NATIONAL QUALITY FORUM

Moderator: Reva Winkler
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11:00 am CT

Operator: Good day, ladies and gentlemen, and welcome to today's conference. Please note today's call is being recorded. Please standby.

Reva Winkler: Hello everyone. This is Reva Winkler with the National Quality Forum. Thanks so much for joining us today for the workgroup conference call for the Pulmonary and Critical Care Endorsement Maintenance Project.

The Asthma Workgroup today will be discussing - doing preliminary discussions of ten of the measures in this project.

As a reminder this is a public meeting. We do have several audience members listening. And at the end of our call we will be giving them an opportunity to make any public comments.

The transcript and recording of this call will be available in a couple of days and they will be posted on NQF's Web site. That will allow anyone of interest to review the discussion.

Today our goal is for the workgroups to have a preliminary discussion of ten of the measures related to asthma.

The workgroup has been able to focus on just ten of the 35 measures in this project related to asthma and really take a detailed view of them against the criteria.

And so I think the folks that have submitted your ratings to us online, I believe that Katie sent out as a spreadsheet with the results of the ratings, the preliminary ratings from at least four of the workgroup members.

This will serve as a starting point for our discussion for each of the measures.

What we'd like to do is really focus in on the areas where they have touched your concerns or ((inaudible)).

If everybody is in agreement about criteria and evidence and whatever then there isn't a great deal to talk about it. We can focus our efforts on the things where there is something to discuss.

The summary of the work that you're doing today, the ratings you're submitted and the discussion you're going to have, we will put together the summary. And that will be - form the basis of our conversation for our meeting in March of the entire steering committee.

So it's important that we identify the issues and concerns for these ten measures today so that they can be highlighted going forward.

We also have the measure developers with us to respond any questions or concerns. Perhaps some of the issues you raise may prompt them to want to respond or put additional information into submission forms and in preparation for the in person meeting.

So essentially that's what our goal is. Ten measures is ambitious in two hours so we'll want to be keeping an eye and the time. And I'll try and just kind of facilitate keeping things moving along.

Anybody in the workgroup have any questions about what we're going to be giving?

Okay so then let's just start off with our agenda. Measure number 36 is the first measure we're going to talk about. This is use of appropriate medications for asthma.

This is a measure that's been endorsed for several years by NQF. It comes from NCQA and we do have our developers with us.

Dr. Lang?

Dr. David Lang: Yes?

Reva Winkler: I understand you're with us.

Dr. David Lang: Yes.

Reva Winkler: Oh great. Did you want to perhaps start the discussion by just kind of reviewing going through the criteria starting with importance and provide your thoughts?

Dr. David Lang: Sure. There's no question that this deals with an important area and I think that's true across the board with regards to the measures that we're discussing in that asthma is prevalent and that there continues to be, you know, there's high prevalence of asthma that's not well controlled. There's unacceptable morbidity and mortality.

We all know that asthma's a treatable condition and that a lot of this morbidity and mortality is preventable and that a gap continues to be exist- continues to exist between optimal care as defined in evidence-based guidelines in normative cares to actually occurring in the community.

In that regard there are number of measures. And I know that we may discussing this from the context of harmonizing these and discussing the differences in age for instance that are specified by these different measures. But let me focused then on number 36.

I don't know, how would you like me to proceed in terms of the best utilization of time given that I'm the leadoff hitter here in terms of I assume that all of you have read and are familiar with the metric or the measures. Is that correct?

Reva Winkler: …folks joining us have all reviewed the measures and...

Dr. David Lang: Okay. So I don't need to review. I could just jump in. So the importance is high.

Reva Winkler: Yes. If you look at the ratings by the four who submitted everyone would pretty much agree with that. The impact is high. The opportunity to improve is rated high and...

Dr. David Lang: Right.

Reva Winkler: ...in general pretty much high for evidence as well.

Dr. David Lang: Yes the only issue and maybe it goes into the other individuals on the call, perhaps you can help me with this or enlighten me.

The numerator stipulates that it will be, the numerator will be comprised of members -- I'm reading -- who were dispensed at least one prescription for a preferred therapy during the measurement year.

And the preferred therapy medications table ASM-D include not only inhaled cortical steroid and combination agents but also Omalizumab, (Alukifying) modifiers, (Fiafalin), (Chromones).

And I guess the, you know, the reason that I rated the quality as moderate rather than high is that there's not as much evidence to support favorable outcomes in terms of reduction of morbidity, mortality with these other agents as there are with inhaled corticosteroids. Now is that an appropriate interpretation?

(Mel): Hi. This is (Mel) from NCQA. We do realize that there's sort of different reported effectiveness with these different medications in that ICF tend to be the most preferred. So we were trying to be as inclusive as possible when designing this measure.

So we just wanted to make sure that the medications that we put in it were sort of aligned with what's recommended in clinical practice. So we do realize that there's a difference depending on the type of medication.

Dr. David Lang: Okay that there's a difference in the level of evidence?

(Mel): Right.

Hayley Burgess: This is Hayley Burgess. I scored it as a moderate as well in the way of quality for the same reasons just because they received one of the medications.

Again it's just a little uncomfortable saying that, you know, what would you do with that information if they did receive one of these medications within the prescribed period? What is that telling us if it wasn't optimal therapy?

Female: Right, yes.

Trude Haecker: And I would agree. This is Trude Haecker. I - unfortunately I couldn't walk and to the system. It wouldn't let me in but I scored that as a moderate as well.

Female: Great. Thank you. Good to hear from you.

Hayley Burgess: Right. I don't think it means it's a bad measure. I think it's just something we need to be aware of. And perhaps you can shed any of the learnings because this has been a, you know, previously endorsed a measure. You know, are there learnings - has the data that you've received provoked action?

You know, because I guess what we struggle with is the number of measures. And, you know, we really want to narrow in to what are the measures that are going to be the highest impact for us?

Why are we going to change care based on what we're receiving, not just to collect more information?

