aligned, 50-75, with the U.S. Preventive Services Task Force recommendation.
MS. SAMPSEL: Okay. So it looks like I was the only one who rated it which, obviously, means brilliance. I did want to say that, even though I was formerly employed by NCQA, I never worked on this measure. So I will just divulge that. So I don't have any bias for it or against it.

I wanted to mention, though, that we do run this measure at WellPoint on a WellPoint population with slightly different specifications, but still stand by what the NCQA HEDIS measure is.

A couple of things, and I guess, Sepheen, it might actually help if you are back. In my review of the measure, I definitely feel it meets all of the importance, impact evidence, etcetera. But there was something in the form that indicated that NCQA is considering adding the virtual CT or the CT contrast, and that was kind of a concern, one, because it is not recommended by USPSTF, and in WellPoint's internal review of
this measure we had strong concerns with
adding that, just because it raises patient
safety issues vis a vis radiation.

MS. BYRON: Yes. I would have to
find where that is in the form and why it was
written in that way, but when we formally
reevaluated the measure, we considered the
virtual colonoscopy and decided against it,
because it did receive an I rating from the
USPSTF. So I apologize if this may have been
older language when we were reevaluating the
measure and considering adding it, but we made
a definitive decision not to add it.

MS. SAMPSEL: Okay. So then the
other just comments that I would make is this
measure continues to have fairly good
variation in that you have a lower minimum, in
the 20s to 30s, and your max is still around
81. Some of that does have to do with data
fluctuation and the fact that you have a
significant look-back period, but since this
is a plan reported measure, all plans have the
same kind of issues on doing those look-backs.

Then regarding reliability of specifications, validity of specifications, the only threats to those, again, have to do with lengthy look-back periods and the period of time that a plan could actually have a data piece using this measure.

We do use this measure, and I would say most plans use and focus on this measure, not only on the plan side but in a community side and a population health side. So this might be a really good measure as well to determine in the future how it would translate to a population health measure, because we are working with a lot of public health agencies across the country on also trying to improve screening on this type of measure in our communities.

DR. WINKLER: Just in terms of this measure, we received a question about the implementation of this measure, that given the look-back period, is there any accommodation
for patient history: I had my colonoscopy five years ago, I am now a new patient, or something -- so that they have already been screened. Is there some accommodation for capturing that in the measure?

MS. BYRON: Yes, there is. As long as they have documentation of the screening, then it counts.

DR. WINKLER: This is also a measure that is listed for clinician -- individual clinician or group, as well as health plan. Is it currently being implemented at the clinician level, and are there any issues with doing so?

I believe this is another measure that has been retooled for EHR and for meaningful use.

MS. BYRON: Right. So this measure -- Many of the HEDIS health plan measures actually are also specified for physicians. We have a physician volume, and so we made sure to enable physicians to be
able to report it, if they so chose. So that
is how it is, but it is part of the HEDIS
health plan set primarily, and it is -- Also,
I believe, it was respecified for meaningful
use.

DR. KINSINGER: Just to clarify
again, so the language still talks about
double contrast barium enema. Is that still
included?

MS. BYRON: that is not included.
I will have to check to make sure that we --
make sure that this form is updated. I
apologize.

DR. STANGE: Any concerns that
people want to bring up?

DR. BURSTIN; I do think it would
be helpful to try to get that clarification.
It is very confusing in the form as to what is
actually in and out and the Task Force
recommendations. That would be important to
clarify that actually now before people vote,
I think, to make sure the evidence actually
matches the measure.

MS. BYRON: Mary, do you want to
add anything in your new role -- Mary Barton?

I will just state that -- and I
apologize, because I know in some cases we are
updating existing forms. So sometimes it
might be hard to catch those subtle changes,
but we did reevaluate the measure and align it
with the U.S. Preventive Service Task Force
exactly.

DR. STANGE: So that should,
hopefully, take care of the issue then. So it
sounds like we have consensus on importance
evidence. Any feasibility/usability concerns?
Oh, my goodness, are we ready to vote?

OPERATOR: Ladies and gentlemen,
we have lost audio from our feed line. One
moment, please.

DR. BURSTIN: We are still here.
Sorry.

MR. MASON: Yesterday we got a
great slide back with all the measures and
stuff. Do we have one for today?

DR. WINKLER: Not printed. They are up there. Do you feel that it would be helpful to have one? We will get one done for you.

MR. MASON: No, that's okay.

DR. WINKLER: The next measure is measure 33, Chlamydia screening, again from NCQA. This assesses the percentage of women 16 to 24 years of age who are identified as sexually active and who had at least one test for chlamydia during the measurement year.

Dr. Stange, I think this is yours. Maybe Sepheen had something to say.

MS. BYRON: I will just sit here, if you have any questions. Again, it is a longstanding HEDIS health plan measure, chlamydia screening, and it is aligned with the USPSTF.

DR. BURSTIN: And is it also aligned with the new adolescent measure that recently went through the Child Health
Project?

MS. BYRON: What Helen is referring to is for the Child Health Quality Measures Project, we also submitted a chlamydia screening measure that was specified at the physician level, and they are all aligned. That one actually requires follow-up. So that is one piece that goes a little further because of the medical record, but this is a health plan measure, and it does not track follow-up.

DR. STANGE: So this is a high importance, high impact topic for the target population; good evidence of efficacy of intervention and of the screening. It is an administratively -- It is done with administrative data, and so the only issue, really, I identified is how do you identify someone who is sexually active from administrative data.

If you look at the codes they have for their -- Anything that has an inkling of
that, they add up. So it looks to me like it is done as well as can be done from administrative data. Because it is administrative data, the burden then is, hopefully, minimal. So I don't have anything other than that, which I think they have done the best they can on.

MS. SAMPSEL: And I can just add on that piece. We have been trying to play with this at WellPoint as well, and I know when NCQA tested this measure. Basically, you do a medical record review to validate the administrative claims, and it really was done the best that it could to identify though claims and to keep the burden down for health plans, which is a huge issue on the plan side that we don't have to go into the medical records, because unfortunately, you can't identify a sexually active patient population just through a medical record either.

So I really feel that this is an example of it's the best we can get to for
such a high impact issue for this population.

DR. WINKLER: Sarah, I just missed that. I just want to clarify. You say at WellPoint you have also looked at the comparison of the two?

MS. SAMPSEL: We haven't done the medical record validation of it, but we have been kind of aligning through our own 34 million members on making sure that we are identifying those current folks in our databases.

DR. STANGE: Any concerns or questions before we vote? Okay.

DR. WINKLER: Thirteen Yes; zero Noes.

DR. STANGE: Looks like we are getting the payoff for the careful work through the process we did on the earlier ones.

DR. WINKLER: Just to talk about this a little bit, because it is important that we are able to convey to audiences the
overall grading of the different elements of
the measure evaluation criteria.

We use as a starting point the
Work Group, but we are going to draft this
summary, and we are going to send it back to
you all, and we want you, really, to pay
attention and look and be sure it does truly
reflect what you believe the ratings are of
the evaluation criteria; and we really are
going to ask you as part of your role as
members of the Steering Committee to really
take on that responsibility for being sure
that what we are laying down, what we reflect
is accurate.

DR. WINKLER: The next measure is
measure 31. This is breast cancer screening,
again from NCQA. It is the percentage of
eligible women 40 to 69 who received a
mammogram in a two-year period.

Dr. Stange, I think this is yours.

Did NCQA want to make any comments?

MS. BYRON: This is an existing
HEDIS measure, longstanding, and it is straightforward, and I can answer any questions about it.

DR. STANGE: So the main issue I would raise is what to do with the controversy about women 42 and -- 40 through 50, because the U.S. Preventive Service Task Force recommendation is to have an informed individual discussion. So that makes it difficult to develop a kind of -- a global assessment of this.

One way to handle that, actually, would be to keep the 40 to 50 year old women in the denominator, but to report the results, which you certainly gather the data. The data already are together on age in a way that would allow stratification of the reporting, and you could report an overall rate for the women in the target age group of 40 to 69, but then you could also stratify the under-50 and then the over 50 among that, which would at least allow interpretation.
There is going to have to be just individual interpretation of what that means, and different people will do different things with that. So that would be my only suggestion, is just to emphasize collecting the data and then the opportunity to report it in a stratified way.

MS. BYRON: Right. And this was actually a discussion yesterday at the Committee on Performance Measurement. So you are all aware that we had some issues with the guidelines not aligning, and we were caught in the middle a little bit there when the new USPSTF guideline came out.

We made the decision at the time to leave the measure as is, because there was no consensus among the guidelines. Given that we did discuss, actually, that that potential solution of stratifying the measure so that people could look at the younger age groups and the older age group separate and, basically, you would be able to present the
results showing years.

If you wanted to look at the
USPSTF guideline, you could look at this age
group. If you were concerned about younger
age groups for whatever reason, considering
other guidelines do point to that, you could
look at it separately, and it is something
that we plan to do, actually, hopefully,
taking to our January meeting of the committee
on Performance Measurement, which is the
governing body over the HEDIS measures.

So it would just be an issue of
stratifying, exactly as you had noted. I
should see if Mary had anything to add. I am
sorry.

DR. STANGE: So Mary, and then
Linda, and then Amir.

MS. BARTON: I think, you know,
HEDIS measures are always routinely updated.
So I think this is going to be part of the
conversation in updating this measure. With
an eye toward, as Sepheen was implying,
navigating a somewhat tightrope-like shoal
between what the Senate has told the
Department of Health and Human Services they
must follow and what the Task Force's approach
to looking at the evidence was, and then
alongside that ACOG and the American Cancer
Society and a lot of other august bodies
having their own opinions as well. So watch
this space.

DR. BURSTIN: I do think we need
to be clear about the fact that this measure
did not get very high ratings on consistency,
not surprising, given the evidence; and since
it is one of the requirements of consistency —
- and I think this one makes it just because
it is three out of four, at least moderate or
high, it is something that, I think, if this
group wanted to make that as a formal
recommendation about the stratification, I
think it might be something. Then NCQA could
bring back as an ad hoc review the additional
strata.
I just think it is -- This is such a high profile area. There has been so much attention. The morning our old USPSTF made that recommendation, our phones were ringing off the hook of when we were going to update the measure, and I know NCQA's was as well.

So this is a real issue. I want to at least have it appear that we are being responsive to the inconsistency there.

DR. KINSINGER: The other change to the 2009 Task Force statement, as you probably know, is that it actually increases the upper age. So it is not 69. It is 74, and why wasn't that reflected here?

MS. BYRON: At the time we made the decision to leave the measure as is -- and it was originally aligned with the 2002 USPSTF recommendation statement, and so part of the leaving as is was to even leave the upper age range the way it was, but that would be part of the considerations that we would take when we look at the measure now.
At the time, I think, because of the swirling differences and controversies, we felt that you wouldn't want to look at it and change one part of it and not the other; whereas, as Mary brought up, the HHS rule which pointed back to the 2002 recommendation statement, which is what the measure was originally aligned with, gave us more reason to leave it the way it was at the time, until we could look at it again.

DR. QASEEM: So -- and I promise you guys that I am not going to talk anymore, but this is -- I think this is one of those measures that I am a little concerned looking at the numerator statement where it says that one or more mammograms during the measurement years, and the denominator is 42 to 69.

I understand all the controversy. We also have a guideline on 40 to 49. I think the issue is, especially between 40 to 49, the shared decision making is very important. I don't think that anyone is saying you don't
screen during that age group, and the measure is not capturing the shared decision making, which is a process part, in any way.

If you look at that measure, if a patient comes to you, and you do shared decision making and all that, what it is saying is whether a mammogram was done or not. Right? If someone has said that, okay, I have talked to you; I understand the problems are more than the benefits, and let's -- I don't want to get the mammogram done -- does that mean that I will be dinged in that case?

MS. BYRON: Yes, and I think that probably highlights one of the difficulties of quality measurement. You know, this is -- You would have to look into the medical record, and you would have to define exactly what would count as the physician discussing and was it shared decision making; did he just bring it up? Did he just write "discussed"?

Unfortunately, when it comes down
to some of those details that we would love to be able to get from the different data sources we have, because there isn't just a checkbox that says "shared decision making occurred," we are faced with that difficulty, and so the measure can do what it can do.

DR. QASEEM: So just repeating the concerns and not getting into too much detail, we really did sit down with some of the societies who do recommend that you screen between 40 to 49, but I don't think there is any controversy in terms of that you do sit down with a woman and do the shared decision making.

So I am actually very concerned, including 40 to 50 in this age, and I know it has been going on. I don't know if it is our role. Again, I am not very clear on the role of the Steering Committee, but the measure, the way what it is measuring, you are running in to make sure physicians, who are maybe doing a very good job, but you are telling
them you are not doing a good job, and that is
against what most of the folks are
recommending.

    MS. BYRON: And I wonder if a
measure such as that would be better served as
a survey measure where you do actually ask the
patient from their perspective was shared
decision making -- or did you have a
conversation with your physician? Did you
feel like you were part of that conversation.

    The limitations of an
administrative medical record measure, I think
-- you have to think about the different data
sources.

    DR. QASEEM: And I completely
agree, and I think the way around that is
that, since we all agree that it is an issue
between 40 and 49, that maybe the measure
needs to change from 50 to 69, because that
measure is supposed to be based on evidence.

    If the evidence is already
controversial, we cannot make a performance
measure that says that you screen everybody between 40 to 69 when you don't have any clear evidence.

MS. BYRON: We do think that stratifying the measure might be a way to be able to address some of that, because there are guidelines that do recommend that for the younger age groups. So by stratifying the measure, you would be able to say this part of our population conforms with the USPSTF; this other part -- you know, the measure rates maybe lower, and it may be okay.

I understand what you are getting at. It is more implied than explicit, but I would just say that certain measures might be better for service as these measures, and you have to think about data sources that are available with the kind of measure we have.

DR. QASEEM: I am not going to hog the mic. This last thing is the way the measure currently exists, what goes into the numerator and what is in the denominator and
what is the denominator exclusions -- none of it is being reflected in terms of what is excluded. The only thing excluded is the bilateral mastectomy and the evidence for a mastectomy.

I think that in the 40 to 49 I am concerned the measure the way it currently exists, for the reasons -- As I say, I am not going to hog the mic.

DR. STANGE: So Kurt and then Reva and then Sarah -- the only time in my life I have ever done that.

I agree that the stratification is probably the best way to handle that, given just the political frenzy around this and how not reporting that could be interpreted, and at least reporting it can contribute to the ongoing discussion of it.

The measurement between 40 and 49 -- there is the administrative burden and just how you would actually do it to decide whether there was informed discussion going on. The
other thing is that there is the competing demands of reporting that discussion and, if we are taking 10 minutes out of a 12 minute visit to have that discussion, all the evidence based services we are not doing. All the patient agendas we are not attending to.

If it is reported, there could be some text that would go around that, that would at least raise these issues and help foster the discussion, but where we are at this point in time, it doesn't seem to me that it is an option to not do the reporting. But we can actually at least frame that discussion.

If it is all lumped together and the rates of doing it between 40 and 49 are the same as your rates of doing it at the higher ages, that is just really problematic.

So I think we need to stratify for that reason, but we don't have easy ways to contextualize what the data mean for 40 to 49, and at least we can report it and let other
people contextualize it in their context and
at least help the discussion. So Sarah, Matt,
Linda.

MS. SAMPSEL: So internally at
WellPoint, we have had a lot of discussions
about this as well. In fact, we are switching
our internal metric to 50 to 69. However, we
still have that tightrope that NCQA has, in
that you have the ACOG and other
recommendations that start at 40.

So realistically, our preventive
services guidelines within WellPoint are
starting at 40, but our measurement will start
at 50, but it has more to do about our ability
to impact and the ability on who we will be
able to directly identify as you haven't had
it, these are the strongest recommendations.

So it is a balance, unfortunately,
and we still show significant variation on
this measure. We still feel it is extremely
important, and I believe it was our
representative who talked about stratification
yesterday on the CPM, because we feel so strongly about that. We want to know that 40 to 49, but it is hard to translate how do you do the "consider" part of it.

MR. STIEFEL: I would say the same for KP. We are on that same type of tightrope, but did I miss? Did you summarize what was discussed at CPM yesterday about this particular issue of 40 to 49?

MS. BYRON: Right. It was about suggesting to stratify the measure, continuing having people report on the younger age group, but to move it out of the older age group so that you could look at them separately.

MR. STIEFEL: But it was approved as is?

MS. BYRON: It was brought up as a potential solution for this measure, and it is something that NCQA staff are going to do, and it probably wouldn't -- We would probably present it in January. So we would have to do a little leg work first, and it would go to
public comment in February; because all of HEDIS measures are in public comment. So we would go to public comment in the spring, final decision in May.

MR. STIEFEL: In the meanwhile, was it approved as is?

MS. BYRON: It was not an approval item. It was a point of discussion.

DR. BURSTIN: I was actually going to ask a question to NCQA staff. This is, obviously, a tough situation for all of us, for the health plans, for all of us. What is the timing of when you are going to potentially make this change around stratification, because I think it is going to be really important. I think it would be difficult for the committee to act when you are in play.

MS. BYRON: We would -- If all goes well, we would present it in January and put it out for public comment February/March, and then a final decision would be made in May
2012.

DR. BURSTIN: So if this group chose to make the recommendation that it be stratified, it is probably going to be in sort of a parallel path anyway. So just a consideration for the committee.

DR. STANGE: Consideration, meaning we can vote to approve it with stratification?

DR. BURSTIN: I think you would potentially put it forward with a modification that it would be approved if NCQA's process -- again, not putting words in your mouth. Just sounds like, if the discussion is the committee wants to move in that direction, it could be approved only if that modification is subsequently made. And again, keep in mind, it is pretty early in the NQF endorsement process. So we would put it out for comment as well.

So we would, I think, just enhance your comment period anyway, but it may just be
one approach to not have us get stuck in this box, and I guess I am still -- would also question whether, as part of this additional process, will you consider bumping it up to meet the USPSTF upper limit of 74.

The other thing for the committee is do you want to also consider?

DR. STANGE: Reva and then Jackie.

MS. MERRILL: So approved yes with modifications. So we just vote yes, and you take care of the implied part.

DR. BURSTIN: Just two things I wanted to bring to the committee's attention. Number one, the specifications are for optional exclusions, and I wonder what your thoughts are in terms of things that are optional when perhaps some choose to take the option and others choose not to. How significant is that for ongoing comparability?

The other thing is this measure has been retooled for EHRs for meaningful use, and given that is a data source that
potentially could start bringing in the
ability to capture data on shared decision
making, what are NCQA's thoughts and plans
along that direction?

MS. BYRON: Optional exclusions
are actually a part of the HEDIS measure set.
What we want to do is give people an
opportunity to show that they are meeting the
measure. It is really sort of giving health
plans the benefit of the doubt here.

So if they were to meet the
measure, even if they could have applied
exclusions, they can count those people,
because they have fulfilled the numerator
requirement, and it is applied across many
measures, and it is applied to all health
plans equally.

So our sense is that it is
something that all health plans -- It should
affect all health plans equally.

In terms of meaningful use, yes,
it is respecified for meaningful use. It is
respecified as it is, and if we were to -- you know, I am not sure what the process would be to be making changes with meaningful use.

DR. BURSTIN: Updated process happens in the summer here.

DR. STANGE: Actually, just a quick question about that, and then Linda and then Sarah.

Is the exclusion because some groups won't have the data for the exclusion?

MS. BYRON: The reasons for the exclusions are that there are some people who, like Amir had brought up people with mastectomies, where it makes sense for them to be excluded from the measure, but it could be that some people have had a mastectomy in the right time period and then maybe had the mastectomy afterward. So they could be included as numerator compliant.

We want to give health plans the opportunity to include those people, because they did do the right thing.
DR. STANGE: So Linda and Sarah.

DR. KINSINGER: My question has to do with a very small number of people, but in thinking about the question yesterday about disparities, how are transgender people handled in this and the cervical cancer one that will come up?

So if you are a male to female transgender -- I mean, the guidelines don't address that issue. I don't know. Are those folks excluded from the denominator?

MS. BYRON: We do not have explicit exclusions for transgendered populations, because it is such a small -- I mean, we would anticipate no impact on the measure. It is such a small population.

There are no explicit exclusions.

DR. KINSINGER: So those folks, they are going to get counted as not meeting the measure, but it is such a small number that it won't affect them.

MS. BARTON: I would ask WellPoint
how they measure such a thing because, you
know, if you have a cervix or you don't or --

MS. SAPSSEL: Oddly, I have asked
this question internally. This is a curiosity
thing. Once somebody gives me access to data,
it is really quite scary. Our database
captures male, female or indeterminant, and
you only -- for the way that the measure logic
works, you would only be looking for females.

So if that member when they filled
out their enrollment form had indicated male
or female, is how they would be included.
Indeterminant, if it is not in a specification
as in include indeterminant genders, it
wouldn't show up. And I'm sorry, it would
really pass that term. Here, she would not
show up.

DR. KINSINGER: A transgender
person who has transitioned from male to
female would, I would think, report themselves
as female.

MS. SAPSSEL: Yes. I mean, I
think it really just all depends how they fill
out that form, and we have no way -- you know,
we don't go out and verify what they have done
or how they have done that. But I also agree
with Sepheen that the impact would be very
small.

I just wanted to comment, Reva, on
your comment about optional -- or a question
about optional exclusions. We exclude anybody
we can, not as a matter of not wanting to
provide the care, but as of a denominator size
and truly being able to measure who needs that
service.

So if we have the information in
our clinical claims system of having a
mastectomy, then we would exclude those
members, and I think all plans -- I don't
know, Matt, if you know any different on that.