And so I like some of the other measures that are coming a little later that are more of the composite measures and give us a little more information about the adherence versus, you know, one prescription was, you know, retrieved during that time. I just feel like it would help to know a little more about the patient to change care.

Ben Hamlin: Yes, this is Ben from NCQA. I'm sorry I'm at the airport so I'm going to try to keep my comments brief.

You know, as mentioned this measure's been around since about 2005. And it was initially designed to address the gap in care which was ensuring that people with moderate to severe persistent asthma were receiving medications, you know, to help them manage that measure.

And it's been around for a long time. We've had an absence of better measures. We think that there are, you know, new ones that get developed which we'll be discussing next.

You know, the measure is in widespread use right now so it's - while there is a little variation it is still ensuring that people with moderate, severe asthma are, you know, being addressed. And so we have chosen not to retire yet because it's in such broad use.

So we are looking at as, you know, the next generation of meds that will address, you know, improved outcomes in that population now in a little better way now that the data it is better and more accurate for managing the population.

Female: Yes that helps me at least to think about this. And Rita I guess I would just ask you as we are looking at some of the new generation measures is it the goal of the committee just to go individually by measure and say, you know, yes we would continue to endorsed this measure or would we want to start consolidating the measures as to this is the direction that we're moving versus having ten measures or, you know, not all of these are outpatient but, you know, an X number of measures that we would prefer to be the ones that are followed moving forward versus what, you know, based on where we've gone with new data and advancements and et cetera?

So just a question of the committees, you know, because I approved this measure. I mean I don't, you know, it is in practice today and, you know, we're not going to turn the Titanic tomorrow. So they'll continue to collect the measure.

But as the goal of the committee should we be looking at it one by one or thinking about, you know, other recommendations of where we're going?

Reva Winkler: Well the answer to both of your questions is yes. What we like to do is particularly since this is a previously endorsed measure and it's under maintenance review is we do want to look at each of the measures independently and individually.

However you will then be asked at before final recommendations if given a group of measures is there a subset that is preferred and perhaps we don't need all ten of them are whatever subset you decide?

So we will be asking those questions. We're just going to do it in order. We're going to...

Female: Okay.

Reva Winkler: ...look at them individually and then the second look pass will be to ask that very question is do we need all of these?

Female: Okay that helps. Thank you.

Reva Winkler: Okay. So it's we've talked about importance and everybody feels comfortable that it meets the criteria for importance. How about reliability and validity? Dr. Lang, your thoughts?

Dr. David Lang: Right. The major issue and the reason that there's an moderate here for me is that in the denominator details, I mean the measure stipulates that we're focusing on moderate to severe asthmatics. And there is an issue of control versus severity which as we all know are not the same thing.

And you can have a patient with mild persistent asthma that's poorly controlled in the emergency department or that has frequent clinic visits. And those patients may be included in this measure.

So I guess in terms of my understanding of reliability and validity in the measure properties that I just, you know, wanted to point that out as a, I guess I want to say a potential source of lack of precision to the measure.

Reva Winkler: ((inaudible)) anything else?

(Crosstalk)

Ben, go ahead.

Ben Hamlin: Okay so yes we recognize the slight lack of precision. I mean we've tested this measure, denominator identification algorithm multiple times, you know, with the recommendation that it's fixed in admin only base identification.

And then or (piece) - come back to this is the most reliable way to identify that particular population. You know there are a few inherent weaknesses that we hope to address in the future. But at, you know, at the current time it was the best - sort of the best of the best as far as, you know, pure admin claim identification of people with mild to severe asthma.

Dr. David Lang: Okay, fair enough. Are there any other comments regarding reliability and validity?

Female: How about usability or feasibility? It seems to be rated pretty high.

Dr. David Lang: Yes, I think that's rated high across the board. And again I think to conclude I - you know, my major concern is the inclusion of alternative controllers that which we've discussed.

Because as the evidence for those, you know, you can have a patient with moderate to severe persistent asthma who fulfills criteria here for this metric based on getting a prescription for a (anti-lycatryine) or, et cetera, for which the information is not as clear.

Female: Right.

Reva Winkler: So with those two caveats does anybody in the workgroup think that that represents a fatal flaw to the measure?

Female: No.

Male: No.

Female: Yes.

Male: It's not a fatal flaw but, you know, it's a ding.

Reva Winkler: Okay weakness. All right we'll be sure and highlight those so because everybody felt pretty good about the otherwise the measure meeting the criteria.

Okay if so we can move along to measure 1799. Now this is a new measure. I think this is what Ben Hamlin was referring to. NCQA has some new generations of measures coming along. And Haley I believe this one was yours?

Hayley Burgess: Yes it is. And this is a new measure so I'm glad that the NCQA group is on it so you all can help us with some of the questions.

It looks like you all have reviewed these as well as I have. And our comments are there. So the member ages are similar to what's been previously endorsed, the five to 64 years of age.

What makes this one different would be those patients who are identified. And back to the, you know, previous statement about the identification, it is the same as what we just went through in 36 so we can talk about that.

This is looking specifically at those patients who were dispensed appropriate medications. And we can come back to that statement that remained on during the treatment period and then 50%, 75%.

I love the spirit of this measure so we're getting more to an adherence of, you know, appropriate utilization of medication versus just having one. At least we're looking at a period of time that patients would remain on their medications.

And then the piece as you can see proportion of days cover by at least one asthma controller medication prescription in the measurement year.

So I guess if we go through the same way of looking at, you know, impact I felt like it was a high impact. I think the group did also. Let me scroll down on my worksheet and I'll see where the other folks landed.

Female: I would agree as well.

Male: Yes.

Hayley Burgess: Yes I do, I like the spirit of these two measures a great deal. Let's see, okay so and please jump in if anyone has any other thoughts.

So moving through right guess my greatest concerns about this is actually the capturing of the information. I feel like, you know, reliabilities, we're using claims information, we're identifying the patients the same way as we had before through this NCQA measure. You know that's - that part doesn't change.

Collecting information from claims database would be very similar. I guess just maybe a little of information from our contacts around the reliability of collecting that information and the algorithm of the calculation if you will for the 50% and 75%. Ben, would you want to speak to that?

Ben Hamlin: Sure so a little historical perspective here. When we developed 1799 and 1800 one of the things we tried to do was build them off of the current algorithm for admin claims.

So you'll notice the denominator is almost identical for all three of these measures instead of a, you know, the exclusions and also on and so forth.

We didn't try and reinvent the wheel if we didn't have to given that these were - and we also then when we tested these two new measures we retested a lot of those algorithms like I just mentioned earlier that sort of ensuring that they are still sort of the best way to capture those populations.

With the new measure MMA, the appropriate medication - Medication Management I'm sorry, really the focus of our field test for this measure in particular was the access to pharmacy data and the reliability of the pharmacy data.

And then sort of what we did is actually we took member level files from nine health plans and did a series of calculations ourselves looking at the percent of missing data which was actually surprisingly very low.

And so what I alluded to earlier when we had to wait for that next generation of measure that was almost seven or eight years was the data wasn't ready in 2005 but now to our field test and to our analysis which is going to occur in a couple of months here we feel that the data is there, it is reliable.

And there's very little missing data in the pharmacy right now for most of these - for most of the members that we've had. So we're very comfortable with this measure as far as the ability of health plans and organizations with the appropriate access to administrative claims to have this data and be able to calculate this measure.

So the 50% to 75% were a consensus-based thresholds that were set sort of a, you know, through our expert workgroups understanding that different populations may have, you know, now this was in the papers. I'm not saying that the pediatric population may be in every other date right, get the more appropriate. So therefore that date, you know, 50% would be a great rate for the five to 11 or the five to 17 population.

The 75% would, you know, perhaps look at those plans that we're doing - we're selling in this arena and, you know, having very good medications adherence and compliance.

And so they wanted to propose those two as you said, you know, a starting point to look and see where people or plans and group sellout and how they did.

And are touching data again that and I think as we include in the table show that there is definitely some variation between the plans. There's some room for improvement but also, you know, the numbers were kind of along the lines of what we expected.

Hayley Burgess: Okay that's helpful. And I see where you have the ages stratified out in stratification details and variables.

So what you just said from, you know, the 5 to 11-year-old would you maybe not consider the 75% if 50% compliance is, you know, probably a really good marker because the marketplace may feel like they've not hit the mark if it's not 75% if there's not a way to, you know, have that caveat really elaborated upon or clarified?

Ben Hamlin: Sure. So these are all actually reported separately. So each age state is reported separately and along with a total rate for all these measures.

So, you know, again, we could say that the - you know, the benchmark for most plans in the pediatric population would be that 50% threshold.

The 75% threshold either says the plan is doing very well with their medication compliance but perhaps in the pediatric population that they may have a more chronically, you know, a much more severe population if these measures are not risk-adjusted or severity adjusted at the moment. So that's sort of a, the balance of a, you know, high-performing plan versus identifying and at risk population opportunities for improvement starts balancing the rate.

But again, you know, we're going to look at these two thresholds for the next two years of reporting and to see how the plans are falling out, what their variation is, what the feedback is from the reporting process and then, you know, make additional determinations whether we need to either eliminate that one for the pediatric population or maybe set a different threshold and so on and so forth.

But, you know, they can do an ongoing assessment and new measures year by year to determine, you know, if we're still on the mark.

Trude Haecker: I think that's really reassuring. This is Trude. Because I feel like that we serve an inner-city population with huge disparities here so the fact that you're taking into consideration the higher risk urban indigent families that we see that's very important to me. I was kind of concerned about that.

Ben Hamlin: And we may see, you know, perhaps in the commercial population a different rate in the 75% than in the Medicaid populations. Perhaps in the Medicaid population we would expect to see, you know, a higher ((inaudible)).

Female: We lost him.

Ben Hamlin: ((inaudible)).

Female: I think we lost him. Ben we're not able to hear you if you can hear us. Okay.

Ben Hamlin: Yes I can. I'm sorry. Like I said, I'm and a very noisy place. I'm trying to speak into the mic here.

Female: Okay.

Hayley Burgess: So other questions from the group, I did when I was going through this approved this measure, you know, based on this discussion today of understanding a little more of how we'll learn over the next couple years and make this very usable but actually more accurate.

And I think Ben was able to describe how they would be doing that over time.

Kevin Weiss: Maybe...

Female: Yes.

Kevin Weiss: This is Kevin. Maybe I should join because I was the one who - I think was the one who on the survey said no because of concerns.

So it would be helpful to and better understand this construction of this new concept.

But first I have to say I too am really intrigued. I really think that this was a really great attempt at trying to break through the current measures into a more graded measure of the quality of treatment recognizing the limitations that are with in terms of using a pharmacy data here.

And you've got a great group on the respiratory map here who are thinking, you know, great thinkers on the stuff.

But you - if you could help me explain if I understand this right there's this thing called an earliest dispensing event which you call an IPSD. And that can happen anywhere in the measurement. In the first month over the last month you can go up to an ISPD.

And then you look at how many days that are covered by that period and then look and see how much inhaled - well a controller therapy is being administered and then create a simple proportion. Is that essentially what's going on here?

Ben Hamlin: Yes, that's correct.

Kevin Weiss: So a person could get the 50% if they were doing just the minimum...

Female: Right.

Kevin Weiss: ...the three months and two prescriptions or they were doing six months and 12 months which would mean the half a year that they're missing in one case and one month they're re missing in the next case which is a huge difference in terms of quality of care...

Female: Right.

Kevin Weiss: ...for a patient like this. Even at 50% part because of the nature of how the measure was specified that it can be anywhere from 12 months of observation based upon an IPSD of 12 months, the line for 12 months versus a two month IPSD which really would just be whether on two months they were getting controller therapy so no minimum was set or anything like that?