DR. WINKLER: Then perhaps is
optional really the right word to use here,
simply because it gives the sense of you get
to choose, and that sort of makes me feel that
standardization isn't optimal, but if it is
more a matter of we can if we can, I am not
sure that is the same thing as optional, I can
if I want to.

MS. SAMPSEL: That may be
something to talk to HEDIS policy about
general guidelines, because we will follow, we
will interpret the general guidelines.

Then EHRs -- you know, we have
really been trying to transfer data and pull
as much data as we can out of EHRs to simplify
the medical record abstraction, because for a
health plan, that is the most expensive part
of HEDIS abstraction.

Unfortunately, the percent of
physicians -- and I don't know, Amir, if you
know what that percent is, but over the years,
while it has been getting bigger, there is
still not enough physicians on EHR talking the
same language that we are able to convert to
that. So I think it is great we have the
specs, but --
DR. STANGE: Amir, in follow to Jackie, that is not a remnant. That is a current discussion. So you are next then.

MS. MERRILL: What are the implications if we were to vote no on this, because it seems like it is not ready for us to vote yes because of all this change that is going on.

DR. STANGE: After Amir, if there aren't other discussion, I will set up what the vote would be, and then we can discuss that.

MS. MERRILL: Okay.

DR. QASEEM: I just want to follow up on that, and I don't know. Maybe this is the measure where we may want to go through each separate rating. That might take too much time. I don't know, but just reading what you yourself are presenting in terms of evidence of high impact, it reads that mammography screening trials indicate breast cancer mortality is sufficient benefit, blah,
blah, blah. False positive rates are common in all age groups, leading to additional imaging and biopsies, and highest rate between 40 to 49.

I think we really need to keep that in mind when we vote on this measure in terms of where it currently stands and what it reads. The evidence that has been presented in there -- it is acknowledging that you should. But the measure is not really reading the way what it has been presenting.

If you look at the reliability and validity section as well, validity is completely missing, and again, as I said, I wasn't the reviewer for this measure, and maybe it needs to go back to the subgroup. But if you just read what is being presented versus what is being recommended there, they are not jiving right now, I think.

DR. STANGE: I guess this is such well plowed ground that I wonder if many people have really looked at this evidence
recently. So I am not sure that we are constrained by what is written down on the form as much as we are to make a broader decision within the larger context of how this will be interpreted.

If we were going to vote, one vote would be yes to approve as is or no. The intermediate vote would be to approve contingent upon a year period in which NCQA will really look at the two issues of reporting in a stratified way, and then looking at the upper age range to make it more congruent with the recent Task Force recommendations.

So that would be -- If we were going to vote now, that is what we could vote on. I wonder if, considering the political context, if that isn't the best we can do right now for all the totally true issues that Amir is raising about the risk-benefit ratio is lower in that age group. I don't think there is any doubt about that.
DR. QASEEM: Is it possible to do like what Sarah pointed out, something that WellPoint has done. There are folks who have done it in the 50 to 74 group. At 49 to 49 you want to know it, but it is not part of the measure. Is it something that can be -- Is it on the table or not, that we just leave 40 to 49 out of it?

DR. STANGE: In the current political climate, I think we need to think about unintended consequences of what if NQF said, no, we are taking the 40 to 49 off the table for reporting. What are the consequences of that in creating more noise, instead of staying at the table to really be in discussion about how do you handle this issue?

DR. QASEEM: No, we are not taking it off the table. What we are saying is we are acknowledging there is an issue with the evidence right now. That is what they are saying. It is not ready yet. I don't think
NQF is in the position to take a side on one way or the other.

If NQF goes with the 40 to 49, I think we are more likely to run into the problem that the Task Force and everyone -- some societies are saying not to do it. Others are saying you do it, and NQF is taking sides when there is controversial evidence, which we all acknowledge.

DR. WINKLER: Just in response to your question about what is or is not on the table, we aren't the measure developer. We have to accept what NCQA is doing. We have certainly heard what their plans are.

So it is vote on what we have got in front of us as is right now or, if you want to, the good faith contingent on all things they sound like they are planning to do within the next year. That would be your option, but in terms of breaking the measure apart and remaking the measure, no. That really is not something you can do.
DR. BURSTIN: I think the only other option, and Reva won't like this one, but I do this a lot, is if the measure is truly not ready, the other question is do we just defer and come back to it at a later date when it is ready.

This committee is going to be staying together through the next phase of work anyway, and just hold this measure in abeyance for a while. I just don't know that you can actually act on a whole lot of potential considerations and contingencies that we don't know are going to happen.

I almost rather would have us just say this measure is withdrawn until a later date when NCQA can provide more detail on the actual plan, and the committee can vote on the actual plan. Otherwise, I am just not sure -- If it is so uncertain, I don't know what to do.

MS. MERRILL: That seems like the most politically prudent approach.
DR. BURSTIN: And your timeline is you think January or early winter you would probably return to us?

MS. BYRON: We would say we would have a final result in May, because as we have noted, it is based on public comment. It is based on a multi-stakeholder expert panel review. So we can't even guaranty what would happen after we get all the feedback and go through the evidence and do our entire process for HEDIS measures.

DR. BURSTIN: Check with Elisa on timing. Does that work?

MS. MUNTHALI: That works. We could put it into the second phase in the fall.

DR. STANGE: Keith and then, Frank, I don't know how long your card was up that you just put down. If I am not seeing you, wave or something.

DR. LEONE: Oh, no, no. That is okay. I am satisfied with -- I had a
question, but it was satisfied.

DR. STANGE: Okay, thanks, Keith.

MR. MASON: I was just going to say, it sounds like they are going to put something to your members, though, in January, right? For comment. So what is that, and how would that be different than what you have in May?

MS. BYRON: I will just give a really quick rundown on our process. Our Committee on Performance Measurement is an external, multi-stakeholder panel with representatives from users, research, academia, all of that. They make the decisions about or recommendations to our Board of Directors about the HEDIS measures. They meet three times a year.

So as part of the HEDIS process, because it does go into our HEDIS publication for health plans, all the measures are -- They are presented by January in order to go to public comment in February and March.
So the process is that you would to this committee in January, recommend whatever we are going to recommend based on our review, based on our Measurement Advisory Panel input, based on input from numerous NCQA panels of experts, technical advisors, and then they would approve or not approve the measures in a certain fashion to go to public comment.

After public comment, we would have to process all the comments that we get from that and make a final recommendation based on input from numerous organizations, and take that to our committee in May. That is when the final decision gets made, and then it gets implemented into the HEDIS volume that is released in July that summer.

So that is how it works, and then health plans can start to implement it. So it is aligned with our HEDIS publication process, which is what health plans are using in order to change their measures.
DR. STANGE: So the most expedient thing to do, really, would be to table this, it sounds like. Any objection to doing that? You don't need a push from us. The things we have talked about doing, you are going to be doing anyway. That seems fine.

DR. BURSTIN: Really, you have heard the committee who is going to be reviewing this the next time. So it shouldn't be a surprise that the exact same issues will come up. So, hopefully, we will get resolution on the stratification of the upper age limit. I just think it is going to be -- It is a hard one either way, but I think in its current form it is, obviously, not going to pass today. So I don't want to have an artificial vote of no confidence.

DR. WINKLER: The next measure we are going to look at is -- We are going to go to measure 32, cervical cancer screening again. Sepheen, stick around.

This is again another NCQA HEDIS
measure, the percentage of women 21 to 64
gyears of age who received one or more PAP
smears to screen for cervical cancer.

This measure was assigned to Dr. Medows. She is not able to be with us today.
So I will try and kind of go through the
measure. Let me find it.

Again, this was evaluated by Work
Group members for cervical cancer screening.
Again, this is a measure for health plans, but
also it is specified for clinician use.
Again, it has the optional exclusions for
patients who have had a hysterectomy.

It is lined up with the U.S.
Preventive Services Task Force. Sepheen, did
you want to say anything? I'm sorry, I jumped
in.

MS. BYRON: No.

DR. WINKLER: Okay. The current
performance in commercial health plans is
about 77 percent, and for Medicaid plans
about 63 percent. Dr. Medows particularly was
interested in bringing up issues around potential disparities. This is the only way that the measure is stratified, is by the commercial versus Medicaid plans, but there is definitely a difference there.

The testing was done similarly to the other HEDIS measures for reliability and the similar face validity. So the methodology is really the same. Measures are audited for consistency and accuracy.

The feasibility is, again, administrative specs. This is another retooled measure for EHRs for meaningful use, and one question Dr. Medows has was: Okay, these are process measures. Is there any plan to tie them to outcome measures?

Any other comments from other Work Group members? I know, Sarah, Kurt, you both looked at this measure perhaps, Sarah, you have used it.

MS. SAMPSEL: It seems like looking at these over the weekend was so long
ago now. We do use this measure, and it is one of the measures that, actually, Angela Braly, the CEO of WellPoint, is very interested in, just because she is very interested in women's health, and so continue to track it.

Our measure results kind of track the same as the HEDIS results, and we really have no problem implementing this measure or have ever had, really, any strong concerns about the measure at all.

DR. STANGE: For me, it is a mom and apple pie thing. HPV vaccines are not going to change this during the rest of my professional career anyway, I think, and the optional exclusion of having a cervix seems like it is optional, because you might not always have data on that, I would guess.

DR. BURSTIN: A somewhat related question, but I agree with this measure as is. We have had discussions over the years with NCQA potentially about to kind of create some
overuse measures of the converse, of when it is not needed, to get at the issues of older women or increased frequency. Has that been considered at all or is it on the plate?

MS. BYRON: Right. NCQA has thought about doing overuse measures that are based on things like that or maybe C and D recommendations from the USPSTF, that sort of thing. That is something for the future. I am not sure what our immediate plans are for that, but right now this measure is --

DR. STANGE: Not formally, but just informally, that could really be helpful in a conversation around mammography and have something that is less controversial, the interaction for women's health, and you can say do less. You can be for women's health and be for doing less. That could really have a good unintended consequence or at least an indirect consequence.

MS. BYRON: Right, and we agree.

I think those could be important measures, but
we do look at this measure and see that the
rates could still significantly be improved,
especially for the Medicaid population. So we
think it is important to keep it.

DR. STANGE: Just to have the
other as part of the conversation would be --
Just to have a way to have it into the
conversation would be so helpful.

DR. WINKLER: Is there any plans
to further explore the disparities issue? You
break it down by Medicaid plans, but that is
a fairly gross division, and I think that the
interest and focus and priority on disparities
really is pushing us to want to do more than
that.

MS. BYRON: We do know a lot of
health plans that take HEDIS measures and
stratify them according to race, ethnicity
information or other sorts of sociodemographic
variables, if they have them.

The measure itself is simply you
got the cervical cancer screening or you
didn't, and the same with colorectal cancer screening or any of our other measures. We think it doesn't preclude plans from going further and using race, ethnicity information if they have it, and applying it and doing quality improvement analyses.

NCQA does have in its descriptive domain measures that look at race, ethnicity, diversity of membership, language diversity of membership, and it is our hope that they could apply those measures in conjunction with some of our effectiveness of care measures and look at disparities.

We also have -- This is outside of the measure's context, but just to give you some context, we have a multi-cultural health care distinction program that does just that. It talks about collecting race, ethnicity data. We know that this is difficult for plans. Even plans that have been doing it for a really long time probably only have about 25 percent data on race, ethnicity.
So we do see these as part of the greater context of work that they would do for quality improvement, and we do have different tools trying to push the field forward on this.

DR. WINKLER: Sarah, do you have any experience with WellPoint with that? Do you guys try and do that?

MS. SAMPSEL: Yes. I mean, not only -- You know, Sepheen's estimate was fairly accurate. We probably only have on our 34 million people where someone has filled out face and ethnicity information, so what is coming in from the actual member. But then our team is one of the groups that has won an NCQA award in that we are doing some predictive profiling, and this is one of the measures that we do that in order to know what kind of materials, resources, etcetera, that do we need to go out and do those member interventions.

So it is imperfect, and the way
our system works is based on a ZIP Code and surname and trying to predict if there is a -- and putting it through an algorithm to identify those folks.

We do have some bad hits out there, and people aren't always pleased with it, but the team has really done an incredible amount of work, and we are at least moving, and I know Kaiser has as well.

MR. STIEFEL: Yes. Our rates are much higher, but we also use, for those for which we don't have self-report data, the same geocoding algorithm, and it actually is quite effective to do the geocoding.

DR. STANGE: So this is an issue that transcends these measures. I have been trying to just push things forward, but can we take just a minute or two more on this now and just tell us a little bit more, Sepheen, on what you are doing to push the field forward.

We have reporting fields that people can have, but is there a way that you
have for people that they can aggregate
measures and say we are looking at disparities
in this way.

    Is there another way you can
report and get credit for actually having gone
the extra mile, rather than just you can do it
for any of the individual measures. Tell us
more about what you are doing to try to push
the field forward.

    MS. BYRON: NCQA launched, I
believe last year, a multi-cultural health
care distinction program. What this is, is a
set of standards that encourage plans to --
and really kind of shows a pathway toward
achieving quatro and linguistically
appropriate services.

    The first standard within that
looks at collection of race, ethnicity and
language information. The measures that we
have go hand in hand with this program, and
they are aligned with the Institute of
Medicine report on collecting date for race,
ethnicity and language.

So what we are trying to do is outline a standardized way that plans or anyone could collect this sort of information. It recommends the Office of Management and Budget categories for the race, ethnicity data, things like that, that were recommended in the IOM report.

So in a field where standardization was an issue, you will have people asking about ethnicity as a race category, for example, whereas the OMB recommends doing it two ways or asking it in two different ways, asking about race and then asking about ethnicity.

The HEDIS measure provides a cross-wall for, if you have done it as a two-question format versus a one-question format, you could combine the data, and you would report out the measure.

So those are some of the ways that we are trying to promote some consistency with
the way disparities -- with getting the data
to be able to run these analyses that could
tell you about disparities.

Then from there, there are health
plans, such as WellPoint and Kaiser, that have
been doing just that, using that information,
running it against the effectiveness of care
measures; and the multi-cultural health care
standards really blaze a path toward doing
that as well.

So it starts with data collection,
and then the lat standard says did you then
use these variables to run quality improvement
projects and, if so, you get some credit for
that.

So we really think that the best
way to look at this issue is probably not
through one individual measure, but really
through a program where measures are used
within the context of standards and procedures
that are recommended for doing quality
improvement analyses, doing it in a
standardized way, collecting the information
in a standardized way, and getting all the
tools that you need to be able to do
disparities analyses.

DR. STANGE: So there is no
reporting, though, about that. It is just the
next level, up to level 1, which is
collection. It is just that you use it to do
something internally.

MS. BYRON: For that particular
program, it is actually -- There is a
complicated -- or not complicated. There is
a series of standards that you get pointed to
based on, depending on how far you have gone
doing a whole myriad of things.

So it is actually not just the
data, but it is also things like did you look
at your provider network to see that you have
providers that might be able to deal -- speak
different languages or that sort of thing.
That is included.

It is did you do quality
improvement? So it goes beyond just data collection and really puts it into the context of all the different things that we think an organization could do to promote culturally and linguistically appropriate services.

DR. STANGE: So I apologize to the committee for delaying us, but is NQF doing anything; because we have heard that this is an issue for every measure. Is there anything larger that you are doing on that?

DR. BURSTIN: Robyn or Elisa, do you just want to mention what we are doing on disparities? You want me to do it? Okay.

So NQF does have a separate project -- Actually, Nicole is here. She is early. Do you want to just describe what we are doing on disparities?

MS. McELVEEN: Hi. I'm sorry, the question was to just briefly describe --

DR. BURSTIN: Describe what we are doing overall as it relates to the issues around stratification and disparities,
probably the work on the Commission paper and
what the committee is looking to do.

MS. McELVEEN: Sure. We have
recently convened a Disparities Steering
Committee. There are essentially two phases
happening in this project. The first is a
commissioned paper that is looking around
methodological issues related to disparities
measurement, such as implications around risk
adjustment and stratification, as well as
identifying criteria to select measures as
disparities sensitive within the NQF
portfolio.

Another component to that paper
includes information around public reporting,
and then the second phase to that is a
traditional consensus project around selecting
measures for disparities. That will happen
within the next month.

DR. BURSTIN: The paper was done
by Joe Bettencourt and a team at MGH. She
said it so well that maybe we should actually
share it with this group as well.

DR. NISHIMI: I was going to say that. I think the thing to keep in mind is this is just guidance, though. It is not like it is hard and fast things that the NQF policy is going to demand one way or another. So if people have thoughts on it, once they look at this paper, please share it with us.

DR. BURSTIN: So one of the key considerations going forward, Kurt, in terms of process is whether we will try to prospectively have a set of criteria. As people review a measure, you automatically say, as you probably would have for several of the ones we just talked about, this is a disparity sensitive measure; this measure should always be stratified. We can draft additional information on that.

DR. NISHIMI: We would like to get there, but we are not there yet.

DR. STANGE: Okay. Any comments on that discussion on the disparities, before
we move on to publicly voting on the cervical
cancer screening? Madeline?

DR. NAEGLE: Just the thought that
I had, which came up earlier when we were
looking at another measure is that we don't
think about vulnerable populations so much in
disparities, and I think that is something
that we do need to consider, that ethnicity
and minority correlate with vulnerability
some, but the group of sexual minorities that
Linda raised, very important, and also older
people.

In a number of the measures that
we have looked at, we see that there are not
significant numbers of older adults included
in our numerator or denominator. I think that
this is going to be a growing issue as the
population ages, and one that we come across
very often.

So I would like us to give some
thought also to vulnerable populations as part
of that disparities group.
DR. NAEGLE: I just have a quick comment or a question, and I hope it is appropriate. When you go forward to do this on a population or community level basis, BRFSS doesn't break it down in those age brackets. It is different. So it is something that Sarah's team is going to have to probably wrestle with.

DR. STANGE: Any further comments before we vote on the cervical cancer? Okay.

DR. WINKLER: Kristin, go ahead.

We are voting.

DR. STANGE: Twelve to nothing, Yes. Then we are moving on to the cervical cancer screening for high risk populations. Is that the next one?

DR. WINKLER: The next measure -- again, this was a measure that Dr. Medows had done a primary review on -- is measure 579. This is annual cervical cancer screening for high risk patients.

This measure identifies women ages...
12 to 65 diagnosed with cervical dysplasia -- 
that is CIN-2 and, I assume, 3 -- as well as 
cervical carcinoma in situ or HIV/AIDS prior to 
the measurement year who still have a cervix 
and who had cervical cancer screen during the 
measurement year.

This measure is brought to us from 
Resolution Health. Do we have anybody from 
Resolution Health on the line? I thought we 
did. Rufus, do we have anybody from 
Resolution Health on the line, do you know?

OPERATOR: If anyone would like to 
ask a question, please firmly press the * key.

DR. WINKLER: Is anybody from 
Resolution Health on the line?

OPERATOR: And if anyone from that 
organization is on line, please firmly press 
the *key followed by the digit 1.

DR. WINKLER: Elisa, have we heard 
anything from Resolution Health?

OPERATOR: And we do have two 
participants that are from Resolution Health.
The first is Allen Leavens.

DR. WINKLER: Great. Allen, can you hear us?

MR. LEAVENS: Yes. We were having trouble getting through.

DR. WINKLER: Great, thanks. Glad you could join us. I just introduced your measure 579, cervical cancer screening for high risk patients. Do you want to take just one or two minutes to briefly talk about the measure before we begin the discussion?

MR. LEAVENS: Sure. I will let Kevin start, and then I will fill in as needed. Kevin, are you on?

OPERATOR: One moment, please.

Mr. Bowman's line is now open.

MR. BOWMAN: Hi, can you hear me?

DR. WINKLER: Yes, thank you.

MR. BOWMAN: Excellent. So this measure is similar to the previous measure for NCQA cervical cancer screening, however with high risk individuals. The measure was first
introduced in 2004. It has been endorsed since 2008, and it is based on a specific outline from the American College of Obstetrics and Gynecology.

The guideline is women infected with HIV should have cervical cytology screening twice in the first year after diagnosis and annual thereafter. Also, women treated in the past for CAN-2, CAN-3 or cancer remain at risk for persistent or recurrent disease and should continue to be screened annually, so essentially going after the high risk, vulnerable populations on top of the typical cervical cancer screening in non-high risk patients.

DR. WINKLER: Again, this is a measure for Dr. Medows' lead, and I will try and step in as much as possible.

Again, this is a different population than general screening of the asymptomatic population. This is for folks who have particular high risk conditions,
particularly either abnormal PAP smear or
treatment in the past for dysplasia or CIS or
patients with HIV/AIDS. Those patients tend to
have a four to five times increases risk of
cervical dysplasia and invasive cancer
compared to the general population.

I believe what is not specified,
but I do see the codes for patients who have
undergone transplant, because they are
immunocompromised. They represent a higher
risk group.

This is a measure for all levels
of analysis based on primarily administrative
claims or electronic clinical data such in
EHR, and the current performance reported by
the folks from RHI is 78.5 percent.

The issue here is that, for the
general population, screening has been
recommended to lengthen for patients under 32
every two years. So it is no longer
recommended for annual screening for the
general population. However, for this
specific higher risk group, ACOG still recommends annual screening. Their evidence review of that is level B evidence.

So there is a little bit of a difference between the ACOG recommendation and the Task Force which basically says the evidence for more frequent screening is not as solid.

DR. BURSTIN: Although just one reminder, which Mary cautioned me as well, is that, just remember, the USPSTF does not make recommendations for high risk. So it is not conflicting. They just are silent on it.