Ben Hamlin: It wasn't. But one of the things we did we did ensure that we tested was when those ITSDs were actually occurring during the measurement year - I'm trying to pull up the table right now, we just find the majority of them were actually the first quarter of the year.

So most of the patients who are meeting the denominator specifications were actually being evaluated into at least nine months but probably more than nine months because most prescriptions were being dispensed in either January or February.

And I'm just, like I said I'm just trying to pull the table up to tell you exactly what percentage that was but we did look at that to ensure that, you know, that was...

Female: Ben I think it's on page 15.

Ben Hamlin: Yes my computer is running slow. It's just taking time to open up the file.

Male: Yes, it is page 15.

Female: Yes so if everyone can look at Table 6 on page 15...

(Crosstalk)

Female: Oh okay, I see that it's on the WebEx.

Male: We've got - you've got it on the WebEx now?

Female: Yes, so as Ben was saying you can see for both the commercial and Medicaid product lines and for all the age bands most of the events occurred in quarter one based on the field test data.

Hayley Burgess: Yes so I guess the question would be is are those patients, I mean knowing the seasonality of asthma are the patients who have that happen is do they have a different kind of asthma...

Female: Right.

Hayley Burgess: ...process going on and are we getting, you know, a seasonable asthma that probably only needs a few months of therapy? We don't know the duration of therapy for those people in terms of their needs.

I mean there's a whole series of just underlying questions here about whether we're going to falsely be seeing people or getting good care if they're above 50 or if they're below the 50 and...

Ben Hamlin: Do you remember though that these are the people who already meet the two year persistent asthma definition so...

Hayley Burgess: Well correct but persistent asthma can look different within populations even in terms of how it's expressed.

So has there been any work to try to understand the validity of this measure in terms of how it's used for people who only have short minute - with short measurement periods based upon house their IPSD comes versus those who have longer to actually do some audit or some random sampling to see that it's actually measuring good quality so to speak as may be a - by an expert opinion or something else that would look like good outcomes?

Ben Hamlin: No, we didn't do any kind of correlation between when the, you know, the duration of measurements and their sort of where they fell with, you know, with regard to either 50% or 75%. But it's something we could probably look at in the, you know, in the data set that we have.

But it was not something we did because again we were, you know, we accept the two year denominator and found that to be, you know, adequately identifying the majority of the people with persistent asthma. And so we were mostly focused on, you know, the length of time they were being assessed for their PDC versus everything else.

Hayley Burgess: So in my mind then and I'll stop here. The reason why I'm a little hesitant on this measure as per se as it is it feels under tested for the fact either are we going to identify a misclassification bias that is going to wrongly direct people into thinking that they are, not people but systems to thinking that they're doing well or not by a measure that we don't know in fact how well it's correlating that measure to actual good quality?

And so we just don't have enough information. I was put it as incomplete in terms of the validity piece.

I definitely would feel very uncomfortable about 75% having more meaning than the 50% until we have a better understanding of that.

And if this measure were to go forward which it feels, you know, a little bit premature and worth some more testing at least we probably - we would want to be very concerned about offering up two measures when in fact we don't even know that the first measures doing what it needs to do.

Dr. David Lang: Yes, I would add there still is the same issue with the numerator and the medications that are - the definition of controller therapy that again, that there are a non-inhaled corticosteroid agents that would allow a particular case or patient to be categorized as fulfilling the inclusion in the numerator where...

Ben Hamlin: Yes I mean this is something that continually comes up with our medication tables. And it really was, we've tried to keep it in this ICS only rate but unfortunately with the pushback there's been, you know, there's such a broad range of practices in regard to measurement of persistent asthma, you know, even though the percentage of people who are getting the ultimate of medications other than ICS is lower it still, there's still, you know, a significant enough proportion that we fill it's still necessary to include them in the - for measurement.

So we do see some trouble with small denominators in the persistent asthma population even in the health plan level so...

Yes I mean...

Kevin Weiss: …broad a population as possible.

Male: Yes one issue you're going to - I mean all these things are going to get into especially when you're looking at adults and pediatrics is there's a tendency to use less inhaled corticosteroids in the

pediatric population and probably more Singulair or maybe more a tendency to inhale, use inhaled corticosteroids in the adult population and maybe perhaps less Singulair.

So I mean just seems to keep on...

(Crosstalk)

Male: ...problem medications, yes.

Male: But some of these metrics stipulate moderate to severe persistent asthma for which, you know, monotherapy ((inaudible)) trying.

Male: No, no. I understand, I understand. But there's a hesitancy I mean within real-life...

Male: No, I understand.

Male: In the real world, yes, yes and so...

Male: Yes and...

(Crosstalk)

Male: Yes.

Male: When you design the measure I think, you know? I mean that's probably a longer conversation. But we should probably have a conversation and develop a consensus regarding the - this definition.

Male: May I ask Reva a question about if the measure feels like it's good enough for sort of quality improvement work but it doesn't yet have enough - it's incomplete in terms of our understanding of issues such as misclassification class that may be occurring is it possible to endorse a measure just for quality and not for public accountability?

Reva Winkler: Not at this point in time. And NQF's focus is really around uses for accountability. So we are looking for measures that are good enough for that use, so and that's been a pretty clear-cut distinction at NQF pretty much from the beginning.

(Crosstalk)

Reva Winkler: So you're looking at the criteria for these measures being used for some accountability function.

Ben Hamlin: And I mean this measure suffers from the same misclassification bias as ASM does as well in the sense of, you know, if you have a two year administrative claims denominator that gets this population down as sensitive as possible but until more sensitive coding practices come around that's some of the best of the best we can do right at the current time which was one of the reasons why we built that measure using a similar concept.

Male: Well I think then that you're - it was a great - I mean it's a great basis to build, the foundation to build additional measures.

I think David's concern with gets washed out a little bit when you're not getting into trying to define the quality of management as opposed to just whether there is a controller now we're trying to figure out what proportion of that time is on controller.

So David's concern of the denominator kind of gets kind of ramped up a bit here as I see it. I don't know David is that what you're seeing a bet?