DR. WINKLER: Correct. Yes, it is just that the developer did mention that in the submission. So I just wanted to point it out to you, that they didn't support increased cervical screening, including for those with high risk factors. But again, as both Mary and Helen have pointed out, that is really not their purview. They are looking at screening the general population.
ACOG, of course, is the American College of Obstetrics and Gynecology, and their recommendations are for annual screening for the high risk patients.

DR. QASEEM: They are in the process of revising that as well, and I don't know what they are going to say, but they are in the process of updating it.

DR. STANGE: Any further comments?

Any comments on this measure? Linda?

DR. KINSINGER: Including women who already have CIN-2 or 3, it doesn't seem to need any screening any longer. That is really management, follow-up, surveillance. I am confused as to why that group is included in this measure, because it is a screening measure.

DR. WINKLER: Can folks from RHI respond to that? Did you hear the question?

MR. BOWMAN: Yes. I think it is a fair statement. It would seem broad in terms of, I guess, the terminology, but --
DR. WINKLER: We can hardly hear you. Can you speak a little louder?

MR. BOWMAN: Sure. It is a fair statement in terms of if we are talking about the specifics of the terminology in terms of screening, but essentially this population has high risk factors that we are just trying to include a broader group.

We could essentially take out that one population, if we are trying to put them in another measure that is looking at surveillance specifically, follow-up surveillance, but if we are trying to be comprehensive and include all the high risk populations, we felt it was appropriate to keep them in this measure.

DR. STANGE: I think that is a reasonable point definitionally, but as far as a quality measure, I think it kind of nice to have it in there. It seems to be a nice balance. So it makes a lot of sense to go up on the interval for the general population,
but then, really, this is a way of balancing it.

Definitionally, you could put that as a separate quality measure, if you want to make this purely prevention, but if it is an overall quality measure, then this is an expedient way to do it, it seems to me.

DR. WINKLER: Is the question really about using the term screening as opposed to perhaps something else could be used?

DR. STANGE: You could just add follow-up in the cervical cancer screening and follow-up.

DR. KINSINGER: For women with HIV, it really is screening. For the other women, it is not. So maybe it is screening/something, follow-up. I don't know. So it may be just semantics.

DR. STANGE: Matt, is your card up for this?

MR. STIEFEL: Yes. KP's guideline
here is a little different. It is more nuanced. It is all -- They are consensus based. There is not a strong body of evidence supporting that nuance, but I can tell you what KP's nuance is here, if it is useful. I am not expert in this, but this is from our National Clinical lead for prevention. I am going to read it.

"For immunosuppressed or HIV positive women, cytology and HPV testing are recommended six months following treatment per se in two or three, and again at 24 months with colposcopy for any positive result. Routine screening every three years can then be resumed indefinitely. For immunosuppressed or HIV positive women, if HPV testing is not done, two cytology tests at six and 12 months after treatment per se, and two or three recommended with colposcopy for any positive result, then annual cytologic screening indefinitely." And in the third part, at least cytology with or without HPV testing is
recommended for women who are immunosuppressed
or HIV positive.

So it is a more nuanced stratification of the population.

DR. STANGE: That is closer to what I do, actually, clinically, but is that --
-- Are you okay with this one for the quality measure?

MR. STIEFEL: Well, the problem is the goal or recommendation of annual indefinitely is more aggressive than what we do.

DR. WINKLER: Actually, in the ACOG writing, it says for 20 years. So indefinite does have an end, but not short term.

DR. BURSTIN: Amir, do you know the timing of the update of the guidelines on which this is based?

DR. QASEEM: You know, I honestly don't know, but I think they are working with, actually, the American Cancer Society right
now, and my understanding is probably like a few months.

What is their age range when they say go in high risk in ACOG guidelines?

DR. WINKLER: I don't believe they have an age range, because it is based on the diagnosis. It is diagnosis of dysplasia or cancer, diagnosis of HIV or transplant. So it is age independent.

DR. STANGE: Is there something more helpful we could do than vote yea or nay on this, given the evolution of what is going on? Matt?

MR. STIEFEL: Could I just ask the developers if they reviewed and considered this stratification or if the recommendation is based on a more just generic world for this population?

DR. STANGE: So did developers hear Matt's question, and after you respond if you could turn your Mute on. For the developers, that will help us in the room.
MR. BOWMAN: I'm sorry. I had a little trouble understanding the question.

MR. STIEFEL: I just read KP's version of this guideline which stratifies the population to include for subsets three-year screening, if other conditions are met, and I curious if you -- I don't know if you heard what those exclusions were or the stratification, if you considered that or not.

MR. BOWMAN: We did consider it, but again relying on the ACOG guidelines, they indicated that the annual screening was indicated, and we did see the 20-year time frame for HIVAIDS. However, given the populations that we are analyzing, we would not have the ability to have the data to look back to see when an initial diagnosis first occurred. So to limit it to 20 years would not be practical for the measure.

DR. QASEEM: Just quick, to what Helen asked. Could we ask these folks? Maybe they know when the guidelines are going to
come out?

DR. WINKLER: To our developers, are you familiar with the fact that ACOG is updating their guidelines, and do you have a time frame for that?

MR. BOWMAN: I am not certain of the time frame. We know the last update was 2009. However, I am not certain when the next -- the latest guideline update is to come out. However, we certainly follow those releases, and would be prepared to update the measure, should their recommendation change.

DR. QASEEM: Would it be something feasible that -- and I don't know what other options, maybe approve or whatever, but based on -- If something is going to come out soon, maybe we can -- This is for three years or something. It is not going to make sense that we approve something, and it is going to be changing.

DR. BURSTIN: Agreed. I think we may just want to table this until we get the
information.

DR. WINKLER: We will find that information out and see what the time frame is from ACOG, and we can get back to you.

DR. STANGE: Any objection to that? Okay, so it is tabled.

DR. BURSTIN: And, actually, it would be helpful if you could also send in that information, Matt. I assume it will have some additional references that might be helpful for the committee to take a look at.

For the developer on the phone from RHI, I think our feeling is we would like to find out the timing of the ACOG update. So I think we are going to table a decision on this measure for today. Any concerns about that?

MR. BOWMAN: No, that sounds fine.

DR. BURSTIN: Okay, thank you.

DR. STANGE: So looking at the schedule here, we have done phenomenal catch-up work. What I would like to ask the group -
- We have three measures on our morning agenda. It is 11:20 now. Do people need another quick break or do you want to try to forge ahead and get these three done and, if we get them done quickly, then take an early break for lunch maybe, if that doesn't mess up the phone thing, and then if we keep forging ahead, save a little time at the end for some more discussion about next steps or the bigger picture thing.

So anybody need a break now?

Okay. So it's forge ahead. So I guess the next one is osteoporosis in older women. So that is number 37.

DR. WINKLER: The next measure is 37, osteoporosis testing in older women, again from NCQA. This is the percentage of female patients aged 65 and older who reported receiving a bone density test to check for osteoporosis.

This measure -- Who is our reviewer?

Oh, it is Kurt. Okay. And again, Sepheen is
here.

MS. BYRON: I just want to check. Judy Ng, are you on the phone? We have someone calling in from NCQA as well.

DR. NG: I am on the phone.

MS. BYRON: Great. It is really low. I wonder if you can speak a little louder. Judy?

DR. NG: Yes.

MS. BYRON: Oh, that is better.

Okay, great.

All right. So this is the osteoporosis measure. Again, it is in a HEDIS measurement set, and Judy, did you want to add a little description of this?

DR. NG: Sure. This measure -- It comes from a survey, the Medicare Health Outcomes Survey, which is a health status survey administered to random sample Medicare beneficiaries and health plans every year.

This particular question in the survey assesses female members aged 65 and
older who responded affirmatively, yes, to a question in the survey asking if they have ever had a bone density test to check for osteoporosis, and the question says that this test is also thought of as the brittle bones, and the test could have been done to the person's back, hip, wrist, heel or finger.

DR. STANGE: I will step in as the person from the committee who looked at this. The only two issues I had: I just had a question of why this is a self-report measure. It just seems like it would be incredibly easy to do with administrative data, and reduce the reporting burden.

Then the other thing is from my reading of this Saturday New York Times, in the Business section, the front page talks about two FDA Advisory Panels.

I was looking at the names, but the one on women's health and the one more specifically on this have actually raised questions about the long term safety and
efficacy of the major treatment, once you identify this screening, which would be bisphosphonate therapy, and saying there is really no evidence of the long term effects of this for safety, and no significant advantage of continuing it beyond five years.

There has been some problems with weird femur fractures for women without trauma, just standing around, and their femur breaks, which could be pretty disconcerting, and then rare osteonecrosis of the jaw, which is still rare, but a big problem.

So the screening looks effective. It is low rates, but what do you do about it, now that we are not doing estrogens very much for this purpose is actually a little bit in question. So that was the only issue I would raise.

There is just uncertainty. The bisphosphonates have been around a short enough time that we don't actually have long term efficacy or safety data, but there are
just some concerns emerging. Sarah?

    MS. SAMPSEL: Hey, Judy, it is

Sarah Sampsel. This measure is currently one
of the Medicare stars measures as well. So a
plan's performance is being measured and,
obviously, we are receiving some payment on
them if we perform appropriately. But
Medicare is putting out for public comment
removing the measure from the star program.

    Have there been discussions with
CMS on if it is just while the GMAP is
reviewing the measure or, you know, what
really is the status on this measure, also
included in stars, and do you have any other
insight behind CMS' rationale for removing it?

    DR. NG: I think possibly what
that might be -- and this is not just specific
to this measure, but as I said, because this
measure comes from a specific health outcomes
survey, CMS is thinking of revamping the
survey and possibly making some changes to it.

Of course, that would directly affect any of
the measures in there, including this one.

So that might be part of the
larger context behind what you are hearing in
terms of this measure possibly being removed
or possibly being updated or changed.

DR. STANGE: Why would it be
removed?

DR. NG: I can't speak directly to
that, but again I think it is connected to
this idea that CMS wants to update the Health
Outcomes Survey in the future, and since this
question is in the survey, there is a
possibility that there might be changes to it,
and one of those changes could be removal.

DR. STANGE: Just also, why is
this a self-report measure?

DR. NG: This is one of those
measures that, I believe, when it was first
formulated some years ago and added to the
survey, the idea was that osteoporosis in
general was a condition that was undertreated,
derunder-discussed, under-managed, and with the
USPSTF Guidelines that every woman 65 and older should have some kind of bone mineral density test, this measure was trying to get at how well the plans were even addressing this topic in any sense.

Since plans don't have -- You know, because the USPSTF Guidelines don't put in a specific interval for frequency for screening, I think what this measure did was it also went along with it and just want to see, if you are 65 and older, did you at least have a test at anytime.

A person in a health plan can change plans and, therefore, it is not -- If they change plans and whatever plan they are currently in when the survey is administered would not be able to capture through just administrative if the person had a screening before.

DR. STANGE: That makes perfect sense. So is the amount of uncertainty about the context around this such that this should
be deferred to?

DR. NG: Well, at the moment I don't think CMS has direct intention to remove this measure. My only -- My guesstimate for why someone may have heard that is possibly because it is connected to CMS plans to possibly update the survey as a whole, but I have not -- You know, with working with the GMAP, with some of our technical advisory groups, and working directly with the Health Outcomes Survey team at CMS, we have not heard any single person say directly that they want to remove this particular measure.

They do want to update the survey and make it more effective which, of course, could introduce changes, but I have not heard anyone say directly that this measure should be removed. And because we are working with them in the coming year to help guide them on some of these changes they want, this is something I can easily bring to their attention as well, that this is a -- It seems...
the general feeling is people may not want this measure to be removed from the survey.

DR. STANGE: So we will have Mary follow up on that, and then Jackie and then Matt.

MS. BARTON: I think the extraordinarily rare side effects of one of the medications that is used to treat a condition is not necessarily a compelling argument to remove a screening measure.

So I think that, when looking at the question of what can be done to protect the health of women over the age of 65, the idea that preventing potentially daily function affecting fractures like a hip fracture or spinal fractures is still relatively high in the priority list of most clinicians who take care of women in this age group.

So I think, given the fact that exercise, calcium, calcitonin perhaps -- you know, another set of things are also effective
and could be effective, or even estrogen, in
helping people to maintain their bone density
and to prevent those sometimes life changing
fracture events -- I actually think that the
gestalt evidence for supporting continued work
in improving plans' improvement in this area
is absolutely intact, notwithstanding the
FDA's concerns about those bisphosphonates.

DR. STANGE: Thank you. I was
kind of scanning for any possible concerns,
but what I said about it was very unbalanced,
and thank you for balancing that. Jackie?

MS. MERRILL: That was really my
comment. You don't screen if you can't treat,
but you are right. There are other
alternatives. It is just the idea that, if it
is going to be removed from the CMS survey,
the plans can still independently ask for it
using this measure. So that is a reason to --
you wouldn't do it?

MS. SAMPSEL: So plans -- You
know, if we have a Medicare Advantage -- If a
plan administers a Medicare Advantage plan, the Health Outcomes Survey is one of those quality measures for that Health Outcomes survey.

If this measure is removed from that survey, we really don't have incentive to continue -- You know, surveys are incredibly expensive and a high burden. The information we had, Judy, was actually from CMS that they are considering removing this, and they are not really even talking about in their materials changes to the HOS. They are considering dropping this particular measure from stars ratings.

So I guess what I would encourage NCQA to do is, even though you work with the HOS group, is that HOS group working with the stars group, because we do know CMS is a pretty -- let's just call it a large organization, and there may be some communication issues, because the communication we have as a plan is we may no
longer be incentivized to be tracking this measure.

DR. NG: Okay. I know that the HOS team within CMS is reaching a lot more to the stars team. So I think there will be a lot more improved communication in the future, and that is a great point to bring up.

DR. WINKLER: Just a question. This measure is based on survey, and the whole question around here is the ongoing use of this measure within surveys. Previously NQF has endorsed a measure that came from NCQA, measure 46 which is osteoporosis screening or therapy for women age 65 years and older and who have had a -- those patients who have had a central dexa measurement ordered or performed at least since age 60 or a pharmacologic therapy prescribed within 12 months.

This is based much more on the traditional medical records and is not a survey. However, apparently, they have kind

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of -- We didn't get a full submission for
maintenance review, and so this is sort of an
alternative way of measuring this kind of
process of care.

So, Sepheen, did you want to
comment on that, because we weren't able to
bring it to the committee, because you all
said you weren't ready or able to submit it to
us at this point in time. What is going on
with that measure?

MS. BYRON: I will ask Judy to
fill in, if she has anything, but there are
actually two separate measures. So one is the
survey measure that is in -- and as Judy
described, and the other one is the health
plan measure. Judy, do you know what the back
conversations might have been around that?

DR. NG: I am not completely
certain, but I think the other measure you are
referring to may possibly be -- I don't know
if that is the osteoporosis management in
women who have had a fracture measure. If so,
that is another measure of ours that sort of tracks women who have already had a fracture, and that gets more at whether or not they had a bone mineral density test or some kind of drug to treat that fracture.

What that measure gets at, really, is how well plans are managing women who have already had a fracture and, therefore, are at a much higher risk for a second fracture or additional fractures.

That measure intent is a little bit different from this one that is in the survey.

MS. BYRON: Judy, this was a measure that was presented to the CPM yesterday?

DR. NG: That is correct.

MS. BYRON: So it could have been that, at the time of submission we --

MS. BARTON: I think the bar to bring things to this committee was population measures, things that were relevant to the
general population, which, clearly, the
osteoporosis screening for all women 65 and
older fit, and I believe that probably the
thinking was that a measure that asks health
plans to document that they treated the people
who they found an abnormality in is completely
and squarely outside of the population health
agenda.

DR. WINKLER: But that wasn't the
measure we are talking about. This is
screening for patients that either had the
dexa or not, because they were already on
therapy, which is not about treatment.

MS. MERRILL: But anyway,
assurance is part of public health mandate.
So it is within the purview.

DR. WINKLER: I think that we can
talk further with NCQA and see what the issue
around that measure is, but --

DR. BURSTIN: That is 49?

DR. WINKLER: It is 46.

DR. BURSTIN: Forty-six was -- I
thought that was what this one was. That is not what this one is? Okay.

DR. STANGE: So then, if there are two measures that the main difference is the measure data collection, does that mean that plans can choose which one they do? Is that the advantage for having two measures?

DR. NG: Actually, if it is the measure I just described, the measure actually -- They are two different data collections, but they are actually quite different in that one of the measures, the survey measure we are talking about today, targets all women age 65 and older, asking them about screening.

The other measure really targets women who already have had a fracture. A risky event happened to them, and that one really gets at how well that plan is managing these women who, because of the fracture, are at additional risk for a second fracture. That measure gets more at did you treat them in some way, either with the MD test to
monitor or for other purposes or with drugs.

DR. WINKLER: We are not talking about the post-fracture measure. There is another NCQA measure that has been through NQF, and I just handed it to Mary, the title and the description. Maybe she can comment on it.

MS. BARTON: We will go back and figure this out, because it was endorsed in 2007, and I am not aware of why it was not submitted this time.

DR. STANGE: And welcome to your new job, Mary, one week into the job. So does this mean we need to table it? I think we have had some assurance about the patient report measure but not enough that we wouldn't approve it. So it is only this context that is the issue, it sounds like.

MR. STIEFEL: This is the only other one where the KP guideline is a little different and based on shared decision making. Again, I am not expert in it, but from our
national clinical lead it is, while we recommend screening, it is with shared decision making with a member and a calculation of the frax score to determine ten-year risk, and giving the decision to the member.

MS. MERRILL: I feel very uncomfortable about the three measures, and I feel very uncomfortable about moving measures forward that seem to have controversy involved with whether they are needed or not. So that is what I think.

DR. STANGE: I would like to -- Since I am the one who maybe brought the controversy up, I really think that Mary's view of that was much more balanced than mine. I really brought up some -- I think her characterization that these side effects is very rare compared to how incredibly common osteoporosis and fractures from that are. I think that is how we should look at this.
MS. MERRILL: Part of it is that the data is being captured in another way that has less burden, which is it is included in that second measure, you know, people screened and treated.

DR. STANGE: I think that is the bigger issue. That is the uncertainty that we have, is that there is another measure that captures the data in a different way, and that it is really -- Seems to me, that is the difference in reporting burden. Do you capture the people that got it elsewhere and self-report or do you capture that through the data from the health plan where that is reported through the health data. It almost is an exclusion criteria.

It sounds like it would be helpful to NCQA, if we think this is a measure that meets the importance and evidence and usability criteria, to move it forward. There is a reconciliation issue about this and another recommendation that has a different
data collection.

DR. BURSTIN: And also this question of whether it is going to continue to be collected which, I think, is kind of an important issue.

DR. STANGE: So from your point of view --

DR. BURSTIN: To allow us to have more time to figure out the differences between the measures, because I do think there is a survey measure and, if the other one is not survey based, we need to understand.

MS. BYRON: Right. I am looking at this, and it is a clinician level measure, and I wonder -- I am not certain, but we have a lot of measures that we had submitted as physician level a long time ago, and that was before we were able to check different levels of measurement based on one measure.

So sometimes we have got measures that are physician level and then that are health plan level, and they are both NQF
endorsed. Some are used in the PQRS. Some are used -- which is the Physician Quality Reporting System for CMS.

We did develop a whole host of measures when that program was launched by CMS, so that physicians would be able to report on quality measures, and they were -- Most of them were based on HEDIS measures.

So we will talk offline and make sure that we are certain about what happened here.

DR. STANGE: So we will defer this then until you can bring it to us in a consolidated way, and I would guess that we are going to have some of the same issues about the steroid use that have become some population of high risk steroid use. So we should probably defer that.

DR. BURSTIN: That is another NCQA measure.

DR. STANGE: But I just sense that, since we are going to want to look at
the whole package, we should probably defer
that, too.

MS. MERRILL: Isn't that your
goal, is to try to look at groups of measures
together and try to see what is redundant,
what is creating burden, and what is
unnecessary?

You know, this is the first time I
have been at this meeting, and I have to say,
it is bewildering, and it also seems like
there is a lot of -- I'm searching for the
word, but there is some sort of like
redundancy, and the different competing
interests are at play.

DR. STANGE: That is a big agenda,
clearly.

So the last one then we will try
to get done before our lunch break is the
screening for the American Automotive
Association -- I mean for abdominal aortic
aneurism.

MR. MASON: So on the other
osteoporosis one, if someone is on the phone, they should be told they can get off the phone. Right?

DR. WINKLER: They are the measure developer for this coming up measure, too. So, hopefully -- Are the folks from Active Health on the line? Who are we expecting? Rufus, is anybody from Active Health on the line?

OPERATOR: That was Active Health?

DR. WINKLER: Correct.

OPERATOR: And we have Sarah Lackner on line.

DR. WINKLER: Okay, great. Did you hear the discussion about the osteoporosis steroid use measure?

DR. VIR: Yes, we did.

DR. WINKLER: Great. Okay. So we are moving on to measure 629, male smokers or family history of --

DR. VIR: Can I ask a question before you go on? In terms of the
osteoporosis steroid, was there anything specific that you wanted us to address?

DR. WINKLER: No. I think we want to be able to look at all measures addressing osteoporosis together as a group, and there are questions about some of the other measures.

DR. VIR: Okay. Yes, thank you. And you will let us know when that will be?

DR. WINKLER: Yes.

DR. VIR: All right. Thank you very much.

OPERATOR: And we also have Lindee Chin on line.

DR. WINKLER: Great. Thanks, guys. Let me just introduce the measure.