Dr. David Lang: Yes.

Male: So just it - at least is I'm hearing it it feels like it's on the right track. It feels like a good measurement process.

But because of this lack of really sort of getting underneath it a little bit and seeing what this new concept of a start date with variable measurement period for different persons with asthma might do in the context of this measurement scheme it, in terms of misclassification of a good or bad control is a little bit of a guess and putting out there for public accountability a little bit risky because you may have a lot of misclassification going on there.

And so group practices may be trying to fight over differences that aren't real in terms of where they're going to get paid or not. And then so that's the kind of way we have to sort of think about it.

I would definitely shy away from the 75th percentile in my mind for certain. And I personally would feel a little more comfortable deferring this one till it gets a little more data.

Trude Haecker: Yes I would tend to agree. This is Trude. It's a little too unclear I think. And the vagaries of that seasonality really does bother me as well.

Reva Winkler: Okay. What we'll do because there does seem to be somewhat differences of opinion and maybe need to think about it a little bit more is at the steering committee meeting Hayley it'll - you know, you can present to the entire committee that concerns, the issues.

And then actually the entire committee will be voting on the ratings. And how that welcomes out will determine the entire recommendation of the entire committee.

Hayley Burgess: Okay.

Reva Winkler: Okay? All right, perhaps we need - in the interest of time can we go on to measure 1800 which is again another, a new measure from NCQA?

And is Dr. Glomb with us? No. He submitted his ratings. But this is again, I think in a similar vein, percentage of members age 5 to 64 who were identified as having persistent asthma and had a ratio of controller mediations to total asthma medications of .5 or greater during the measurement year.

Since Dr. Glomb isn't with us perhaps Rubin, Kevin or Hayley would you like to give us your thoughts since you did submit your (Pruvi)?

(Asan): Well this is (Asan) here. I'll jump in. the ratio measures in asthma are a little vexing...

Female: Yes.

(Asan): ...because of the issue of you can have a higher or lower ratio because of the numerator or denominator shifting a bit.

And there is the good work by (Fogerty) et al. And I only say that tongue in cheek because I was a co-author when I said good work.

But it was a piece looking at this ratio question and looked at a couple of different measures. So the ratio works better when you have more exposure time to the medication. And it works

differently in terms of it relates to outcomes at least by emergency room use whether or not you're getting a lot of months of medicine versus a few months.

And so I would think that it would be important to look at that question. And particularly I think since (Ann)'s on the respiratory map as well as a couple other works on that paper to ask - just ask the question between now and March, you know, is there a threshold of months of reliever medicine below which you would not want to see this? And maybe that would be an exclusion for the nominator issue and then the ratio may be more stable for this kind of question? But that would be my thoughts here.

Reva Winkler: Thoughts from anybody else?

No, I think you're right on target. I would agree.

Female: Yes agree, definitely concerns about the ratio.

Reva Winkler: Yes. Are folks from NCQA, Kevin, here's a question. Was that information you could perhaps provide for the in-person meeting or by the in-person meeting?

Male: ((inaudible))

Reva Winkler: Is Ben still with us?

Male: ((inaudible)).

Reva Winkler: Ben if you're there we're not hearing you. Ben did you hear the question?

Ben Hamlin: Can you hear me now?

Reva Winkler: Yes, yes okay. Good.

Ben Hamlin: Okay when is the in-person meeting?

Reva Winkler: March 21, 22.

Ben Hamlin: Okay, I mean we can go back and take a look in our research data set that we have. I'm hoping that - I can't promise anything but we'll certainly give it a try.

Reva Winkler: Okay. I think that would be particularly helpful for the committee for ((inaudible)). Any additional thoughts or concerns on measure 1800?

Okay I think that the four folks who've submitted their ratings have outlined some good issues. And I know Trude you said you haven't been able to get in the system but it's no...

(Crosstalk)

Reva Winkler: I'll just add yours in we'll have that for the summary.

Trude Haecker: Yes, yes I'll definitely.

Reva Winkler: I think that would be very helpful for everybody when we go to the in-person meeting.

Trude Haecker: Yes I voted no as well. I mean I...

Reva Winkler: Okay, all right. But perhaps NCQA can provide us with some information to address Kevin's concern. All right, so I think those...

Male: Just in reading one of your comments here this is only subscription suspense. It's not actually written. So I don't know if that helps clarify the number of medications here. I noticed one of the comments was worried about that prescriptions may or may not be filled whether, you know, whether they're written or not.

Reva Winkler: All right in the interest of time perhaps we can move on to Measure 47. And this is a measure from Physician's Consortium for performance improvement. And I've got a pharmacologic therapy for persistent asthma.

Dr. Lang, I think this is yours again.

Dr. David Lang: Right, this measure - well first of all the importance is high but the - in contrast to some of the other measures we've been discussing such as the measure we first began with, number 36, the age range here is different. It's 5 to 50 as opposed to 5 to 64.

The concern regarding the inclusion of alternative that is not inhaled corticosteroids in the numerator exists with this measure as well.

And is there any other comments from any of the members regarding anything I've said so far?

Reva Winkler: Dr. Lang, just one question. Given we've got two age ranges for basically very similar concepts what does the evidence show the age range should be?

Dr. David Lang: Well other people can feel free to jump in. I think that there's a - at least I read somewhere that there's a desire to be as broad or inclusive as we can in terms of the population for whom the measure is targeted.

The higher you extend that upper limit of the age range the more diagnostic confusion there is with patients who may have COPD.

So the less precise the measure will be. And I think it's a balance between the trade-off that, you know, a few points lower in terms of precision that yet the - on the other side measure reaches a broader population.

Mark Antman: Reva this is Mark Antman at the AMA. May I comment on the age range?

Reva Winkler: Sure, go ahead.

Mark Antman: So thank you. So NCQA kindly shared with AMAPCPI last year their testing data where they field tested the extended age range that is going up to age 64. And we shared that with some members of our development group.

And our preliminary intent is to revise the age range of our measure, of Measure 47 to match the age range of NCQAs.