This is male smokers or family history of abdominal aortic aneurism - screening for AAA, percentage of men age 65 to 75 years with history of tobacco use or men age 60 years and older with a family history of abdominal aortic aneurism who are screened
for aortic abdominal aneurism.

This measure is from Active Health, and our developers, did you want to just say one or two sentences to introduce your measure before we begin discussion?

DR. VIR: Yes. Can you hear me?

DR. STANGE: Yes.

DR. VIR: This is Dr. Bani Vir. I am one of the medical directors with Active Health on the clinical research and development team. We just wanted to say good morning and thank you for reviewing our measure and giving us this opportunity.

This measure is directed toward male smokers or men with a family history of abdominal aortic aneurism to consider screening for AAA. It addresses men ages 65 to 75 with a history of tobacco use or men age 60 and older with a family history of abdominal aortic aneurism, and measures whether or not they have been screened for AAA.
DR. WINKLER: Sarah, I believe you are our reviewer for this.

DR. VIR: I'm sorry. It is difficult to hear you.

DR. WINKLER: I was talking to a committee member, to Sarah Sampsel.

MS. SAMPSEL: On this measure, as the form was completed, I think there are a few things to bring to the Steering committee's attention.

One would be consideration of actual impact, and while there is a USPSTF recommendation for part of this population, not the full population in the measure, from my reading, as well as, you know, it is four to eight percent of older men and a half-percent to one and a half percent of older women.

So in thinking about importance, does this meet the importance criteria would be one consideration. I don't know how large all of Active Health's population is for the
field results, but there was only

identification of about 3,000 members.

I also think there are some, I
guess, feasibility issues or scientific
acceptance issues having to do with

identification of this population through

whatever mechanism. Smoking is one thing, but

history of -- or family history of something

else that is very difficult to administer,

depending on who it is.

I don't even think a medical

record would provide that information a good

portion of the time, but I could be wrong.

So, really, in my review, while I
do think there is evident support for the

measure, thinking about overall impact and

need for the measure as well as some of the

feasibility issues in deployment would be a

concern of mine.

DR. BURSTIN: One point of

clarification: Under the impact criteria, it

is not just purely numbers. It is also the
severity and the impact. So I think just in this case small numbers, high impact in terms of ruptured AAA would have been reasonable. Nothing about the evidence per se.

DR. VIR: I just want to mention that our initial data was test data and, since then, we have had a run on a total population of over 13 million lives, and from that we found over 31,000 people falling into the denominator, and only about 18,000 people fall into the numerator, which shows a compliance of about 57 percent on this particular measure.

DR. STANGE: Any comment on the feasibility issues of the data collection of family history? That does strike me as something that is not reliably available from medical records.

DR. VIR: Right. We get most of our family history information through direct patient derived data that is collected from discussions with nurses in our Duties.
Management Program, as well as from our personal health record.

DR. BURSTIN: So this came through a project, actually, Reva led a couple of years ago on clinically enriched claims based measures. So they actually -- This was a clinically enriched measure that could pull in data from THE, CHRs as needed.

DR. VIR: Correct.

DR. QASEEM: I think Sarah brought up a really important point about family history, and I am not going to go into that. One thing I wasn't really -- I think we all agree, the mortality benefit is there between 65 and 75 for one-time screening. Repeat screening has no benefit. Right? At least in my opinion, the repeat screening, once it comes up negative, it does not have shown any impact on mortality.

I am not really sure if that is being captured over here, because the numerator statement, the way it reads right
now says men who have had AAA screening. But I think we need to be a little bit careful. WE cannot keep on screening for folks for AAA once come out negative, and I am seeing a little bit limitation, aside from the history, the way it is currently written.

DR. VIR: We only look for the screening to be done once, and then it is considered complete.

DR. STANGE: So that would be clarified by 2.a.1.1. Instead of having men who have had AAA screening, men who had one-time AAA screening?

DR. VIR: Yes. When it comes to screening, with the way that our rules around this particular measure are built, you can maybe see. We submitted all of our code sets that we use to capture the information to complete this measure.

It is only one time, and then it is considered complete. That is built into our rule.
DR. STANGE: I think Amir is just looking at unintended consequence of over-screening. If you just make it clear to people -- No, it is nothing about what you are doing. It is just communicating it.

DR. VIR: Sure.

MS. SAMPSEL: I think in 2.a.1.2 it says anytime in the past. So maybe it just needs to say one time in the past or at least once. I don't know.

DR. VIR: We can certainly change that, if that would --

DR. STANGE: Linda.

DR. KINSINGER: We have thought about this issue a lot for the VA, because, obviously, this is -- You know, this is where the studies were done. This is the population that this applies to.

The issue we have run up is that many men have had abdominal CTs for other reasons. Sometimes the abdominal aorta diameter is read. Sometimes it is not, but if
they had a stand on where the diameter was read, there is no reason to put them through another screening test of an ultrasound, but it is inconsistent.

Then we developed some guidance from our radiologist to be sure to always read the aortic diameter, if they can, when a study is done for any reason. But this measure doesn't pick up any of that. So it might encourage people who have essentially functionally had a screening test done, but it wouldn't be counted that way, and so they would have to go back and have an ultrasound done.

DR. VIR: Actually, if you look at our numerator details, we allow for completion. If you have had a CT scan, an ultrasound, any sort of imaging that would capture abdominal aortic size, you are considered complete.

DR. STANGE: That makes sense to me. It is hard to imagine a radiologist not
commenting on any risk greater than six centimeters on an abdominal CT scan.

DR. KINSINGER: Well, but it is three.

DR. STANGE: It's three, really?

DR. KINSINGER: Yes, it's three. I mean, that is the -- The cut point is 3 centimeters, and they may or may not comment on -- particularly, if it is less than three, they may not comment that it is less than three. They may not say anything about it.

DR. STANGE: Right. But it is really an issue of if it would be missed. So do you think it is not true that a radiologist wouldn't call something that was -- In my experience, they mostly over-call things.

DR. KINSINGER: It is just that, if it was normal and not stated, then it wouldn't show up. It would appear as if it had not been done, when in fact it had been done.

DR. STANGE: But, no, here for
this quality measure, if you had a CT scan, it is assumed. The abdomen is assumed. You are positive for having had the screening test done. I mean, they don't go and look to see whether it has been called out.

DR. VIR: That is right. They only look that the study was done. We don't look for the fact that the radiologist has put in a reading for the exact centimeter size or diameter size. We are assuming -- and, you know, from a clinician standpoint, I have never found in my years of practice that a radiologist does not comment on an aneurism that he sees. So we consider it complete if they have had the study alone.

DR. KINSINGER: Our radiologist -- The chief of radiology was concerned that, unless it was specifically commented on, you couldn't -- He was uncomfortable assuming that it had been evaluated and read. I don't know whether he actually pulled data on it, but that was his strong feeling, was that is an
assumption he as not comfortable making.

        DR. VIR: I understood. We hope that we will -- In our situation, we would like to give the physicians and people being measured on this particular performance measure -- we would like to give them the benefit of the doubt and allow for credit to be given where it is due.

        Sometimes the diameter is not always in data that is capturable. So we do give credit if you have ordered the study and done the study.

        MS. MERRILL: Where is that described? I don't see it.

        DR. VIR: I'm sorry?

        MS. MERRILL: Where is that located?

        DR. VIR: Where is what located, the imaging study?

        MS. MERRILL: In the documents.

        DR. VIR: In the numerator details, Section 2.a.1.3.
DR. STANGE: So, Linda -- Let's let Linda look at that and think about whether that is a fatal flaw from your point of view or whether for a screening measure that is giving them credit for having had a CT scan done once is adequate.

While Linda is doing that, are there other issues people want to bring up in anticipation of a vote on this?

DR. KINSINGER: Does an ultrasound for gallstones count?

DR. VIR: I don't believe that it has to be an ultrasound specifically on the aorta.

DR. KINSINGER: So what is the definition of abdominal imaging procedure?

DR. VIR: That is one of our codes that specifies -- That element particularly specifies only certain codes that would be specific for a AAA. It wouldn't count all types of abdominal ultrasound. That would be an add-on within this element that we have not
-- we didn't break it out for you here, but it is in the element.

DR. WINKLER: Apparently, there is a set of codes that go with that, and if it is important to you, we will be sure we get it added in.

DR. STANGE: Linda, would you be - - It is an important issue that you are raising. Would you be okay with us voting on it, on this contingent that you are looking at that and seeing that it is not underreporting like counting -- I personally would be willing to think that, if you had an abdominal CT scan reported, that is probably for screening purposes adequate. But I would totally agree with you that gall bladder ultrasound I wouldn't count, be confident that a radiologist would pick that up. But would you be willing to have us vote on this, contingent on your looking at that in more detail and, if you think it is inadequate, then we will bring it back to the group?
DR. BURSTIN: I think it is actually up to the developer to tell us whether or not write-up or quadrant ultrasounds are included or not. I mean, because you order those differently. They wouldn't capture the aorta.

DR. VIR: That is right, and we could certainly provide the components of this element for you.

DR. BURSTIN: I'm sorry. We couldn't hear you.

DR. VIR: I said we could certainly provide the components that make up this element, the various studies for this particular element, if you are interested in ruling out the fact that a gall bladder study or something that is nonspecific could be in there. We could certainly do that for you.

DR. WINKLER: Because it is part of the specifications, we really do need to have that level of detail for people.

DR. VIR: Sure.
DR. STANGE: Would you be okay with us voting with that contingency, Linda? You have the power to pull back the vote.

DR. KINSINGER: Yes.

DR. STANGE: Any other comments before we vote? So vote yes or no, with Linda said, whoa, that numerator measure is inadequate.

DR. WINKLER: All right. It is nine Yes and three No. But we will need the details of those code lists to include in this document so everybody, all the audiences, will have the opportunity to see that.

DR. STANGE: And Linda is a subcommittee of one to look at that and, if you think that is inadequate, I guess then we will table it and bring it back to the next consideration.

MS. SAMPSEL: Can I make another request, and I guess it is of Active Health, because the other -- and I guess the question first, though, is to NQF.
On the steroid use osteoporosis screening form, I don't think there was any data in there on what testing results or what has been deployed, and from this conversation it sounds like there may be more data on some measures. I think, if that is being tabled, it would be nice to see some actual data out of the databases.

DR. WINKLER: Did the folks from Active Health hear that comment?

DR. VIR: Yes, and we are working on getting that data.

DR. WINKLER: Thank you.

DR. VIR: Then as far as the code sets go for the details, will we receive any sort of information about who to send that to or should we just send it --

DR. WINKLER: We will send you a prompt, but certainly, anything about the project can be sent to Elisa.

DR. VIR: Great. Thank you.

DR. STANGE: So, Rufus, could you
open it up for public comment on any of the
last three measures we have talked about?

OPERATOR: And again, if you would
like to ask a question, please formally press
the * key followed the digit 1.

We have no questions on our roster
at this time.

DR. STANGE: From in the room,
Mark is going to come up and give us a
comment.

DR. ANTMAN: Yes, thank you. I
have had the opportunity since the discussion
of measure 41 a little bit earlier to confer
with our clinical experts, the PCPI's clinical
experts for preventive care, and quite
frankly, they are uncomfortable with making a
quick decision on the committee's
recommendation for complete harmonization with
the standard time frame recommended by the NQF
for immunization measures.

So I am wondering -- With the
committee's indulgence, I wonder if I may ask.
So our plan is to go back to our full Work Group and ask for them to carefully consider, number one, willingness to simply revise our measure to match the NQF recommended time frame of October 1 to March 31st for the influenza immunization measure, or if they feel that there is a strong reason to not match that time frame, to modify our measure as it is currently specified to try to harmonize more closely, but not necessarily match that time frame exactly, because there is a -- The co-chairs have expressed to me a point of view that there is good reason to, and there was a good reason for the Work Group to advocate for the February 28th end time. But we are -- The co-chairs and I are hesitant to give you a firm conclusion on that without going back to the full Work Group.

So my request, and I will try to be quick about it, is that if you would be willing to take a fresh look at the measure and look at the other -- whether or not the
measure met the other criteria for potential endorsement and, contingent on our coming back to you with a conclusion on our further discussion with the Work Group, we would greatly appreciate that, but rather than simply move ahead with a non-recommendation of the measure based, as I understand it, on quite simply that one disharmony with NQF recommendations.

DR. WINKLER: Mark, the other issue, I think, was the handling of the exclusions. The way it is presented, it really looks like the exclusions are in the denominator, and that did not match up either.

DR. ANTMAN: I'm sorry. Thank you. So is this the time for more detailed discussion of that or -- I know that you are up against the lunch hour, and I don't want to disrupt your agenda.

DR. STANGE: It makes perfect sense that holding a gun to your head and say get us an answer on that in the next few
minutes doesn't make sense. I mean, you need
to go back to your group. So I think that is
why we tabled it, so you have time to really
do that.

DR. ANTMAN: So by all means. So,
Reva, thank you for that reminder. By all
means, we can take that second issue back to
the group as well.

DR. BURSTIN: And, actually, as
long as we have a few minutes, if Amir or
Linda or anybody else wanted to make specific
comments that Mark could take back to the Work
Group, this would actually, I think, be time
well spent.

MS. MERRILL: Was the Work Group
involved in the development of the NQF
harmonization standards? They were not
included in the Work Group? I mean, is there
any reason to petition this group to modify
standards?

In other words, if your group
feels so strongly that the date should be
February 28th, why wouldn't other people feel the date should be February 28th?

MR. ANTMAN: Again, there was a strong point of view in the Work Group for -- I'm sorry, for the PCPI Work Group. Sorry, I should be clear. There was a strong point of view for March being a longer time frame than necessary, and not representative of actual clinical practice of the major of practicing physicians.

MS. MERRILL: That is my point.

Then perhaps you would wish to petition, you or others.

DR. BURSTIN: It is not so much an issue of petitioning to change the standard specifications. That work was done based on the evidence and what the guidelines said. All the other measures have now come in with the same time frame, with the exception of this one.

So it is less an issue of the standard specifications. It is more about
harmonization. We don't want measures that
have different time frames and different
settings. We would be fine hearing back from
the committee as to why they feel strongly,
but I think, actually, some evidence, Mark, on
what is the additional burden or what would be
the additional exclusions to go an additional
month to be consistent would be really
helpful?

I don't know that you have that
information, but it is hard to just make that
assessment without having some evidence that
it is actually a significant burden when you
are then not harmonizing across the entire set
of measures that have the exact time frame.
But I actually think the exclusion issue is
the bigger issue, about not being able to see
the proportion of patients who decline in a
way that is really accessible in the strata
that were presented in the other measures.

That was exactly the issue we
presented yesterday. Reva presented on how
incredibly different those performance scores are when you include declination as numerator category.

DR. QASEEM: Mark, i need to say a few words. I am not still following it, and maybe you can't because of whatever the confidentiality. Why can't you include more? I am not really understanding the issue over here.

DR. ANTMAN: Well, Amir, I think I spoke to it as well as I could earlier, and again I am at a disadvantage with not having our clinical experts available to speak to the issue.

Rather than my trying to justify it again, I would rather be able to go back to the Work Group and have us articulate that more formally.

DR. STANGE: We all certainly understand the vagaries of committees. You can see people saying, damn it, we are just being asked to do one more thing. I never do
it then. You know, just give me that one month. But there is additional — One thing you could take back is there is additional burden from having different measures. That would be something for them to consider.

DR. ANTMAN: If I may be clear, the PCPI absolutely recognizes the disadvantage of disharmony among measures, and we have done everything we can to harmonize with other NQF endorsed measures or go to other measure developers related to potentially endorsed measures, and try to harmonize wherever we can. But again, I am hesitant to speak for the Work Group, given that they are willing to --

DR. BURSTIN: I think you need to at this time. I think, really, the key thing now is to lay out the key issues, have you bring it back. I am sure we will get a letter from PCPI with a response, and we will bring it back to this group. But let’s just get the issues clearly identified for him.
DR. STANGE: Right. So toward that, we are going to wrap up, but any issues from Linda and then Amir?

DR. KINSINGER: Just one quick issue, Mark. The reason you gave was that, if there is low availability of vaccine, that people who are not in the high risk group would not likely be vaccinated in March. But in fact, in the years where there has been vaccine shortages, it has typically been early in the season, and by late in the season often there is vaccine to be wasted.

So saying that only March would be excluded is what doesn't make sense, because if there is vaccine shortages, it could happen throughout the season and, more typically, early in the season rather than at the end of the season. So that is why that explanation doesn't really quite fly, to me anyway.

DR. QASEEM: Kurt, mine is more of a process issue. The issue that I had all the time doesn't change. In this case, we voted
no to the measure. Looking at what we have
done this morning, it was more of a tabling
issue than a no issue.

I was just going to ask if NQF
staff could clarify a little bit, that why was
this no whereas others was tabled?

DR. WINKLER: I think there is a
difference, because you voted on the measure.
Now in all the process, we try and be as open
and back and forth negotiation as possible.
So it is not at all unusual if measures get a
no vote, if the work group -- or if the
measure developer hears the discussion and
they go back and modify, respond to it in some
way, and want to re-present it. We leave that
door open, but what you have said is, no, not
as is.

The others, I think, were elements
of we can't make a decision, because we don't
have all the information. For instance,
things are controversial around breast cancer.
I mean, you are right. At times it might be
subtle, but I think in this particular case, it was crisp.

What you are saying is we don't want the measure as written and presented to us today, and there is an opportunity for them to go back and hear and potentially respond, and perhaps present us with a revised measure. That is something that we do relatively frequently, but it would be a revised measure, not a re-discussion of the same old thing.

DR. QASEEM: I agree with that, and I think that does apply for some of their measures as well, and then to be just politically sensitive, would it be more reasonable to just say that we are tabling the discussion rather than saying no?

DR. WINKLER: I don't think those are the same thing. A no is no for this, and I think that is a very clearcut decision on the committee's part. Tabling means we are not sure, because we don't have enough information or something else needs to happen.
before we can make a decision.

DR. QASEEM: And the only reason I brought it up was in that case I think there -- with the breast cancer one especially. I feel like then maybe we should vote on it, because in that case I think the way the measure read currently, there were issues with it, and I don't think -- As I said, it is a process issue, and I don't really care that the end result is the same, but it may be -- That was the point I just wanted to raise.

DR. BURSTIN: If I could just respond to that, I think there are issues when there are externalities to the measure itself, which I think there is an issue in the breast cancer measure. I think in this case, it is actually internal decisions by the PCPI Work Group.

You have spoken to where you disagreed with what the PCPI Work Group decided, and I think they then need to go back and consider whether they could modify the
measure, bring it back to us.

The breast cancer one, there is just too much swirling around. I think they clearly need to go back, revise the measure completely, not just a little discussion with the work group. They are going to completely redo that measure by the time you have it back to us. So, to me, it is really a deferral of a totally new measure rather than revising what was on the table and refused.

DR. ANTMAN: My concern is that -- not to quibble, Reva, with what you said about how the No is defined at this point, but my concern is that, if the Steering Committee recommendations simply go forth with a No recommendation for this measure, there is no acknowledgement of the fact that -- other than the two issues which we have said we are willing to consider further and come back with revisions for, there is no acknowledgment of the fact that the measure, hopefully, met all of the other criteria, since you didn't go
through the process of voting on importance,
on testing data, etcetera.

So if the report will convey that,
then I am perfectly happy with that, but
please understand my concern is that, if the
report says that it is a No recommendation,
then that will be difficult to argue against
later on.

DR. BURSTIN: This is not done, I
think, is the point. We are not putting
anything in a report right now. This is the
assessment of the Steering Committee for the
measure as presented. We used to have
approve, approve with modifications, refuse.
We are not really doing that as much anymore,
since we are trying to get the work moving
along. But I think there is nothing in this
discussion that says PCPI cannot go back, and
I think the committee would need to revote on
the revised measure.

Without being able to see the
revised measure, it is hard to vote to approve
with modifications, because we don't know what modifications you can do.

MR. MASON: To a point Reva made earlier, she is going to send these all back to us, and we are going to have to do Yes, Yes, No, No, for every single one of these yes or no, endorse. So --

DR. ANTMAN: Thank you all.

DR. STANGE: I would like to bring this to a close soon. But, Matt?

MR. STIEFEL: Is our task going to be to answer every single question for every single measure or just say whether or not we agree with what you summarize?

DR. WINKLER: I think it is more the latter.

MR. STIEFEL: Okay. thank you.

DR. BURSTIN: And in fact, we are going to ask you to -- although you guys didn't vote on every single element. We are also going to ask you to agree that the Work Group's assessment -- that you agree. So you
don't have to vote on every single one, but
you have to say -- and actually, that is the
difference also, Mark, is that the Work Groups
made that assessment. We are going to ask the
full committee to agree, concur. That's the
word, thank you.

DR. STANGE: And I heard Matt's
thank you as thank you for answering his
question, and then a deeper thank you on
behalf of the whole committee. So thank you,
that deeper thank you.

DR. WINKLER: We do want the final
report of what goes out for the result of here
to reflect the entire committee. So part of
your obligation as a committee member is
really to look at that and be sure that it
does reflect.

If you have a differing opinion,
then please let us know. We certainly will
want to capture that. You may not be the
majority and you may not be the one that sways
it, but by the same token, we want to be sure
that your issue, concern, anxiety, whatever it is, is captured in the discussion elements as well, so that what is presented to our audiences truly reflects all the different perspectives around the table that comprise the Steering Committee.

This is sort of a way of taking the tediousness of voting 1,000 times away from you, but the converse is we need you to really pay attention when you see the report and really reflect on what is presented.

DR. STANGE: So it is 12:14.

Thank you, thank you, thank you. We are back on schedule. So we are going to revisit some immunization measures which will bring together some of the -- We will do those individually, and then we will do the overall look at the harmonization/consolidation issue, I think, for the pneumococcal ones, but the childhood could have raised some other issues, I suppose, although I am not sure.

The other thing we said we were
going to do yesterday -- I think it was Matt's suggestion -- is that we use this process of looking at the existing clinical preventive service measures just to ask the question, does this inform the other work about developing population measures.

We clearly said that just adding them up doesn't get us a population measure. We have already decided that, but we will go through these. We will do the harmonization/consolidation, and then, hopefully, we will have done the other quickly enough that we will be able to pause and just take a step back and say, did we learn anything from this that informs the other discussion that we are doing; and if a miracle happens and we have a little time and everybody is not racing out the door, we will just ask if there is anything else about next steps or any further reflections on the larger process.

So let's take a break for lunch.
Oh, bag lunches. They are ready for people. Do people want to come back at 12:45 or do you want to have a shorter thing and do a working lunch, and would that work with our people that we have to have on the phones for the next discussion? It would? Fifteen minutes and come back or a half-hour lunch? Okay, 15. Bring a lunch back. So be back at the table in 15 minutes, at 12:30.

(Whereupon, the above-entitled matter went off the record at 12:15 p.m. and resumed at 12:35 p.m.)
DR. STANGE: Let's get started again. Rufus, I guess, if you can open up the lines, please. For those on the phone, I just want to let you know what you are missing visually. We got bag lunches with these really great party hats, and so just to get a good visual of us with our party hats on, we are doing the final measures.

We are going to walk through them, I think, in order of the pneumococcal ones. Then we will consider the harmonization/consolidation issues, if there are any among those, and then close with childhood immunizations.

After that, we are going to consider what we have learned from discussing these specific measures that might relate to our larger, more formative task about developing population health measures. Then if we have time, we will close with any last
considerations for that larger agenda. So, Reva?

DR. WINKLER: Just as a reminder, as part of the previous harmonization efforts there are standard specifications for the pneumococcal immunizations. They look remarkably similar in the numerator, and the denominator is lined up with ACIP with the specific populations, greater than 65 or long term care facility or younger with high risk conditions. So just as a reminder.

The first measure we are going to look at is measure 43. It is pneumonia vaccination status for older adults. This is again from NCQA. This is the percentage of patients 65 years and older who ever received a pneumococcal vaccine.

This is another survey measure, and the level of analysis is clinician, group, plan, facility, integrated system, etcetera.

So Sepheen, are you here again?

MS. BYRON: We also have staff
calling in. Do we have NCQA staff on the line yet? They might be in process. All right.

Well, this is as Reva described it. It is a survey measure, and it asks about pneumococcal vaccine and whether or not they have had it.

DR. WINKLER: I believe Amir is the primary discussant, but this measure was reviewed by folks on the rest of that Work Group. Jackie or Linda, do you have any comments? I don't see where Amir disappeared to -- or Jason? This is the survey measure. This is what is up here. Use your microphone. It is measure 43. If you would like, we can wait until Amir comes back.

DR. STANGE: If he is prepared, we want to focus discussion on it.

MS. MERRILL: I don't see a lot of the points there, which is a good sign.

DR. WINKLER: Rufus, are you hearing us?

OPERATOR: Yes, ma'am. Please go
ahead.

DR. WINKLER: Thank you.

DR. KINSINGER: I looked at this briefly, and I didn't have any issues with it. I thought it looked pretty straightforward.

MS. MERRILL: Yes. There is one study, a cohort study coming out of Canada, that found that PPV did not significantly reduce risk of death or subsequent hospitalization, but that is death as an outcome.

DR. KINSINGER: One thing I would like clarification on is the valence of these different pneumonia vaccines that we are considering. I am assuming that all of these in this series of measure proposals are the valence 23, even though sometimes they cite studies that are valence 7. I don't have enough expertise about vaccines to know if that makes a difference or not. I am assuming it does.

Basically, valence 23 is 23
different immunizations in one shot.

MS. MERRILL: Twenty-three valence is the one that is recommended currently for this age population. There is discussion about -- Actually, there is now a 13 valence vaccine that may, in fact, be better, but ACIP has not yet voted on that.

DR. STANGE: Any concerns about this measure?

DR. BURSTIN: Just for consistency, there is a standard specification for pneumococcal vaccine. So I guess you would want to know that it is aligned.

MS. MERRILL: It is the 23.

DR. SPANGLER: I don't have any issues either. It looked like it aligned well with the standard specifications.

DR. WINKLER: I guess one question is the population is just the age 65 and older. It does not address other populations for which the vaccine is indicated. What is the survey vehicle typically used for this?
MS. BYRON: This is an HOS measure.

DR. STANGE: So we might need to come back to that issue when we have discussed all the pneumococcal vaccines.

MS. MERRILL: So this is just looking at the population over 65, not looking at the risk populations from five to 64 that it is recommended for. So why would we not want to have this be an inclusive vaccination that is stratified?

DR. STANGE: That is the issue that we will discuss once we have discussed all of the pneumococcal vaccines. Any other comments before we vote on this one. Sarah?

MS. SAMPSEL: The one point would be that, since this is administered through the HOS, this comes back to a data source issue as well. So HOS is just administered to the Medicare Advantage population, which is typically 65 and older.

Then the other thing I just wanted
to bring up is this also has a BRFSS survey which it is in alignment with, so on more of the population health level.

DR. WINKLER: I guess the other issue is this is applicable to the Medicare Advantage population, but how much of that compared to the entire Medicare population? What is the relative utility, I guess?

MS. MERRILL: Well, doesn't that fall into the issue we are going to discuss later?

DR. STANGE: So let's keep track of these issues that we need to discuss with harmonization. Amir, we are actually just about ready to vote on the first measure 43, but anything you want to have us consider?

DR. QASEEM: And I was reviewing this. Right?

DR. STANGE: Yes.

DR. QASEEM: I was? Okay. Let me just open it. I'm so sorry. Forty-one, you said?
DR. STANGE: Forty-three.

DR. QASEEM: Oh, 43? I think you probably have already discussed most of the issues, and so there is nothing, really, probably to add, nothing major.

DR. STANGE: You don't have any major concerns about this?

DR. QASEEM: Yes. I think it is probably okay.

DR. STANGE: Everybody good to vote?

MS. MERRILL: Can we just see the other comments that reviewers made? Oh, yes, there was a contradiction there. So the developer, you should realize that you contradict yourself there; 4.b.1 contradicts 2.a.1. One says only electronic sources, and the other one says paper sources. Somebody didn't catch that.

DR. STANGE: Let's go ahead and start our clock for voting. I guess we are ready to vote here. So 11 Yes, zero No.
DR. WINKLER: The next measure is 617, pneumococcal vaccination. This is from Active Health. This is the percentage of patients 5 through 64 with a high risk condition or age 65 years and older who received a pneumococcal vaccine.

The high risk conditions laid out are the same that you saw in the standard specifications, diabetes, heart failure, COPD, end stage renal disease, asplenia.

This measure is specified for multiple levels of analysis, including clinician, plan, integrated system. It is based on administrative claims or electronic clinical data, EHRs.

Are the folks from Active Health on the line?

OPERATOR: We do have Lindee Chin.

DR. CHIN: Hi. Can you hear me?

DR. WINKLER: Sure. Just one or two sentences about the measure?

DR. CHIN: Sure. This measure is
looking at the percentage of patients, again like you stated, age 5 to 64 with a high risk condition or older than 65 who have received a pneumococcal vaccine. You can see the rest, I guess, in front of you. I am not sure what you are looking at, but you probably see the form that we submitted.

DR. WINKLER: Jackie? Oh, sorry.

MS. MERRILL: Okay. So this measure, as I understand it -- and it is not always easy to understand what you are trying to get at -- is inpatient and outpatient. So this includes inpatient and outpatient, and it is the percentage of patients in those age criteria.

So you are really saying who were screened and received prior to discharge, if indicated. So it seems like there is a whole bunch of things that are just left out of this description of the measure.

DR. CHIN: We -- Oh, I'm sorry.

MS. MERRILL: So you have got
patients who are being seen, but you are not just asking them did you get the vaccine, and that is what you are looking at. You are looking at -- You are asking them, and you are also -- if they say no, you are giving it to them, and then you are including that in the numerator. Is that correct?

DR. CHIN: Well, we are not looking at it, in particular, if they have been in the hospital or out of hospital, a diagnostic event. So we are just looking at everyone who meets the denominator criteria and whether they have received an immunization. Either we ask them, if they talk to our nurse, or we receive codes and claims for that.

MS. MERRILL: Okay. So just based on administrative data. So you don't get into any of that. It is just yes/no?

DR. CHIN: Yes, or if they talked to one of our nurses and they told us they received the vaccine.
MS. MERRILL: Okay. All right. The other something is 1.c.14 on page 4, the controversy of contradictory evidence. There is a statement that there is no contradictory evidence, but in fact, I believe that there is some evidence that it is not that efficacious. There are some studies showing that they are only really given -- Ten percent of people actually get protected from the vaccine. So that was not addressed by the developers in terms of contradictory evidence.

In that sense, too, I don't see any sense of where you evaluated the developer's assessment of the quantity, quality and consistency of the evidence, and that may just be because the form changed in the time.

DR. CHIN: Yes. We had a different form when we submitted originally.

MS. MERRILL: Yes. But that is an important thing to address, because there is evidence. There is a fair amount of evidence
that -- not saying -- it is not a good use. You would imply that it is not a good use of scarce resources to give this vaccine. So I should think you would want to address that.

DR. CHIN: Okay.

MS. MERRILL: But otherwise, the reliability and validity testing seemed fine. There is extensive validation rules, extensive documentation of data elements. It is really quite a lot of work to put this one together.

DR. STANGE: So open to regular discussion. Linda?

DR. KINSINGER: This seems to have the same issue about the denominator exclusions as the influenza measure that we just talked about. So they exclude patient or provider feedback indicating allergy or intolerance to the pneumococcal vaccine in the past, and patient or provider feedback indicating there is a contraindication to the pneumococcal vaccine.

It looks to me like -- I mean,
those again are supposed to be in the numerator, not in the denominator.

DR. STANGE: Any comment from the measure developer?

DR. CHIN: Yes. These measures are also based on what we do in our clinical decision support. So we don't alert physicians if they have told us that the patient has an allergy or there is a contraindication that they need the vaccine. So this is sort of measuring that population who can get it.

DR. STANGE: But the issue of whether that is in the denominator or the numerator -- So the other measures we looked at treat that in the numerator.

DR. WINKLER: This is a question of harmonization and a question of to what degree have you looked at the standard specifications and in harmonization with other measures of pneumococcal vaccination.

DR. CHIN: Are you talking -- I'm
sorry. You are asking whether we should move this into the numerator? I know we had talked about that on a previous call, that this should be in the numerator.

DR. WINKLER: Right.

MS. MERRILL: So people with complications are put into the numerator. People who are excluded from getting the vaccine are put into the numerator. You have them in the denominator.

DR. CHIN: Yes. We could move that population out as a separate group into the numerator. We would just break that apart from our clinical decision support.

DR. STANGE: Sarah?

MS. SAMPSEL: My question is actually about the testing results. So your results were right around 10 percent, and do you -- and I didn't see it in here, but do you do any type of medical record validation of those results; because it seems like a really low rate, especially -- You know, maybe it is
just because it is in this high risk population, but have you compared that to other results?

DR. CHIN: Actually, we just ran the measures again on our over 2 million population, and we got a 23 percent compliance. The denominator is about 1,400,000-plus people and about 306,000 did receive the vaccine, who came out to be 23 percent.

We don't necessarily validate it with medical records, because we are getting claims from -- We are getting information from various sources. So it is not just someone's charge. We are getting it from health plan claims. We are getting it from whether the patient told us they got the vaccine or if they entered that information as well into their personal health record.

MS. MERRILL: Also, if they are excluding those people that should be in the numerator, the rate would go up then, too.
Right? Because they have got all those people in the denominator now.

DR. CHIN: Yes. Right now they are excluded.

DR. STANGE: Any other concerns?

MS. MERRILL: So our recommendation would be?

DR. WINKLER: What we are talking about again is another harmonization issue. I think previously, we have been looking at the harmonization or the lack of harmonization, as we did previously, in the overall endorsement. so just consistent. If your issue is around the standard specification, that is a specification harmonization. It fits both under scientific acceptability and usability. So it will factor into your overall evaluation and vote on the measure.

MS. MERRILL: So there are some additional rationale for why it may not be ready for endorsement yet, which is the
discussion of the younger age group, the 5-18.
Are you covering them in some other way?

DR. CHIN: I'm sorry? The 5 to 18?

MS. MERRILL: Right, 5 to 18.

DR. CHIN: Right. That is included in the denominator.

MS. MERRILL: All right.

DR. BURSTIN: It says five to 64 with high risk condition and over 65.

DR. WINKLER: Whose comment was that? Jason, Linda, Jackie, Amir?

MS. MERRILL: It might be mine.

DR. WINKLER: Okay. Can you clarify a little bit what the issue was?

MS. MERRILL: I didn't see that they were including all patients -- Why not include all patients? Why are you just looking at the high risk patients, because it is recommended for the five to 18 group. Right?

DR. CHIN: Right. Our denominator
has both patients 65 and older as well as
those five to 64 with a condition. I don't
know if you have the same page numbers. It is
on page 8 and 9.

MS. MERRILL: This is also a
childhood immunization, too. Right? Children
get this. The younger group get it. They do
not? Are you sure? Are you sure it is not in
the CDC recommendations?

DR. QASEEM: I don't think so. We
could pull it up pretty easily, though.

DR. CHIN: I'm sorry. What are
you looking for?

DR. BURSTIN: We are just
clarifying what the evidence says on the ACIP.
I think we are okay. I am still left
wondering. Does this meet standard
specifications in terms of the ability to see
numerator exclusions?

MS. MERRILL: As it is written
now, it doesn't. So they have to -- We can
say that other elements of it -- We should
probably see it again, because the testing is based on a faulty denominator. So that means that the testing results are also going to be different.

DR. WINKLER: I think we need to vote on what is presented to us. They would have the same option that PCPI would, if they wanted to reformat the measure, reconstruct it and bring it back addressing these issues, but I think at this point what we really need to do is look at what is put in front of us.

DR. STANGE: So I think we are ready to consider this measure for a vote. This is the vote. It is nine No; four Yes.

DR. BURSTIN: So for the sake of Active Health management, that was primarily — the No vote was primarily related to the fact that it did not match the standard specifications around having the transparency in the numerator details. So again, should you want to reconsider that, we would be happy to follow up.
DR. CHIN: Okay. Yes, we can take that back. We can change the measure and work on that. We will follow up with this.

MS. MERRILL: I would suggest also discussing the contradictory evidence, too, in your reapplication.

DR. CHIN: Okay.

DR. WINKLER: The next measure is 1653. This is pneumococcal immunization for hospitalized patients. This really is very similar to the flu vaccination measure we saw this morning. Again, we don't have our developer on the line, but again this was a measure that was done in pneumonia patients, and again, you know, why a narrow slice. Broaden it to everybody that is applicable.

So this is the revised measure brought back to us, and Amir, I think, this was yours.

DR. QASEEM: I think, without getting into the issues that we already talked about in terms of measures and harmonization,
my main concern with this measure was I felt
like something that I voiced this morning,
that the denominator I am struggling with a
little bit, because I think what is happening,
the hospital is -- If you are going to ask for
definitive documentation of vaccination rather
than patient self-report -- and this morning
we actually did approve many of the measures
where patient self-report was being used.
Right?

I think it is really important
that we keep that in mind. If a patient self-
report does say that they have been vaccinated
in the past, they should be excluded from the
denominator, because what currently is going
to end up happening is that, if you are going
to ask for definitive documentation, most of
the hospitals that feel like that they are
double and triple vaccinating folks when it
comes to pneumococcal vaccination, especially
-- and without getting into the nursing home
patients and the issues with that, many of
them cannot give the history, and family
members, they don't want to say, well, yes,
they were vaccinated elsewhere.

So it is more of an issue of -- I
felt like that the denominator needs to very
clearly say that, if a patient self-report
says they have been vaccinated in the past,
maybe they need to be excluded.

DR. WINKLER: The standard
specifications include patients who are
immunized or have been immunized in the past.
So they are counted as patients who are
immunized. So we know their vaccination
status, rather than excluding them from the
denominator, because then you lose track of
those patients.

DR. QASEEM: Okay. So this
measure, if patients say that they have been
immunized in the past, they will not be --
they will get credit for it? Okay. Then I
am okay with it. That is how -- I didn't read
this measure. Then I don't have a problem,
because that is not my read of this measure at least when I looked at it; because in the denominator exclusions, the way it has it is patients who expire, ICD, blah, blah, blah. I am not seeing that. Maybe I missed that information.

DR. WINKLER: Well, the numerator statement, and I think it is not as explicit, and that is perhaps something we ask for clarification, but it is inpatient discharges who were screened for status and received the vaccine prior to discharge, if indicated.

DR. QASEEM: That exactly. So the way it reads right now is the problem is the way it is being interpreted.

DR. WINKLER: Right.

DR. QASEEM: They are seeing that you need definitive documentation.

DR. WINKLER: Go down to numerator details. It says, the following patients are included in the numerator: patients who receive the vaccination during
hospitalization; patients who receive the vaccination anytime in the past; patients who were offered and declined during this hospitalization; and patients who have a -- I am going to say that the word is contraindication - or allergy sensitivity to the vaccine, blah, blah, blah.

This is under numerator details, 2.a.1.3.

MS. MERRILL: Tell me if this is something you want to discuss later, but this is that idea of saying the same things in the same way. So if they are quoting directly from the specification, then we can say it meets the specifications.

DR. WINKLER: Right.

MS. MERRILL: But if they interpret the specification and -- So this is really for all the developers. Interpreting the specification creates problems for everybody.

DR. WINKLER: Right.
DR. STANGE: What I heard from Helen before is that that is not a rule they are going to make, but that is certainly something that can be said, that if you want your measure to have an easier go of it in review, that is what you would do.

DR. BURSTIN: And given it is the same developer for the influenza in the hospital, we should make sure those numerator details line up as well.

MS. MERRILL: It would be acceptable to cite what is in the specification and then say we operationalized the specification this way, and then you put all the things that were there. But if you don't state that you are meeting the specification and we have to sift through it, and then we might not understand what you mean, and then you get all these kinds of problems.

DR. WINKLER: That is an excellent point.
DR. STANGE: Any other points related to the vote?

DR. QASEEM: So I was reading the numerator details. Sorry, it took me a little while to find this information. So I am still not seeing it, that if it says anywhere the patient is self-reporting that they have been vaccinated, then they don't have to be vaccinated. This is the problem, is with the interpretation. Right now, the way the hospitals are using is a patient is thinking I may have gotten, maybe I got it, they are getting vaccinated.

DR. BURSTIN: I think it may be -- and this may be a question back for Obama, but I think it may be that there is a lot of -- It is unclear what "if indicated" means.

DR. QASEEM: How about that?

DR. BURSTIN: So I think that this may need to be a bit more clear, because I think the fact that all those things are in the numerator details, to me, implies that
they are going to, in fact, be -- So they specifically have under numerator details, you have received it anytime in the past. So I think that automatically means it is a numerator -- it will be in the numerator along with it. But I think, given the overuse of vaccines, I think it is a really important point, Amir.

DR. WINKLER: I think you are bringing up possibly one of the unintended consequences, that perhaps to be sure that you hit the performance targets you just vaccinate everybody, and regardless of whether they need it or not sort of thing. I think you are raising a concern we have seen with other measures that are similar, as an unintended consequence of the measure.

DR. QASEEM: And the only reason is an anecdotal problem. Maybe in your own practices, you may have seen it, but I am seeing at the hospital the patients are -- We just did it, and we saw that the patients were
getting extra vaccinations. There is definitely overuse going on.

DR. STANGE: Helen, how do we handle this? I'm sorry, Sarah.

MS. SAMPSEL: Can I just make one more point, and that is on their testing results. They are already showing performance at 98.6 and 97.6 percent. So my question would be: What is the opportunity for improvement or is this actually showing that overuse issue, and that is how it is captured?

DR. WINKLER: Remember that the testing data was done only on a population of patients with pneumonia and not the entire hospital population.

MS. SAMPSEL: Okay. Then that begs another question, that if NQF is no longer doing time limited endorsements, shouldn't we wait to see testing results or something on this?

DR. WINKLER: Well, our testing requirement is it is okay to test on a subset
of population. I mean, we try and make the
testing requirement as flexible as possible
and not be overly prescriptive. So one of the
things that is allowed is being able to test
on a subpopulation.

DR. WINKLER: Actually, what it
really is, is that NQF allows testing at
either the measure at the data element level
or of the score. In this instance, I think
the data elements are the same. They have
just broadened the population.

I guess the question should be
whether we would expect there to be any
difference in the reliability of the measure.
It is a broader population, certainly.

I think it is a reasonable
question to ask Oklahoma. My guess is they
have potentially got some additional pilot
data on the non-pneumonia patients that would
be worth looking at.

DR. STANGE: The point that --
just follow up on that, and then Mike is next.
Sarah's point about the really high rates -- really, you don't get rates like that if you are not -- you are having a lot of over-vaccination. So I think it really supports Amir's concern.

Helen, so is this something we ask for clarification? How do we handle this in the vote? Is this something that we can say that, if your assumptions about what is in the numerator and how that is measured are correct, we can approve this, but -- I mean, how do we handle this?