Unfortunately we've been a little bit delayed in confirming that approval and the approval of the PCPI simply because we have a number of other - a number of other asthma measures that go along with this one. And we had some delays in finalizing those and didn't want to go back to the PCPI piecemeal. But we hope to be able to do so very shortly.

And we expect that there will be approval of that extended age range and will therefore match the NCQA measure, Measure 36.

Reva Winkler: Great. Thanks Mark. So does that - I think that helps a little bit on harmonization. I'm just going to add one additional comment that we've received is it's been noticed that there are no asthma measures for the Medicare population. And any thoughts from the committee?

Male: Well I think the - that what has been the - kind of the bugaboo is this diagnostic issue of misclassification with a mixed model of asthma COPD or is it a misdiagnosis of asthma for COPD? And so that's what's held the upper boundary of the age in which David talked about.

Beyond that, you know, at some point in time there's no reason why one couldn't begin to test these measures in the older population and see if they make sense. But as you said, other members of the workgroup ((inaudible)).

Male: Yes the only way you're going to be able to do that is if you get some kind of picture of smoking and you could say (here's just) smoking for greater than ten years you eliminate that would be more COPD than asthma but...

Male: Right.

Male: ...getting into the COPD issues yes, that's a real problem yes.

Dr. David Lang: The other issue here is that the measure pertains to individuals with a diagnosis of persistent asthma as opposed to moderate to severe persistent asthma.

So, you know, the challenge here is to correctly identify individuals who have persistent asthma so that you're eliminating in your description patients who have intermittent asthma.

So I think that's - you know, I think the question I had as I read through this is, you know, can you - you know, there is a tendency to sometimes over treat patients with intermittent asthma.

And, you know, based on the - what they stipulate here such patients would be included in this definition when they don't really have persistent asthma.

Reva Winkler: Right, I think that's a really valid point.

Kevin Weiss: One quick question to Mark if - this is Kevin Mark. How is persistent asthma defined? I was having a hard time in trying to ((inaudible)) sorted out in your document.

Again I'm supportive of this measure but I'm just - this is just a question for information.

Mark Antman: Right. Kevin are you asking how the guideline distinguishes intermittent from persistent or how we filter out those patients from the denominator of this measure?

Kevin Weiss: The latter, not the former.

Mark Antman: Okay. So this measure relies upon - this is a clinician level measure. And so the intent is for physicians to make the determination that patients have persistent asthma.

And so we're asking that they affirmatively classify patients as having persistent asthma and not intermittent asthma.

Now what's not said in the measure is that we are counting on physicians to evaluate the patient's symptoms and follow the algorithm provided in the current guideline for assessing whether or not in fact their asthma is persistent versus intermittent.

But beyond that we defer to the clinician to make that distinction and categorize the patient appropriately.

Hayley Burgess: This is Hayley. I just have a question and it's I guess kind of along the lines of 36 of the usefulness of measures that are saying that the patient has had one prescription in a 12 month period.

And if this measure has been in place -- and it has since 2009 at least endorsed through NQF, I'm just speaking more practically, what has changed in the outpatient care arena based on these measures right?

But I want to be very practical about any measures that we would be using. Is it - does the data that come back, is it showing us that we have greater gaps and then, you know, physician practices are closing those gaps?

Because honestly I like the adherence measures a little better than just - and I know there's issues with that certainly though. Many adherence measures have been approved through NQF before in different disease states.

But I guess I just have a question of practicality. If it's just saying that, okay we've identified persistent asthma patients that have had at least one prescription filled. Is that still getting to the point of are we providing good care?

And maybe it's a philosophical question but, you know, and I know that we are evolving measures over time but are these the type of measures that are really causing us to do something different in the practice setting?

Reva Winkler: Mark in - what is your knowledge of the use of this measure? Where's it being use and how's it being used?

Mark Antman: Reva you're referring to Measure 47?

Reva Winkler: Correct.

Mark Antman: Yes this has been in the CMS PQRS program I believe since the beginning of that program which would be 2007 or perhaps 2008. So it's been widely used in PQRS.

Reva Winkler: Do we have any idea what the data has shown over years since that?

Mark Antman: As to the rate as to the...

Hayley Burgess: Like improvement over time perhaps?

Mark Antman: If that was not included in our testing data we can certainly access that data and provide that Reva.

Reva Winkler: Yes I'm just I'm looking quickly Mark. If it's in here I'm just not...

Hayley Burgess: And maybe I missed it too but I don't - I guess I Just have a real problem with data for the sake of data. Like is it information that's going to move us to change and what are we doing with the information that we're receiving?

Rubin Cohen: Yes I agree with that. I mean I sit on the ACCPQI Committee. This is Rubin Cohen. And you got our comments. And I think in our committee the majority of members had exactly what you're saying is it's - the data's good. I realize there's a problem. There's a lot of good data.

But do all our practitioners use these in their offices and is that really changing the practice of care? And I think there was an Excel sheet with the ACCP comment. And I think a lot of these measures had more or less the same comments.

It's a general question. I'm not picking on any topic yes.

Hayley Burgess: Right. It's kind of philosophical. But I think it's - you know, that's what they're calling us to ask the question of, you know, with the usability, et cetera.

Male: Right.

Hayley Burgess: You know, that's my questions are really getting to that. Are we using these in the right way and is it the right measure to use in this way?

And now that we've had some experience it would be great, you know, to hear from those owners of these measures of, you know, what has the trend been over time?

If we've been reporting this back has it caused us to move in a certain direction? Have we changed? Are we doing better...

Rubin Cohen: Right, exactly.

Hayley Burgess: Because if the measure is not moving us or having us do anything better in a practical sense with our patients is it - I mean is it one that should move forward?

And I'm not picking on this measure. I mean this would be for any of them. But that's why I really like the spirit of these newer measures because at least it's getting to more of a adherence, you

know, across a continuum. And maybe we don't know exactly what that is for asthma yet with all the things that we've identified as questions.