DR. WINKLER: It is not unusual to have questions go back to developers that help clarify. So you can vote, and we will get this information back and respond to some of these questions. Again, as we have said multiple times, this is our first pass through these. It is a dialogue, and so raising these issues so we can clarify them and find additional information is really one of the first elements.
If this had a fatal flaw somewhere else, though, for which you wouldn't want to approve the measure, then all that extra work is not probably worth the effort, but if that is really the one issue you are concerned about and isn't a fatal flaw for the measure, but you really want to be better informed about it, you can go ahead and make your decision, and we can get that information. We will go get it.

DR. STANGE: Michael is next, and then Jackie.

DR. STOTO: I have, basically, a philosophical question about these high rates for vaccines and preventive services in general. I think that people in preventive medicine think that the reason that we are doing so well is because we are paying attention to this, and that if we stop paying attention to this by not having a measure, we would drop off.

Even though these numbers may not
reflect the general picture, I think it is a philosophical question in saying how much weight should we give to that for these preventive measures?

DR. STANGE: I didn't hear anybody arguing for not continuing to measure this. I think it was just that was being used as evidence that there is probably over-vaccination going on to get to that high a level. Jackie?

DR. BURSTIN: NQF does have an option. We put it forward this past year, that for measures that are otherwise --

MS. SAMPSEL: It is a variation of an old measure, isn't it?

DR. BURSTIN: Let me just finish my statement. Reva is making a technical point. That is probably true, but we have created something called reserve status, reserve endorsement.

So for measures that are otherwise reliable, valid, etcetera, really important
but at those really, really high thresholds of performance, they can be moved into that reserve status, meaning people can periodically go back to them and do surveillance.

At the next three-year window we can reassess whether it remains at that high performance or if periodic surveillance would suggest that, actually, exactly that decrement occurs.

There is very little on the health services research literature at all, a tiny little bit I have seen from the VA, about whether or not performance actually falls when you kind of take your eye off of it. I would be curious if Matt or Sarah have any experience with this, but it is a really big issue.

So we have at least for now tried to move some of those into reserve status. Reva's point is this is technically a new measure, because it is an expanded population,
but again I think the bigger issue I we don't actually know what the numbers are, and I think we need to get that from Oklahoma.

MS. MERRILL: There may be a typo in both the brief description of the measure and in the denominator, in the denominator statement. So you have got the criteria say five to 64. You have got six to 64 in both places. I don't know if that is just a typo.

DR. STANGE: As we approach a vote for this -- Sarah, your card is a leftover? Okay.

As we approach a vote for this, Helen, could you restate for us the criteria for how we might consider the concerns here?

DR. BURSTIN: I think there is really two separate issues. The first is that the high level of performance that they provided to us is only in patients with pneumonia where, you could argue, certainly, probably have a much higher rate of vaccination, because they are in there, and
you want to make sure they get vaccinated or have been vaccinated.

When you go into the broader population, my guess would be the level is probably not as high, but you sure need to know that, and I think we need to know that really in advance of endorsing this measure. We don't know what current rates of performance are for the general population.

If, in fact, it remains equally high, if they can share with us that it doesn't actually matter, and the general older population and we are still shooting everybody up as they walk in the door, then I think we would need to consider whether it could be in reserve status.

DR. STANGE: Actually, my question was about the other issue, about we think that the things that are in the numerator are probably being measured appropriate, but we just want some clarification of that.

I guess you are suggesting that we
include how concerned about that we are, as
whether that bumps over from a Yes to a No or
how do we handle that?

        DR. BURSTIN:  I think it is up to
the committee.  How much do you feel like you
can't really assess this measure without
knowing what the current levels of performance
are. Importance of measure to report is a
must pass criterion.

        If you don't actually know the
measure gap -- and I was actually just looking
to see whether they provided anything from the
literature. It doesn't have to be from their
measure per se, but what is the known measure
gap in terms of performance?

        DR. QASEEM:  What we did this
morning -- do you think this would fall in the
criteria of table it and get some more info?
I feel like we are doing it with a lot of
measures. We are going to have a busy
February meeting.

        DR. STANGE:  I will you my larger
concern with this group is. If this was the main task of this group, I would be in favor of that. I think we have other tasks that are really going to take a fair amount of energy, and we have -- with the balance of our energy, without any advance prep, really, we had an open discussion of a large new area that, I think, we think is important that we want this committee to address.

So I think we need to do the right thing here with each measure, not gloss over and push things on, but also this is not the only task of this committee. I would say it is not the most important task. It is not the unique task of this committee. Others could do this. Others could this work, other committees, but -- Okay, that is a personal opinion.

DR. WINKLER: One comment is this aspect of these measure evaluation is going to be moving forward. You are not going to be seeing any of this in February. So this is
moving forward directly after this. We are
going to wrap it up over the next month or
two.

The other thing is you can make
your vote conditional on review of that data,
the information from Oklahoma, that there is
an opportunity for improvement in a broad
population.

PARTICIPANT: Hello? Hello?

DR. WINKLER: Hello. Yes, who is
on the phone?

PARTICIPANT: I don't know. I
think I lined up here. I'm sorry.


So you can make your vote
conditional on looking at data, see what they
have got, and clarification on the numerator
specifications to be sure we have got it, and
perhaps maybe clarify the language that makes
it more crisp in terms of what their intention
is.

DR. STANGE: Linda?
DR. KINSINGER: I wanted to go back to the question about performance gap, because as Helen says, they say the most recent national CMS rate is 93.3 percent. Is there a sense generally of how large that performance gap needs to be to say it is large enough? That seems like a pretty small performance gap to me.

DR. BURSTIN: Some of it depends on how large their overall population is. So that it could be a significant opportunity for improvement, just given the number of hospitalized older patients, but again that is a judgment call. We don't have a specific threshold for exactly that percent.

I would also be curious -- I was actually just reading the exact same paragraph you did. It is not clear to me how they know what the recent national CMS rate is. Is it of the older measure of pneumonia or is it this measure, and that is what is not clear.

DR. KINSINGER: So it says it is
from the CMS Hospital Compare website, the sentence before.

DR. BURSTIN: I believe that is only pneumonia.

DR. QASEEM: Kurt, would it be reasonable for first the committee motion can be whether we should table it or not, and then if the majority feels like we shouldn't table it, then we can vote. But maybe we do need a motion. I think it seems like there is a lot of issues going on here.

DR. STANGE: I think that is helpful, Amir. so all in favor of tabling this? We will do that as a first level, and if the majority doesn't want to table it, then we will consider the next step. so all in favor of tabling this, raise your hand, please. Raise it high, and hold them high.

So it seems to me that is something -- We have a majority, a slight majority, but that is something, if we have a substantial minority that feels like they are
not sure enough on what they are voting on, it is a reason to table it. So it sounds like that trumps the other consideration. So --

    DR. BURSTIN: I think these are very straightforward questions to ask CMS. The issue is there has been some issue with Oklahoma, and some furloughs and things. So it is not an issue of their unwillingness to participate. They were not able to participate, and there is no one from CMS.

    So I would just feel better having you actually make the assessment with some real information.

    DR. STANGE: Just thinking about all these committees doing this, it is hard to keep the overall reporting burden for all measures in mind, and it seems like that is where the performance gap really is, and is an issue. Voting on one measure at a time, it is easy to go over that. So I don't -- It almost seems like there needs to be some larger process to handle that.
Okay, next measure.

DR. WINKLER: Okay. We have got the last measure. This is measure 525. This is from CMS, percentage of home health episodes of care during which patients were determined to have ever received pneumococcal vaccination.

Do we have somebody from CMS on the line for this measure? Ms. Cassia? She was here with Keziah. They were here with us yesterday. Anybody? They knew about it, right? Doesn't sound like it.

In many respects, this measure is the parallel measure for a pneumococcal vaccination that it was for influenza for patients in the home health community.

Whose measure was this to look at?

Okay, Jackie.

MS. MERRILL: Remember that comment I was making for 617, is what I meant for this one. So this is percentage of home health episodes of care during which patients
were determined to have ever received.

So this implies that they are
screened, and they receive it, if they need
it, and then they have ever received it. If
that is the case, it would be nice to say
that.

Other issues: Another is just the
level of precision in the document. So in
1.c.1 you say, "As CDC recommends PPV for
Americans 65 years older and those with
selected chronic conditions, those between 5
and 64 with selected chronic conditions." It
is kind of --

DR. STANGE: So I think that is a
larger point that we will take forward. So
things that can inform our vote on this
measure, I think, is what we want.

MS. MERRILL: Okay. So their
system for grading the body of the evidence:
they cite CDC saying that there is a limited
number, but there are randomized controlled
trials. So I think that the body of evidence
is fair to good.

Oh, in this measure they are requesting follow-up for stratifying for disparities. So that is actually a request that they are making. They want guidance on that, and it is also one data source. Otherwise, I don't have issues with it except just for that sort of rigor in the preparation of the document. Anybody else?

DR. STANGE: Jason, did you have any comment on this one? What we are specifically wondering, is that your comment under the rationale?

DR. WINKLER: About meeting the standard specifications? You raised the issue yesterday that we immunize people, not episodes. So is that the same issue?

DR. SPANGLER: Yes, same issue about persons and episodes.

DR. WINKLER: I think we can deal with that in the same way we are going to be dealing with the immunization. We are going
to put them side by side and look at the
details that you have asked us.

      We've got the big picture
harmonization, but there are little detail's,
and I think clarification -- and an episode
really does represent a person -- would be
important in communication for folks.

      DR. STANGE:  So this population
has a unique data source, and that is probably
why it is a separate measure. Any other
considerations before we vote?

      MS. MERRILL:  There is a comment
about 4.c.1, audit for errors. Data accuracy
could be audited, but they have not done it,
apparently.

      DR. STANGE:  Mike?

      DR. STOTO:  It's funny. I spoke
at the resolution for the one yesterday that
had the same format.

      DR. WINKLER:  You approved it, but
again it is part of this follow-up where we
want to put these smaller details side by side
and really evaluate and see if we can get them
to harmonize, and to Jackie's point about the
language, so that audiences can readily see
they are the same instead of having sort of
unusual language that is hard to interpret.

DR. STOTO: I just want to be as
consistent as we can.

DR. COOK: Hi. This is Keziah
Cook from Acumen. I was on a non-speaking
line earlier.

DR. WINKLER: Hi, there. Thanks
for joining us, and thanks for speaking up.
We have been discussing the measure. A lot of
the issues that came up yesterday with the flu
vaccination measure are again discussed.

I think, again, using the
terminology around episodes is just difficult
for broad audiences who don't have the insight
or terminology from the home health world, and
the notion that we don't immunize episodes; we
do immunize people.

So some way of making that
communication in the specifications is probably necessary, as we expect broad audiences to read this and understand exactly what is going on.

Jackie, were there -- Your other points were just some clarifications in the care with which some of the wording in the document -- and the characterization of the evidence.

MS. MERRILL: the other thing was the developer's request for guidance from the group on the stratification by disparities.

DR. WINKLER: I think they are asking for guidance from this group, being open. I would just point out that this -- If you look on page 3 of the submission form, you will see that the data is stratified by race, by age, and by gender, and clearly, they are able to do that.

I guess -- Are you guys asking for whether this is the right kind of stratification, whether it should be something
1 different?

2 DR. COOK: No, we collect the data to stratify the measure, but the measure as it received time limited endorsement was not a stratified measure. It would be publicly reported for all home health patients rather than separate for different groups of home health patients.

So we collect the data, and we can certainly track the disparities internally. The question is whether there is interest in publicly reporting a stratified measure?

3 DR. WINKLER: I think that, considering the discussion of disparities and how important they are and such the high priority -- I've got heads nodding all the way around the table that you can't see -- we certainly would want to encourage and whatever we can do to get stratified results reported. Yes.

4 DR. HITTLE: This is David Hittle from the University of Colorado. I am on the
same team as Keziah.

When this was publicly reported, it publicly reported on a tighter basis, each home health agent, and are you suggesting that it should be stratified at that level or more at the population level?

DR. COOK: I think that is part of our question for the committee, is we did find evidence of disparity was the appropriate way to address this in the reporting.

DR. NISHIMI: I really think that is up to you to identify whether, in fact, you have enough n at the facility level. The report that is on the website right now from the Disparities and Cultural Competency Steering Committee would give you some guidance on whether that is feasible, but absent looking at the individual data for your measure for individual facilities, it is sort of hard to give you any specific guidance. But from the Disparities and Cultural Competency Steering Committee prospective,
that paper should be helpful.

It is on the web, and Elias, I am sure, can send it to you.

DR. HITTLE: I can say, actually, right up front that the n would probably be too small for about 80 percent home health agents out there.

DR. NISHIMI: Right. So I would just look at that guidance and then you should be able to take it from there.

DR. HITTLE: Thank you.

DR. STANGE: But the question of reporting aggregate data -- certainly those kind of data are helpful in looking where we put our efforts and from policy decisions. So I don't see a downside to reporting that.

Are people ready to vote? So the vote is 10 Yes; three No.

MS. MERRILL: With the recommendation that they define the home health episode to conform with the standards.

So they have to define that so we know it is
an individual patient's episode.

DR. STANGE: Yes, thank you, Jackie.

MS. MERRILL: You're welcome.

DR. COOK: I'm sorry. I think I missed some of that discussion. Could you just briefly recap what your recommendation was for redefining a home health episode?

MS. MERRILL: The home health episode has to be defined so that it conforms with the standard. So in other words, you have to define the home health episode as that which is involving one patient, because what we are interested in is the immunization for one patient, not for an episode.

An episode is a thing. We are interested in the individual patient.

DR. COOK: Right. So can I flip that back to you quickly, just so that I can make sure I am understanding? So for any type of encounter measure where you are measuring the immunization status of a patient who has
an encounter -- so a visit to a physician, a hospitalization -- if that patient has multiple encounters, is it appropriate for the immunization status to be established during each encounter?

MS. MERRILL: No.

DR. COOK: So if a patient is hospitalized, but their doctor previously established their immunization status, they shouldn't be counted in a hospitalization measure of immunization?

I am just confused, because, you know, a patient can receive home health from multiple different entities. So he might have a home health episode in January with one home health agency, a home health episode in October with a different home health agency. The same patient, but they had two episodes.

DR. WINKLER: I think this is another question of harmonization, because truly, the situation will arise with hospitals, for multiple hospitalization. I
think this is an opportunity for additional harmonization, and we can take that conversation offline and kind of see how those line up.

    DR. COOK: Okay. That makes sense. It is not something that is specific to how home health episodes are defined, though. It is the circumstance that arises when patients have multiple encounters with a provider type.

    DR. WINKLER: Right. Thanks.

    DR. STANGE: We have one final measure, which is childhood immunization, but before we do that, I have asked Reva, since I have kind of lost track of it, what the issues are across these measure regarding harmonization and potentially consolidation. So we need to have a discussion of that.

    DR. WINKLER: Of the four measures, one of the measures, the one from Active Health, were concerns about not conforming to the standard specs. So that one
is off the table for the moment. It is possible they will bring us back a revised measure that does conform.

What we have left is measure 43, which is the survey measure, which is only for patients over 65 and really is implemented only in the Medicare Advantage programs, and asking about patients who received immunization.

We have the home health measure we just discussed, some clarification there, and also wording to help facilitate understanding that harmonization is or isn't there.

Then the other measure is the measure for hospitalization where we have tabled it, because there are numerous questions. Some of those address the harmonization issue, and some do not, and some are other questions.

So that is where we are at this point. So I think there are enough open-ended questions that those three measures, we will
see what we can clean up the information.

   MS. BYRON: Yes. You noted that
the flu shot measure was 65 and up, and I just
wanted to --

   DR. WINKLER: Pneumococcal.

   MS. BYRON: Oh, I am sorry. Okay.
We are talking not about flu?

   DR. WINKLER: No, we are talking
about pneumococcal.

   MS. BYRON: Okay. I am totally
confused. Sorry about that.

   DR. STANGE: So it sounds like you
have a charge to go forward from the
discussion we have had. Is there anything
else that would be helpful at this point from
us looking across the measures?

   DR. WINKLER: I think we need
additional information on enough of the
measures that we will need to come back to you
to see if there is any further change in your
recommendations going forward before we go
final.
DR. STANGE: So we will go ahead and do number 38, the last one, the childhood immunizations. Then we will open for public comment, and then we will take a deep breath and just step back and just consider what we have learned from this discussion on some specific clinical preventive service delivery measures, how that might inform our larger work on developing population health measures.

So Number 38.

DR. WINKLER: Michael, I apologize. I don't have the form right in front of me to read it. So if you would just introduce the measure in your discussion, and then Sepheen is here from NCQA to discuss it.

DR. STOTO: Well, you all have got a lot better at this, this morning when I was away. I also realize I missed some things in my first review. So, hopefully, I will pick them up now.

This basically is a measure that NCQA has already been using -- I guess has
already been endorsed, right? -- to measure childhood immunization status. What they do is they look at 10 different vaccines that are recommended for kids to be given before the age of two.

They look at kids in their second birthday. They have a second birthday in the measurement year, and they see whether or not they have had the appropriate number of those vaccines, of each of those vaccines, by their second birthday. So for some it may be two, for some maybe three or one, and so on. But then they report it many different ways.

To tell you the truth, I have lost track of how many different ways, because there are 10 different vaccines, and there is either two combinations or someplace else it says 10 combination rates. So either way, it is a whole bunch of numbers. It is not just one rate, even though it is only one measure.

I frankly, don't know which ones it is. I went back to some of the NCQA
reports following the combos, and there were nine of them there. I think that is a big issue is, you know, what is the number. It seems to me that it would be useful to say here is the main measure. Then you maybe you want to be able to break it out by vaccine types. Do you want to respond to that?

MS. BYRON: I'm sorry. I just missed that question. Nine rates or -- Oh, combos.

DR. STOTO: Yes. There are many different rates.

MS. BYRON: Right.

DR. STOTO: Ten different vaccines, and some two to 10 different combinations of those vaccines.

MS. BYRON: Yes. The combinations are -- There's two assist plans and others who are looking at measure rates to trend, because over time as more vaccines are added to the immunization schedule, we have added new
vaccines, but then you can't trend back with
original things.

So the combos -- Usually, you have
the combo one. That may be the first three.
Then you add the four. then you add number
five, and all the different combos allow you,
if you want to look at specific vaccines, to
track it, because of the way the measure is
set up. So that is why there are so many
rates.

DR. STOTO: Yes, and I think that
is a problem.

DR. STANGE: So I am clear for
this, not one overall measure and then sub-
measures. There are multiple summary
measures?

MS. BYRON: There is an overall
measure, and then we provide the combos to
allow for trending. The combos take into
account the different -- all the different
vaccines.

DR. STOTO: So when you look at
the quality compass, look at the one I looked
at, the most recent one I could find, there
were nine different measures that were all
tracked.

   DR. STANGE: Sarah is going to

   comment on that.

   MS. SAMPSEL: I think it is just a

   semantics issue. It is all the same measure.

   So technically, you are looking at 10
different vaccinations, but it is how they are
reported out, and the reporting out is what is
the trending issue, and that is what is really
important for plans.

   So we only -- So WellPoint, while
we report all of them, we trend combo 2. So
it is kind of up to the plan, but they are
technically not different measures. It is all
the same measure.

   DR. STOTO: Well, I understand

   that point, but on the other hand, if I were
a consumer trying to compare two different
plans, I wouldn't know how to do it, because
some would look better on measure one, some
would look better on other measures. Some
would look better on the DPT. Some would look
worse on the HIB.

DR. STANGE: So what is the
counter-argument, and what is the advantage of
having the different reporting?

MS. BYRON: The different
reporting really -- As Sarah said, you might --
- As a plan, you might decide that you only
want to trend the combo that includes X, Y and
Z vaccine.

One year HIB was -- There was a
vaccine shortage, and so we did not require
HIB, the HIB vaccine. So there is an example
where having the other combinations was
useful, because then you could go to the
combos that did not include HIB and look to
see what your rates were in past years.

So it is really -- It is a
reporting out issue.

DR. STOTO: It seems to me that a
compromise here might be to say that the primary measure is so and so, and that probably would be the biggest combination, and then say there are these other ways of reporting it for trend purposes.

MS. BYRON: We could clarify that and make sure that people understand that it is the same measure, and it is just a reporting out issue and trending issue.

DR. STOTO: Well, no, it is not the same measure.

MS. BYRON: I'm sorry. So the measure is did you get these immunizations by the time you turn age two, and the immunizations are aligned with the ACIP recommendations. So it is aligned with the immunization schedules.

Whether or not you want to trend back on every single vaccination or you just want to look at rotovirus plus HIB plus this or that, you do using the combo rate. So I realize it is confusing, and I realize that
there are a lot of different rates, and maybe we could have just provided it on the total measure.

DR. STOTO; We probably should go forward, but to say that whether you got these three vaccines and whether you got these 10 vaccines -- they are two different measures. Okay.

Second -- and either way, I can't figure out some of the documentation exactly what is being spoken about.

Number two is about the contraindications. They exclude a child who has a contraindication to any of the vaccines from the denominator. Now the issue is the denominator rather than the numerator. So that is the harmonization issue.

DR. WINKLER: This measure -- We can talk about whether it needs to have the same harmonization. This is the only measure of childhood vaccination. You may wish to say that maybe globally all vaccine measures of
all types should conform, and that is
something you all can do.

DR. STOTO: I don't think this is
-- I wouldn't worry about that so much. I
just wanted to point out that. There is,
however -- I find a sentence in here about
that, but I can't quite figure out what it
means.