But I think this is just something to consider. And perhaps if the measure owners could come in March just to talk to that a little bit that would help us understand are these really the right measures to begin with that we should continue endorsing?

Mark Antman: This is Mark again at the AMA. This is very helpful feedback and we can certainly come to the March meeting with as much information as we can on the degree of improvement that we've seen with the use of Measure 47. And we'll be interested in further discussion.

Hayley Burgess: Thank you, really appreciate that.

Mark Antman: Thank you.

Ben Hamlin: Yes this is Ben. We can do the same thing. I mean one of the reasons that simulated our development of a new measure was the fact that we've seen our 036 improve up to a point where it's now, you know, performing in the high 90s.

So we do see that it was useful at the time but we're not seeing much variation now. So we're not really, you know, it's kind of like well what is the next phase to get to that, you know, the next level of (specimen) so...

Reva Winkler: Right. Okay I think we need to move on. And I think we're going to go to Measures 143, 144 and 338. These are three measures from the joint commission.

These are for patients aged 2 through 17 for inpatient asthma. And 1438 I think Trude I think that's yours, (relieve) your spring patient asthma.

Trude Haecker: Yes I think that's - you know, it's kind of the kind of thing that we all ((inaudible)) now.

Reva Winkler: Make sure I can see what everybody else says so thank you.

Trude Haecker: It's really a high impact. Asthma's the number one diagnosis for children but it's the hospital it's the number one chronic disease ((inaudible)).

So clearly the use of reliever in the inpatient setting is kind of for many of us kind of no brainer. So I think it's a high impact high reliability.

You know, the relievers are the mainstay of what we do and efficient to the inhaled cortico their use of systemic corticosteroids.

So, you know, I think we all agree that it's a yes. You know, it's become a gimmie in our organization so just to be honest with you where do we take the next step?

But I think most of us who practice within pediatric settings see that this is about 100. It becomes part of a pathway in the electronic health record.

So again, it is part of the Joint Commission. It's a requirement. I don't see a lot of controversy around it. So I would open it up to my colleagues.

So I agree with everyone across the board here on all the studies. And clearly it's been the mainstay of what we've done for years in pediatric asthma management.

Kevin Weiss: Kevin here. I think the one person who kind of was concerned because (it has) succeeded so well that it's at 99.9 some percent.

Reva Winkler: Exactly, exactly for all of us. We're almost at 100%, exactly.

Kevin Weiss: So I don't know what it's doing for gap anymore. And without a gap I mean it - there does come a time of retiring a measure.

Reva Winkler: Right, exactly. That's another thing I was just going to say. I think we're in the same boat for both the status systemic corticosteroids.

Kevin Weiss: Exactly. Those are the two. And the downside though is if you do those two then you're left with just the...

Reva Winkler: Home management plan which is a whole other kettle of fish.

Kevin Weiss: Exactly. But I - but the question to Reva I guess is when you get a measure that's a 99.5% test in other areas what does - what do other...

Reva Winkler: Right.

Kevin Weiss: ...I mean how does ((inaudible)) sort of view that issue?

Reva Winkler: Well indeed your...

(Crosstalk)

Reva Winkler: ...questions are exactly the ones that are put forward and the reason that we have Criteria 1B opportunity for improvement. And when the - you know, the underlying premise of the

measures NQF is looking to endorse are that they are actionable and can drive quality improvement.

And if already if you're pretty much topped out there's very little movement to be had. And so perhaps we need to look to other measures to be endorsed.

We do have a situation where we've had measures that have been in use for a long time publicly reported. In our recent cardiovascular project, a lot of measures on hospital compare being used for AMIs are at this topped out range.

People were reluctant to remove endorsement cause they were concerned that they were definitely good measures, met all the other criteria except of the lack of gap.

And what has been done is that the board has approved a special status for these measures called a reserve status. And they otherwise meet all criteria with the exception of the gap.

And the idea is they're kind of on the shelf because they're - you're not going to have a lot of utility in them in driving additional improvement but they're still good measures.

Where that's going to go in the long term remains to be seen. It's only been something that's been developed in the last year.

Kevin Weiss: Well if it's possible to meet, you know, propose these reserve measures, these two, this and systemic steroids for inpatients cause they're really have topped out and...

Female: But they have and I agree. I mean they're part of the joint commission measure so all organizations are going to be monitoring this. I mean it's kind of a safety net for this measures.

So I would agree, you know, putting this into reserve status. This is implicit in everything we do for a patient that's submitted to - for asthma.

Reva Winkler: And ((inaudible)) comfortable that the reliability and the validity of the measures are good, the usability's good, the feasibility's good. It's been used.

Female: Yes.

Reva Winkler: It's just the fact that it was highly successful.

Female: Right.

Female: Yes I agree...

William Glomb: This is William Glomb. I apologize. I came on Central Time so I've obviously come in very late. Are we on 1800?

Reva Winkler: No, we're on 143 and 144.

William Glomb: Okay. I...

Female: ((inaudible)) because they're pretty forward so...

William Glomb: Okay.

Female: Yes.

William Glomb: Again, I apologize.

Female: There's a way to put these into a reserved status I think that's crucial. I mean as most hospitals go to electronic health records or the federal government this is a pathway that's built into everybody's orders set.

I don't see it changing. I think the compliance will be very high so...

Female: Okay.

Female: And the evidence is clear so and the nuances are do you do continuous, do you do (interpropian), you know, those are different questions. But the use of a, you know, reliever and a systemic steroid is not in question at all.

Female: Okay. The only other question that I would ask is for this the age, lower age range is two years...

Female: Correct.

Female: ...and where the other measures we saw were five years. Would somebody like to comment on the eighth the lower end age?

Female: Well so for under two we have the whole issue of how do you define asthma?

Female: Right.

Female: How many attacks do you have, it's a very big moving target because it's bronchiolitis issue. So I as a pediatrician I have no trouble with over two.

I - that was a question I did have is how did we pick five for the other measures. And I would ask probably ((inaudible)) chime in on that one. This is my first time on this call so I apologize.