An organization that -- This is in
2.a.1.8: An organization that excludes
contraindicated children may do so only if the
administrative data do not indicate that the
contraindicated immunization was rendered.

I have parsed that a couple of
times. I don't know what that means. So that
needs to be clarified.

Number three: In terms of the
evidence, what they basically do is say,
well, I the ACIP recommended this, and see the
ACIP reports. To some degree, that is about
all it can do, because there are 10 different
vaccines we are talking about there, and it
would be impossible to kind of summarize that as all ACIP report, but the point is that we really don't have much of an independent review. I am not concerned about that.

DR. STANGE: You mentioned the words, we have gotten better at this. One of the things we have done is we have focused the initial discussion on things that we think the persons who have looked at it in detail -- what are the things that you think we really need to pay attention to that are germane to the overall --

DR. STOTO: Okay. I wouldn't put that in that category.

They mention adverse effects and say that adverse effects -- people worry about it, but it is not a problem. I don't think it is quite that simple, but again I don't think it is so -- the adverse effects are big enough to worry about.

The next point has to do with the data sources. They say here data source:
administrative claims, electronic clinical
data: registry, paper records. So that is
kind of an odd mix of things, and they are not
any clearer about that later.

What they say later is that the
data comes from HEDIS and, of course, HEDIS --
it has to come from someplace, and there is
really no discussion about that.

I guess I don't think that is a
problem, because they have worked this out
pretty carefully at HEDIS, but I would like to
see a little bit more about that before I was
really confident about that. To what degree
do they -- It sounds like they rely on records
rather than recall, patient reports, but that
is not really stated here.

DR. STANGE: Is that true?

MS. BYRON: Yes, this is not a
survey measure. It is based on administrative
and medical record data.

DR. STOTO: But there were some
other ones that we looked at yesterday where
people were asked to self-report that they
have had a vaccine.

MS. BYRON: Right. That was flu
shot, not this one.

DR. STOTO: So I think that that -
- I mean I am glad to hear that is true. I
think that it would be better to clarify that.
So I am not particularly worried about that.

DR. STANGE: I think, like Jackie,
you are raising concerns that we can bring
forward and that the NQF staff can bring
forward, that if you want your measures to
have an easier time with the committees that
there are ways report this. So I think we can
take that as a general point.

DR. STOTO: The point here is that
we can't assess by ourselves the validity and
reliability of these data.

DR. STANGE: Right. Are there
other things we should consider in the
evaluation?

DR. STOTO: The only other point I
just want to make is that in the detailed statement of this, they talk about encounters with primary care providers and OB/Gyns. Since these are kids, I don't understand why the OB/Gyns are there.

MS. MERRILL: I think it is because of the MCH clinics. That is why, but I don't know, because I am having the same issue in an immunization study that I am doing right now, and based on that, I also want to ask about these multiple data sources.

There is an incredible problem with accuracy when you are using these multiple data sources, because they all record in a different way. How is that being addressed? I mean, accuracy, completeness of vaccines is a hideous problem, and how are you going to be sure that you have accurate reports? It is a very difficult problem.

MS. BYRON: Right. Well, the measure was field tested in administrative claims data and also medical record data, and
found to be a workable measure using those
data sources.

MS. MERRILL: Those data sources
were interoperable or they had data that could
be reused for this purpose, not formatted in
ways that couldn't be reused, because that is
usually the problem.

MS. BYRON: Well, our HEDIS
general guidelines -- and I could get back to
you on that -- outline what to do using the
different data sources. I will say that all
of the HEDIS measures are audited, and have to
pass that bar in order to be reported. So all
of those issues are assessed then.

DR. STANGE: I wonder if this is
one of the issues of it is such an important
measure, and anytime you are doing something
this global you are going to have messy data.
The question would be, is it the best we can
do in the situation, because it is not an
option here to not report it because the data
are messy.
So the question would be is it the best that can be done with pulling together a lot of sources that are somewhat messy, but they give you the best estimate.

DR. BURSTIN: They actually presented their testing results, and their reliability scores are quite impressive. So again, most of these things are charged for. So the claims are there.

DR. STOTO: Right. I am not so worried about the substance here. I just think the documentation -- We are basically asked to trust that NCQA got it right, which they probably did, but except for those reliability things that Helen mentioned, there is really nothing in the documentation about this.

DR. STANGE: It is really hard. You have such well established measures, and we were asked to do a lot of these measures in preparation for this, to really document all the ACIP data -- all the data the ACIP has
come up with to do each of the individual immunizations were just overwhelming. So I think we are hearing --

DR. STOTO: I am less concerned about the ACIP. I mean, I think that -- I trust the ACIP, and they cite that, and you know, we could go look at it if we really wanted to. Anybody else could. But because they take data from these different sources, as Jackie was saying, and I would like to see more documentation what the validity and reliability really are.

DR. STANGE: My hope from this discussion, from both what Mike and Jackie have raised for a number of measures, is that the staff can take that forward, and they are consulting with the measure developers, and just give that as hints to them.

I think for our work here we are focusing on are there things that are at our level of concern about whether we think that these measures have met the criteria. Jackie?
MS. MERRILL: If I am understanding it correctly, the reliability testing, the n is actually pretty small. So probably the reliability test is from a single data source, which you would be able to do.

I don't know -- I mean --

DR. BURSTIN: They have clearly given claims based analyses. Reliability is based on signal-to-noise ratios, and I think that is essentially what they have been able to provide, which is acceptable to us for a large dataset like this.

MS. MERRILL: Does this n on the first one -- If the n is 235 observations -- correct?

MS. BYRON: I'm sorry. Which number are you looking at?

MS. MERRILL: I am looking on page 3, 1.b.2, Summary of Data Demonstrated.

MS. SAMPSEL: The n on NCQA measures is typically the number the plan got reported.
MS. BYRON: Right. The membership for each of those plans is vast. So these are actually -- The reliability was run on the HEDIS measures, and is a very, very large number, and the reliability was found to be very high.

DR. STANGE: Any additional issues we should consider before voting on this?

Ron, did you want to comment?

MR. BIALEK: Just a quick question. I appreciated the breakdown of disparities. That was helpful to see, and a question I have is, in looking at the data and the differences in reporting, was there any work done looking at is there a difference between the accuracy, the validity of the data from a health plan versus an individual physician versus a health department versus a community and migrant health center?

I was just thinking, in those settings you have different potential populations that are being served.
MS. BYRON: We have the reliability data at the plan level. I will say that in prior work we had doing child health measures development, we did also test this measure, even though it is a longstanding HEDIS measure, in physician practices.

I don't remember if we had the reliability data run on those, but I can tell you that the performance data was in line with what we see for health plans, a little bit higher for the physicians which is as expected when you are looking at an individual physician versus a wider health plan level.

DR. STANGE: I guess we are ready for a vote. Thirteen Yes; one No.

So I think, if you are sitting next to one, someone else feel free to pat them on the back and pat yourself on the back. Congratulations on doing two really disparate tasks in two days here and doing them both very well and with attention to detail, and with attention to the big picture, which is a
hard combination to do.

I think the group process really worked well. I feel like I am pushing us to the point sometimes to get through things where we could have glossed, and I think when I started to in danger in that direction, I felt like the group pushed back, and I think everyone attended to their own part of the process very well in a way that was very helpful and striking the right balance there.

So take a deep breath, and just reflect back to yesterday afternoon and this morning, what we learned from thinking about both the immunization measures and these other preventive services, and think about these two different -- these kind of next steps that we talked about in our goals here.

Any ideas that you want to carry forward and, just if we could, just not -- when you start with any ideas, just don't start the sentence with Sarah. Otherwise, she would probably quit. So could we just general
things that maybe both groups should consider or one group. Mention a group name instead of Sarah's name or any other general reflections at this point. Sue?

DR. PICKENS: Well, I was just thinking about this last thing, in particular, and the opportunity to develop measures at a national level that could generate calls for appropriate data gathering nationally.

Looking at the state of Texas, we had an immunization database. It is going away, and to have something like that be available nationally to develop population based measures to know exactly where we stand -- I think it is a really exciting opportunity.

DR. STANGE: And the nexus might be registries or something like that. Is that what you are thinking? It might help drive the establishment of those things.

DR. PICKENS: Not just registries at, say, an institutional level, but at a
community level, having required data collections. I know we collect all inpatient data in Texas, and then the ability to extract that data to do actual real measures of health improvement, systems change, that kind of thing.

DR. STANGE: And there are some states that have tried to do statewide immunization registries. Right?

DR. PICKENS: Texas did, but we have lost that.

DR. STANGE: So that is a helpful idea to bring forward. Matt?

MR. STIEFEL: Well, it is related. It is just reflection about the distinction between these patient level measures and population measures, and what is different about them.

The first observation is that in the model that we looked at yesterday, we are looking at one small box in that model of population health, which is one contribution
of the health care delivery system in the provision of preventive services. But when we look at the whole framework, that is a pretty small box with regard to population health.

So looking downstream from there toward outcomes, I think, is a big part of our task, so somehow taking all of these patient population specific measures for immunizations for flu and rolling them up to ultimately look at how well are we doing in a given geographic area, and you can't just add them together.

You need to come up with some sort of registry, and then looking downstream from that to look at mortality or morbidity related to this condition is an important step in the work of this group.

The other related thought, I think, is the distinction between sort of people and patients as a denominator, and in the aggregation. If the denominator -- or episodes, even further away from people -- If the denominator is NCQA health plan data with
people as denominators, it is actually -- you can envision aggregating, summing across health plans to look to come up with a geographic population, but if the denominator are hospitals or doctor's offices or home health or nursing homes' patients, you can't add them together, because patients don't sum to populations.

So I think, just off the top, those are two, I think, important learnings from this review.

DR. STANGE: That is very helpful, big picture. As we look instrumentally at what we are doing, we said we are going to go ahead with this NQF measurement evaluation criterion on population health measures that has the -- starting with NQF current evaluation criteria, and start to think about cross-walking that to population, which is what you were alluding to. Maybe there are some where you could actually start to aggregate, but what you are saying is that is
a very small box of the larger problem about thinking about population health.

So having a separate work that starts with the population and starts working down through different subgroups, that having those as parallel activities and learning from the differences there, that is the way we set it up here probably is going to be a useful way to go forward.

MR. STIEFEL: I said that without saying Sarah, but it was implied.

DR. STANGE: Oh, she relaxed, and then you jabbed her in the soft underbelly. Ron, did you want to say something?

MR. BIALEK: Yes, I wasn't here for most of today's discussion, which probably helped things go more quickly. What I grappled with yesterday and grappled with even for the few minutes today are the discussions and presentation of data and data sources.

So often in public health, we downplay the data that we have, because it is
not perfect, and we are maybe hesitant to use it because it is not perfect.

So what I see here in the discussions of many of the clinical measures is that there are many of the very same problems with those datasets as we have with public health datasets, and that in a number of instances I could think about, the testing that we did in terms of validity and reliability for some of the clinical measures may not even be as rigorous as we might do for some of the population measures.

So I am thinking, as we get into developing measures, we may want to be kind to ourselves about the data and data sources that we use in public health for population purposes, and that, granted, there is less research done with the data, because research -- public health systems and services research has not been well funded in the past, but just because the research may not be as -- I shouldn't say rigorous; research is rigorous --
- but as much as on the clinical side, it doesn't mean we should discount the use of those data sources that we have.

So it is just something I have been thinking of a day and a half.

DR. STANGE: Another kind of research way of restating that is that the data on individual patients tends to be really done focusing very much on internal validity and just not really worrying about the external validity, and that that could be as big a problem or a bigger problem if you are really trying to make policy decisions or really have some bang for the buck or get some value from investing resources. That is potentially a bigger problem than having data that are good enough but give you give you that bigger picture about the population.

So that is going to be helpful to give us permission to raise our gaze from the usual kind of internal validity standard that we have for research on individual people.
DR. WINKLER: Just to clarify, this is not an unusual thing for steering committees, but I just wanted to -- In terms of your words, Ron, this committee is not going to develop measures. You are going to evaluate existing measures.

One of the things that is going to be critical when we go forward with this call for measures is it is likely we will need to approach folks who may not be familiar with NQF or the work that we do, and we are really going to depend on your assistance to help make that contact with those folks who may be out there that we may not know about, because we are moving into a space that just isn't our usual place where we do business.

So we will be searching, and maybe the searching we have done so far -- you know, there is just a whole world out there we don't even know is there. So we really are depending on you all to help us discover what might be out there, maybe not the usual
characters I think we are familiar with, but there is often folks in the private sector or nonprofit sector that are doing some great stuff, who just may not have crossed our radar screen. So we are really going to be depending on you guys to help bring all these folks together.

DR. NISHIMI: I just wanted to echo what Reva said. Unless the measure comes to us, tested, providing the evidence, and is submitted, it doesn't get considered by you all. I mean just in black and white. We don't develop new things.

You could recommend, and I am sure you will at the end of the day, the types of measures that you would like to see others develop going forward, and that will be very important for the development agenda, but when we get to that February meeting, if the measure hasn't come in, there is nothing really at that point that can be done.

So it will really be important for
you to beat the bushes for these measures.

DR. BURSTIN: Actually, a follow-up to Ron's point of view, especially important as we take a look at that evaluation criteria. Please take a close look at the reliability and validity requirements. I think they would still work, but obviously, your insights would be really helpful there.

DR. QASEEM: Again, this might be a question for NQF folks and NQF staff. You have already been hearing some of the discussions that are going on in terms of guidelines. Of course, guidelines are much more of an advanced line of business where not only accreditation but even National Guideline Clearinghouse is going to start doing certain things.

In terms of performance measures, is NQF -- When we endorse measures, that is good, but is it possible to have something like that we endorse measures saying that -- and again, a simple way of saying it is maybe
some sort of star rating, that this is a one-star measure, this is a two-star measure or three-star measure, because really what we reviewed -- many of the measures, they all -- I feel like we are putting them all in one bucket over here in terms of some were better than the others, but we all said yes to all of them. Is it something -- Is it possible -- and I know it is a long way, and I know this does not fall under this committee's charge and all that, but something.

I think NQF is in a really good position -- something that I have spoken before. It is something we all need to start thinking about. I think performance measures is a young field, but we are in a good position maybe. When we will be doing performance measures, maybe it is not in our committee's charge, but maybe we can still go about doing it or we can say, well, we say yes to this measure, but this is a one-star measure or something like that.
DR. BURSTIN: It is an excellent point, and actually, when we put these measures out for comment, we put out a great deal of detail. So you can clearly see, and that is why the recent Evidence Task Force Report moved toward the idea of having not just a single rating overall for importance, but quality, quantity and consistency of evidence.

So I think that was a pretty important step forward. Again, you are fairly early in the overall process. So when those measures go out for comment, people really do scrutinize those: Huh, I got pretty moderate to low evidence, and they passed it.

Those will get scrutinized, and certainly, when it gets to our Consensus and Approval Committee, they will take a very deep dive on those kinds of issues.

We don't currently have sort of a star rating for it, but we do try to at least move it through the process with maximal
transparency so people can try to make those assessments.

DR. WINKLER: I will just add in.

This is by no means the first time that sort of question has been raised, and there has been a reluctance for a lot of reasons. Different stakeholders have different needs for measures, and their threshold for what is good enough for their particular purposes is variable.

Clearly, over the course of NQF's history, you have seen essentially the criteria has helped to establish what that threshold is, and that threshold is moving up and, certainly, the most recent version of the criteria that really speak to looking deeply at the evidence, looking at the testing and the results on reliability and validity, have moved that bar up, so that the two groups of pass/no pass, when applied to measures, say, that we did eight years go, you would have a totally different result. But that is the
evolution of this process.

So at this point, we really have just the two, pass or not pass, though a bar that is constantly being pushed up as the maturity of the measurement enterprise continues, and the reason is really our multi-stakeholder audience.

MR. STIEFEL: Thinking about the evaluation criteria for these measures versus the population health measures, in the evaluation of evidence and the reliability and validity for these measures, a lot of that evaluation is based on the evidence that this measure is related to the outcome of interest.

When you are measuring directly the outcome of interest, reliability and validity take on a different meaning, I think. So that is another nuance with the criteria.

Then the second part is just a question for NQF. I am just curious if you have -- With this huge number of measures for things like immunizations for pneumonia and
flu, have you ever been presented with
measures of flu or pneumonia or mortality?

DR. WINKLER: A couple of things
around outcomes. What I did not do, to try
not to overwhelm you, is within the measure
criteria are slightly the caveats that apply
to outcome measures. So we don't need the
evidence, quality, quantity and consistency of
evidence if you are talking about an outcome
measure. All right?

MR. STIEFEL: It is at least
different.

DR. WINKLER: Right. There is
something different about it. So we don't
apply those criteria, but since all we talked
about were process measures, I didn't go there
for you and muddy the waters even more.

So outcome measures are evaluated
differently on evidence. It would be nice if
there were some evidence that you could do
something about the outcome, but even that
isn't an absolute, because there are many
times just outcomes are what people want to
know and to track just to figure out what is
going on.

   In terms of reliability and
validity, we still -- Even outcome measures,
and in fact, reliability and validity of risk
adjusted outcome measures takes on a
methodological thing that is really quite
rigorous and extensive, and we actually pull
in statistical consultants to help us
understand all of the charts and numbers and
things to what are they saying, because it is
in a completely different language.

   So that is an important part of
it, and they are done differently. So our
criteria are really appropriate to the type of
measure, with the flexibility that some
measures are process measures, but we are
really very much moving -- have a priority for
outcome measures.

   I just completed a project last --
I don't know, whenever it was -- spring about
outcome measures. Actually, in NQF's portfolio of about 700 measures, I would say right now that 250 of them are outcome measures.

So it is not -- They may not be the kinds of outcome measures that you are thinking about, like long term death or quality of life. I think those are measures people talk about really wanting to have. As yet, we are not there. It tends to be things like 30-day mortality after AMI or readmission rates, but mortality rates are typically -- or morbidity rates, complications after, oh, various procedures and things like that.

So those tend to be those very clinical and perhaps more short term. A lot of it has to do with logistics. How do you capture data for something that the outcome is years away from -- How do you know who had the X risk factor and ultimately what happened to them?

So these are all the kind of
things. People talk about them. They would love to have them.

MR. STIEFEL: I was just curious if you had ever looked at influenza or pneumonia.

DR. WINKLER: No. Nobody has ever brought absolute rates of influenza and pneumonia, but I don't see a reason why those could not be, because I do believe those are monitored at least in a surveillance fashion. Correct?

DR. BURSTIN: I think part of this really gets at this issue of what is population health? So I think one of the issues has been traditionally NQF has had a level of accountability assigned to an entity, so a clinician, a provider, a health plan, whatever the case may be.

It is often difficult to look. Those tend to be smaller numbers. It is hard to really look at that, but again as you go up in aggregation, you can start looking at a
geographic area, as we were talking earlier. I think it would be great to potentially get some of those, but then it is at a very different level of accountability, and it would be hard to assign accountability to, for example, an individual hospital for the community rates.

It is a shared accountability, exactly the issue we talked about yesterday.

DR. STANG: For Sarah, I would just like to say that that is a really good issue, and I think that we need to refer that back to the committee that is run by Matt.

MR. BIALEK: I guess I have to make up for my time not being here earlier.

I heard loud and clear that we need to find organizations who can put forward measures, who can meet the criteria. So a question I have just to further understand and to test an idea whether or not this would be appropriate is, you know, we talked a little bit about tobacco yesterday, and I talked a
little bit about tobacco taxation.

So there are a number of studies that suggest that the tobacco tax does impact in a positive way the smoking rates and life and mortality and morbidity.

So if there were a measure presented as to whether or not a state, territory, tribe has a cigarette tax above a certain level, and the measure basically then is sort of a yes or no, they either have it or they don't, when I think about the evidence here, the criteria, the validity, reliability to meet those various criteria, when I think the nine aims and trying to put it through the HHS quality aims and looking at it that way in terms of vigilance, proactive, etcetera, I think it would meet that as well.

So my question is: Would a measure that is relative simple, which is yes, no, 50 states, is that something that would be appropriate or not appropriate to come before this body?
DR. STANGE: So, Michael, then
Sarah.

DR. STOTO: I think that is a good question. I don't know the answer to it, but
there is an alternative that, rather than
saying do you have the taxes, maybe you can
say something about what is the tax -- that is
a quantitative measure - or something about --
I guess taxing is not an enforcement issue,
but some other things may be how well is it
enforced. That could turn it into a
quantitative measure.

I am not sure that really gets at
what we need, but that is worth thinking
about.

MS. SAMPSEL: I think it is a good
question, too, because the other area that we
see a lot of this is with obesity, and
percentage of school districts that have
vending machine laws or stuff like that, which
are truly indicators of population health, and
they are what the obesity industry -- or the
industry that is trying to change the obesity rate is trying to do, but yes, I mean, it is just really hard.

Michael, regarding your suggestions, I think yes and no gives you a good versus bad, where tax rate you may not know if that is good or bad. So those are things that we would have to think about.

When you conceptualized population health, were you thinking about things like that, or no?

DR. BURSTIN: I think we felt like we needed to get a read from the committee on what they think are the proper parameters here. I think in some ways those are structural measures. We have structural measures at the clinical level as well.

I guess the question is how meaningful is it to have it as a performance measure for a state. That is, I think, really what it comes to.

Going back to the point as well
about Matt's model, in some ways, is that more
of a sort of a causal issue, and are we really
interested in -- I think BRFSS has a number of
cigarette packs sold per state. Is it kind of
better to maybe think about an outcome.

I am just trying to think about --
one of the same issues -- what is the best
measure to look at in that context, and is it
more a policy yes/no? I honestly don't know.

DR. STANGE: Well, I will go next,
and then Matt, and then Mike.

These last few things that have
been talked about, I have been thinking about
it from a scalability point of view. I think
it shows what might happen when sort of
starting from the clinical and going outward.
We start from the highest level and go
downward.

So I could actually envision some
of these measures being measured at a state
level, scalable easily to a county, scalable
to a smaller geographic community, with the
idea that some of what we want to stimulate
with these kind of measures is getting multi-
stakeholder groups to the table as opposed to
just one entity that can do it, but then it is
kind of irrelevant for the population.

You could actually sink down even
to the health care system level, defining what
are the schools in your catchment area. Well,
there's other health care plans. Okay, well,
then you talked to them about it.

So starting at that level and then
thinking about scalability, so that just
looking ahead to what we have decided we are
going to do, we have these two working groups
that are at least a next step. Who knows if
they will last very long, because these things
interact, but we will have one group -- that
is the next step -- who will look at these
kind of framing and scope and developing a
model of how we think about measuring
population health, and then a group that will
be actually looking at how to measure.
Both of those will be starting
with -- not starting from scratch, taking some
of these ideas, but going and doing an
environmental scan going forward.

We do have these people that are
doing the commissioned paper. That, in my
mental scan, is part of their work. So we
need to have these groups asking for what they
need, so talking to the folks doing the
commissioned paper, finding out what they
found.

Elisa and I will talk a little bit
after this about what the NQF staff is able to
do as far as supporting the work of the
committee.

We talked about the NQF draft
evaluation criteria that will also be
something that -- that work that is being done
to move that forward needs to inform and be
informed by the work of these two groups.

So what we are talking about is
setting up at least some next steps. So Matt
and Mike, and then Jackie and Sarah.

MR. STIEFEL: One of the things that we have just been talking about isn't explicitly included in your summary, which is, I think, an important part of the conversation yesterday of unit of accountability.

It may not fit in either of these two working groups as articulated, but it is a really fundamentally important question and comes up when you are thinking about a state where in the existing measures -- it tends to have a very focused definition of the accountable entity.

We talked yesterday a lot about that accountable unit might be a multi-stakeholder collaboration, and that is probably not the same as the county or state government; rather, the group of stakeholders in the county or state that are vested in the improvement of the health of that population. It may be the combination of health plans and hospitals and doctors and schools and
employers and social service agencies that vets a unit, a multi-stakeholder unit, but it is, obviously, a lot more diffuse and more challenging, but in fact, may well be the right unit of accountability.

So I think some work at the front end of thinking about unit of accountability for population measures will be necessary and important. I don't think it fits in either of these work groups. Maybe it can go to the LA group.

DR. STANGE: I think that is exactly it. So I think one of the breakthroughs that we had yesterday and that we need to make sure we convey this fully -- I think we conveyed and discussed it. We need to fully convey it to the commissioned paper groups, as they started out with the frame that we are starting from a point of view of where you are going to have a little bit more rigid accountability, which is part of the reason they have framed it in terms of health
care systems and public health systems.

I think the idea that was added during the discussion yesterday was that it could be multi-stakeholder groups, which is quite liberating for the work of this group. So I think that the group should take that idea forward.

As you are framing the discussion you might take the time and say, okay, now let's frame it different. Let's start with the end in mind. Who are the users for this? Who is the accountability for this? That might reframe the discussion.

So that idea will need to go forward in the charge to the commissioned paper, and I think it should be a starting point or something that is discussed fairly early on in both of the groups, but it is a really important idea not to lose.

Mike, Jackie, and then Sarah.

DR. STOTO: Back to Ron's question, two things. One is measures can be
specified so they are dichotomous at the
lowest level, but then become continuous when
you roll them up.

So you might say, you know, what
fraction -- A school either has a certain
anti-smoking policy or it doesn't, but you can
say what fraction of the schools in a
community do or what fraction of county health
departments do so and so. That is one way of
addressing it.

The other thing, a little more
general, is that I think, to the extent that
we could talk about the intensity of these
interventions, but not whether you have it or
not, not whether you have a program or not,
but how much of it you are doing, how well it
is working, something like that, if you can
capture that in some of these measures, that
would be better.

MS. MERRILL: I just got the email
that they made the formal launch of the FAB.
The Public Health Accreditation Board has

Neal R. Gross & Co., Inc.
202-234-4433
formally launched the accreditation process.

So now there is a bunch of standards,
measurement standards, that exist, and that
might be one place.

Some of those might -- I am not
saying all of them, but some of those might be
candidate measures for this group, and we
would have to then define the sponsor for
that, if it was going to be a community
coalition or -- But the question becomes like
where. Where does the -- the rollup question.
Where does the rollup happen.

So do we need collaborations at
the national level, say, between the Governors
Association and ASTO and the local boards of
health. That is kind of what I am seeing, is
that a group of partners like that would come
forth and put a measure, say a measure of the
smoking legislation laws in a given state.

Then that would be the measure,
and that group would put it forward, but then
that group would be responsible for seeing
that communities lower down bought into it and made provisions to get the data.

So just trying to put a practical face on it, but that is kind of how I see that operating. But then the communities would have something to hang on, but there is going to be some cost involved for data collection. So that is something else, I guess, we have to think about. Just more conceptual ideas.

MS. SAMPSEL: I think my additional comment had been -- and I believe we have already talked to LA about looking at the National Prevention Strategy, because a number of their measures are structural measures, and they are looking at this type of thing. So I think we may want to really take a serious look and consideration for those.

I really think, when we are thinking about that determinant of health as well as health outcomes, especially on that determinant side, and you are talking about obesity, who is accountable? Is it a parent?
Is it the school? Who? It is something we are going to have to grapple with, and that is why I think this group would be a good group to try to start.

DR. STANGE: So we have Linda, Ron, and Mary. Oh, sorry, that was Sarah. I thought it was Linda. Sorry, Sarah

DR. LINDE-FEUICH: I just want to echo, actually, what Sarah just said. She was reading my mind. I think the National Prevention Strategy would be a great framework for us to look at as we are going forward with population health measures, and I am pretty sure that tobacco, obesity and physical activity are target areas in there.

The way the National Prevention Strategy is set up, it talks about what government can do, what you can do at the community level, at the employer level. It is broken down. The thinking has already been done, and I know that there is work going on now to put some energy into it as far as
implementation.

So I follow that in my job at HRSA. So I can help be a link to that. Anyway, as we are going forward, I think that is -- That work has already been done. So we may shorten our work or lessen our work.

DR. STANGE: That is a really important point, and it parallels NQF's role. They are not measure developers, but they have this larger role, and this might not be the group that develops the whole approach to how you approach population health measurement, but that takes what is out there and synthesizes it in a way that uses the unique platform of NQF to move that forward.

So that is a very helpful frame, and it will keep us from reinventing the wheel, if we take that to heart. Ron, Mary, and Matt.

MR. BIALEK: Just to briefly respond to Jackie, your comment about the Public Health Accreditation Board standards.
One of the issues we may have is that many of those standards have yet really to be tested. So there is really not an evidence base yet, which then, I suspect, would not meet criteria that we have been talking about for the evidence.

Back to the tobacco issue, one of the reasons I posed the question is that I think it is going to be difficult for us to find measure sponsors, if you will, folks who can really go through the rigorous process, spend the time, the energy, the effort, the money to develop the measure and present it.

A lot of that, I think, would fall on CDC, and there is only so much CDC can do. Some of it, if we have any workforce measures, might actually fall on HRSA.

As I am thinking about external bodies, and I suspect, if we were to approach the Legacy Foundation and say -- you know, Cheryl is the Executive Director there. There could be some national measures on tobacco and
some of the policy issues that are so near and
dear to the hearts of Legacy and are evidence
based. -- would you be willing to develop them
and put them forward, that she probably would,
and I think it would be great if we were able
to give her enough guidance about what may fly
and what might not.

DR. STANGE: So as I call on Mary
and Matt, I will ask Jason if you would just
think about what Ron said in terms of partners
and measure developers, since partnership is
in your organization's name. If you want to
comment on that, I will welcome it. But first
Mary and Matt.

DR. PITTMAN: Thank you. I am
sorry I missed yesterday. It sounds like a
great discussion that went on, and I was
wondering whether you talked about some of the
environmental indicators that would relate to
clean air, clean water, safe food, toxic
sites. Did that come up in your conversation?

There is certainly another whole
set of indicators related to all of those
environmental standards and metrics.

DR. STANGE: So only alluded to,
and I think that is another thing we can give
the charge to Matt's committee. I
interrupted. Did you have more that you
wanted to say, Mary?

DR. PITTMAN: It seemed like our
frame was staying very close in to the medical
care side, and so I think, if we look at all
of the determinants of health that would have
an impact on population health issues, we are
going to have to broaden that frame.

DR. STANGE: So you might know
which committee you want to be part of.

DR. PITTMAN: I will need to look
them up.

DR. STANGE: Matt?

MR. STIEFEL: We have a big frame.

Speaking of harmonization, we were talking
about the prevention strategy. I was just
sort of curious about how that harmonizes with
Healthy People. Healthy People seems like a great frame to start with.

I love the last decade's version of it where it had at the top of the pyramid length and quality of life and disparities. What a great top of the pyramid for population health. Then the problem is it goes down to 160,000 measures at sort of the next level underneath it, and the hierarchy kind of dissipates, but that is a very, I think, useful framing that we ought to rely on, but I am just not sure about even within HHS how these are harmonized.

DR. LINDE-FEUCHT: They are harmonized, and I can tell you that some of the objectives in the prevention strategy are Healthy People 2020 objectives. So although people love to tell us that we don't talk to each other in government or within departments, we do try. We are aware of all these strategies and try as best we can to harmonize them. But for these two particular
ones, they are aligned.

MR. BIALEK: Sarah, isn't ODPH coming out with leading indicators in the next couple of weeks, which will then further narrow down?

DR. LINDE-FEUCHT: Yes. Yes. I mean, the IOM has already released the leading health indicators, and then there is a review process in the Department to get them adopted and see if the Department is going to agree with or modify them slightly. But, yes, that is correct.

MS. SAMPSEL: I don't know if I want to say this or not, but I actually completed a crosswalk between the National Quality Strategy and the National Prevention Strategy and where those data sources are. So I will put it into sharable format, because right now it is in Sarah format, and could share it with LA or the group.

DR. STANGE: I think we would all
be interested in that, and don't get perfectionist about it. We will just look at it. So feel the love and permission to share something early on. Madeline?

DR. NAEGLE: I think it was Ron who mentioned workforce, and I am wondering if we want to talk and think about workforce and numbers in relation to achieving our population oriented outcomes. It is a huge area, but I think that there are some areas where it has more significance than others, and right now I am thinking about, obviously, the growing geriatric population.

I think that we might want to consider what is available and what we know about that. HHS is a good source on that, and that is something that was very closely tied to the recent IOM report on the future of nursing.

So when we look at the correlation between staffing patterns, numbers of nurses in schools, different kinds of providers,
classes of providers in different settings --
I don't know if we want to spend a little time
thinking about that or asking the people in LA
to think about how they might factor workforce
in looking at care delivery.

DR. STANGE: But it also sounds
like something that NQF might be able to get
another contract for outcome measures that
relate to medical -- well, health care,
education for a lot of different things that
relate to health, whether it is going to be on
health professionals.

DR. LINDE-FEUCHT: Right out of
that report and right on the top, we have not
made any inroads to the new documents on
professional education, another place where
Canada and the UK are far ahead of us. So
thinking about some of that might be
interesting.

DR. STANGE: Right. Thank you.

Jason.

DR. SPANGLER: I will respond to
you. I had a question first, though, to Helen and to Reva. How aggressive is NQF in reaching out to developers and saying, you know, we are about to -- we are thinking about endorsing these separate measures? Do you guys go to people and say, look, please send us a measure?

DR. BURSTIN: We are as aggressive as we can be, which is why in some ways, because this is a different universe with the exception of CDC who routinely submits to us, we would rely on you to help us do that outreach.

DR. STANGE: Reva wants to get in here. They are aggressive about even getting the microphone about this.

DR. WINKLER: The only reason is because it is such a standard part. We try and do the environmental scan: Who is out there? Who is doing something where we have some usual sources. That is what we are concerned about, is this -- What we are
looking for now may not be in our usual sources. So that is where we are really going to rely on you.

DR. SPANGLER: So I will go ahead and say this, basically knowing that I am volunteering to lead whatever I am saying.

Going along with what Ron said is, depending on what we decide on, whether it is smoking, obesity or whatever, we should actually -- I mean, we could do this.

We know all the organizations like Legacy. We know all the tobacco organizations. We know all the nutrition and obesity organizations. We know all the physical activity organizations, and we could put together a list of who we should actually go to, to solicit measures for. So I guess I am chairing that group who is doing that.

DR. WINKLER: Just absolutely. I mean, this is something we really request of all of our steering committees, but when we are doing the usual stuff, we are talking
about the usual folks.

This is not the usual folks, and so this is really an important role for you all to play.

DR. STANGE: I want to thank everybody for going rapidly through -- Okay, sorry. Linda.

DR. KINSINGER: I just have one quick question. Does a group like the National Governors Association -- do they have a health committee or is that -- I was just thinking, we have got the business folks sort of -- they were here represented yesterday, but a political organization, if we are looking at --

DR. SPANGLER: Well, Linda, I would also include not only them but CSG, Council of State Governments, NCSL, National Council of State Legislatures. There is a bunch that have health related -- Yes.

MS. MERRILL: Do they all work together, those three?
DR. SPANGLER: I don't know how much NGA works with them. I know CSG and NCSL work together.

DR. BURSTIN: And part of what we will do, as we work with you and develop that call for measures, we will give it to you in a way that you can send it out to whoever you want. We can have it fully coordinated, if we would like, or also you may just have the contacts on your own you are going to want to send out to.

Again, we want to bring a lot of technical assistance on our side with the developers, making sure they understand it, which is why in some ways, because we are speaking a slightly different language, as we learned yesterday in a big way, it is especially important that we make sure that those evaluation criteria speak to those kinds of measures, because otherwise, they will get really lost in some of that reliability, validity, evidence stuff, and then they will
get scared off.

We scare off many mainstream measure developers. I don't want to scare off others. Again, CDC does work with us very closely. We have all the HAI measures, for example. So we do have a good working relationship with those folks.

I guess one of the real questions is going to be do we want to go down the path of -- this is a bigger issues for all of us -- a whole series of the chronic indicators from CDC are things like that.

We just went through this process -- actually, Reva had that tough nut as well -- with the child health measures where we went through a whole series of measures that emerged from the National Children's Health Survey. Many, many indicators emerged from that.

It is a national survey. You can bring it down to the state level. But again, some of this is also volume. We also want to
be careful of not bringing in hundreds of
measures, if that is not what we want.

DR. SPANGLER: Speaking to Helen,
is there somebody or several people from CDC
that you work with a lot that maybe we should
use as a resource to help bridge some of those
questions or gaps that we have? Since you
work with them a lot, they know all the public
health population health stuff.

DR. WINKLER: It is interesting.
We do have a couple of contacts, but they
actually come from different departments
within CDC for different measures. So it is
interesting.

DR. STANGE: Mike?

DR. STOTO: I would suggest you
probably need very different people from CDC
than you have been working with before. For
instance, at national Center for Health
Statistics, they have got the Healthy People
group. That probably is one to talk to.

MR. BIALEK: Because this is so
new, would it be inappropriate for this committee to sponsor a webinar with potential interested parties? So that is something that -- Okay.

DR. BURSTIN: I actually wrote it down five minutes ago. That would be a great thing to do. As we get the evaluation criteria done and we have the call for measures, it would be great. Actually, that would be something Jason especially could help us with, get the right folks knowing about it, and we could happily do a webinar to run.

DR. STANGE: That is a nice segue, actually, to two things that we have left on the agenda, to just one more time open for public comment, and then Elisa is going to give us a little summary of what she has heard as far as next steps here.

So knowing that those are the two thing son the agenda, anything else people would like to say here? I am really grateful for how people were engaged in the initial
discussion, how everybody stuck with it, and then we have saved some time for this.

This is like my children are grown, but sometimes you -- when your children are babies, you know, they are cranky all day. It is just a tough day. Sometimes you get to the end of the day or sometime when they are on your shoulder and in this quiet alert phase, and that is when all the big thoughts and stuff come out.

So I think we did the hard work, and then we just -- by getting quickly through the others, we just created this little quiet alert space here. I mean, we are quiet, we are tired, but everybody looks alert and engaged to me at this late stage in the hard work. I think that is the kind of thinking that becomes part of what we are as a group, and that will carry forward.

So I am grateful for what you all did to just get to this point, and then how you have used quiet alert space.
That is quite a segue into the comment, public comment. So anybody on the line for public comment?

DR. WINKLER: Rufus, does anybody on the line want to say anything? Rufus, are you still there? Rufus?

OPERATOR: Sorry, hit *1 for those on the line.

DR. WINKLER: Thank you.

OPERATOR: Nobody has signaled.

DR. WINKLER: Nobody is responding? Thank you. In the room?

MS. MUNTHALI: Thank you very much. I just wanted to go over the next steps. We have quite a bit of work ahead of us. Everyone did quite a lot of work. so there is some follow-up that we have to do.

One of the follow-up, the most immediate follow-up things will be the call that we have scheduled tentatively for September 29th and the 30th. I think we have included this in slides that you have had for
the orientation and work group.

This will be to follow up on some of the measure issues that we had. There were quite a few recommendations and suggestions that you had for the developers. So what we as staff are going to do in between that time is follow up with the developers, and they will also be participating on the call. So if you have additional questions of clarity, they will be able to address those during that time.

Yes, Sarah?

DR. LINDE-FEUCHT: Do you have a time set for that call, because my schedule -- I'm sure everybody else's -- fills up pretty quickly, and that is in two weeks.

MS. MUNTHALI: Well, yes. so we were waiting until this meeting to confirm that we are indeed going to follow. So either probably tonight or tomorrow, you are going to get a survey monkey, similar to what you have gotten from us before, with some times for
either one of those dates. It will be
total majority rule, similar to what we have done.

We will do the 30th. Twenty-ninth is out. So let us know if you can't do that date, and we can possibly push it out a couple of days, so maybe the first week in October.

Then one of the major deliverables that is coming up is the due date for our draft report.

DR. STANGE: Actually, just on that last item. So I think it would be important to not just have that be just about the measures follow-up, but to be also about the follow-up of these other issues.

So it is not reasonable probably to have these small groups configured and have met by then, but I think we want to maybe have them configured by the time of the call, and to be able to give a charge to the groups about what they are doing.

I wonder if we want people from the commissioned paper on that part of the
call.

MS. MUNTHALI: And the next slide for Phase 2 has the work group follow-up call.

DR. STANGE: But I would say that I think the call shouldn't be just about the measure follow-up on September 30th. I think we need to keep the other agenda item on there. I think that will help us keep people's interest.

MS. MUNTHALI: So we can do a two-hour call, and so the first part do the measure review.

DR. BURSTIN: She just has it split out by phases. That's all.

MS. MUNTHALI: Yes. So the draft report will be on our website for member and public comment October 17 through November 15th, and we will make sure that we circulate it, as Helen mentioned, to the committee for your feedback at least two weeks before. It will give you some time to review it.

Then following the draft report,
we will circulate any comments that we receive, and staff will help the committee to draft responses. Any comments that are specific to the developers, we will send to them, ask them to comment on that, and then we will have a conference call where members and public will be there to look at the comments and look at the responses.

Then I think that is it. I am having trouble looking at the last bullet.

Yes. So we have the comment there.

DR. STOTO: That all refers to the preventive services measures.

MS. MUNTHALI: Yes. Yes, so Phase 1 which we are calling preventive service measures. So this is Phase 2. This is the discussion that you had yesterday and you followed up with today, and we will be scheduling those conference calls within the next two to three weeks, and we will make sure that LA County is there as well to participate.
Then you will be providing feedback to us on the call for measures for Phase 2, which is the healthy behaviors, and we will make sure that we have a good exchange of feedback through email.

Then the first draft of the commission paper, we are hoping, we will be due by the end of November, but this may change. These dates for Phase 2 are not as strict as they are for Phase 1. So I just wanted you to keep that in mind.

DR. BURSTIN: We will work to make sure that the Work Group stays sort of interdigitated with what LA is doing so that you don't get a commission paper sent to you in a month or a month and a half that doesn't meet at all our discussion. So we will keep those aligned.

MR. STIEFEL: Can you help us with the Work Group logistics?

DR. BURSTIN: We will take care of all that.
MR. STIEFEL: That is not on this list.

MS. MUNTHALI: No. We are going to -- Crystal and I will handle it tomorrow. We are going to confirm who is on each work group, and we will work all of that out.

DR. STANGE: And part of that will be including people who didn't have the benefit of this discussion today. So there needs to be a way for people to identify with the starting groups, although I guess we could use the groups that I had at the beginning of this day.

I want to thank Donald for keeping the AV going, the committee people from NQF, Elisa, Reva, Helen, Robyn, Kristin, Nicole, and the man in the blue tie over there who has been transcribing. His name I don't know. I guess in the NQF staff I should include Bonnie who had a consultative role but had some history in helping to birth this process, and those who stuck with us for the whole day, the measure developers.
So thank you very much.

DR. BURSTIN: Thanks to Kurt for yeoman's work today.

(Whereupon, the above-entitled matter went off the record at 2:44 p.m.)
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CERTIFICATE

This is to certify that the foregoing transcript

In the matter of: Population Health and Prevention Endorsement Maintenance

Before: NQF

Date: 09-14-11

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

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Court Reporter

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