Female: No problem.

Male: Well I'm a pediatric pulmonologist and to back you up - I mean as you say now it is difficult making the “asthma diagnosis” in that age range but it does occur.

Female: Great.

Male: My hesitation is always with kind of the definition that we’ve set up is in the number of prior diagnoses or the number of prior visits with that as a diagnosis because, you know, the pendulum has kind of swung the other way now and I think we the pulmonologists do think that it’s being a bit over diagnosed now so that, you know, one doctor visit with an asthma diagnosis does not asthma make.

Female: Correct.

Male: And I do think we need to consider do we need a higher threshold to call asthma asthma and not just in the very young but in the pediatric population? I would say that's worthy of discussion.

Female: It was just something I wanted to raise as a harmonization issue because the varying age ranges does tend to drive people crazy.

Female: Yes I was I mean I don't disagree with you. I think the, you know, pulmonologist is absolutely correct.

Were - we've sort of as we've gotten a little bit more again when use - the single use of Flovent that sort of drives, that's why I think those measures were concerning. It drives the thought that these are persistent asthmatics. Again I'm not sure that that necessarily correlates and I...

Male: Absolutely, absolutely.

Female: So that's why the nervousness comes from the 1799 and 1800. Yet at the same time, you know, we do see kids, you know, I think two feels to me very safe and clear at this point although not to say that in two years or five years from now that'll change.

I guess what's missing is what's the difference between the 2-year-old and then the 5-year- old in the other measures? Is that just a (conference) - I mean again this is a - I think where I was rationalizing this is because it's a joint commission measure and that's where the then parameters come from.

Reva Winkler: Is anybody from NCQA or PCPI - Mark are you still on the line?

Ben Hamlin: Yes this is Ben. I'm still here.

Female: Okay and...

Mark Antman: And this is Mark and I'm still on.

Female: ((inaudible)) still here.

Reva Winkler: Briefly talk about your age limit, your lower age limit why it's five years?

Ben Hamlin: Sure. It probably it's primarily resulted from, you know, a sensitivity issue and a noise issue in the lower population.

As we heard there's, you know, we use a two year denominator first of all and we use multiple diagnoses.

And in the current set of claims data that was the, you know, that was the age where the testing sort of found it to be sensitive enough to capture them appropriately.

And below that age there was just more noise to a level where we weren't quite comfortable in putting them in the population.

Reva Winkler: Thanks. Mark?

Mark Antman: I don't think I have anything to add. Ben stated it very well.

Reva Winkler: Okay great. This will be this is a harmonization issue because, you know, in some cases, you know, a measure will capture a broader group of children than others and that's - we hear is very much a problem out in the field in implementation.

But given that can we move on to Measure 338 which is the third joint commission measure of this group Home Management Plan of Care Document given to the patient or caregiver.

And I believe Trude this is from yours also?

Trude Haecker: Yes, yes this one's mine too. You know, I think the, you know, just to sort of speak up front this is quite a concern.

And I'm just going to be honest with you I think for most organizations the Home Management Plan of Care has to incorporate all these five topics but seven actual data points.

So I fear that this has become a bit of a homework exercise for the institutions. So I, you know, I struggle a bit with this. We have to do it. We have to get it done as part of joint commission so that does drive it.

The concern here I think as we look at that the, you know, the rationale there are now some newer data that suggest that maybe these home management plans of care don't make a difference.

I think we can all in principle agree that handing someone a patient education document which we all do every day, I'm a general pediatrician so I'll share my stripes is something implicit in what we do.

But, you know, the data out there on this is still a bit debatable. You know, recently in recent studies out with (song) on how it didn't make a difference in outcomes.

You know, we find sometimes that our in the outpatient setting again it's not inpatient but I think in the inpatient setting from time to time these papers tend to litter the waiting room.

So having said all that and I - I'll ask my colleagues to chime in I, you know, I, you know, I tend to agree with the group across the board that this is a again a relative measure. It's very important.

You know, I give a lot of the things that we all agreed yes it is, you know, importance is not a question.

I gave a lot of moderates as well in my kind of diagnosis my thinking too on this, you know, about the evidence.

You know, there's more and more data coming out. It's, you know, it's a little bit makes it a little bit more circumspect as you can see there.

You know, I think the decision to include this I'd open this up to the group, I think we need to because it is CAC III. It is a principle of what we do as physicians to give families information.

And all the points that are on it, the triggers, the medications, what to do for a flare, what to do for a, you know, true attack who to call does speak to all the medical home.

I just think it becomes to be quite honest a bit of busywork where each hospital ends up having someone assigned to just go around and check the boxes off to make sure that it's been appropriately filled out.

So I think the answer across the board is yes we should continue it but with the caveat and its importance is there I think we're all in agreement here.

Perhaps I see you now Kevin maybe has a different opinion. But again I struggle with this because the data now is not coming out that suggests maybe these, you know, people are not using things the way we'd like to do that. So I'll open up to the group.

Kevin Weiss: Kevin here since you mentioned my name. My only...

Reva Winkler: Yes.

Kevin Weiss: ...concern was if we put these other two in reserve...

Reva Winkler: Yes.

Kevin Weiss: ...you know, what is it to have just a this measure which is as you said is not a high leverage measure for outcomes is better...

Reva Winkler: Right.

Kevin Weiss: ...than giving a discharge ((inaudible)) sheet.

But it is not, you know, when you actually look at the studies it is not a major effect modifier for outcomes unless it's supported by other systems changes including follow-up calls...

Reva Winkler: Right.

Kevin Weiss: ...and assured ways of people backing the treatment.

Reva Winkler: Yes.

Kevin Weiss: So it feels as what would be an isolated measure hospitals endorsed by NQF kind of an oddity. And that was my question. I think as a measure it stands okay and although hearing from you the fact that it feels like it may be more like a exercise then a real substantive care opportunity it doesn't feel real assuring.

Reva Winkler: Right.

Male: Well, you know, it's one of those situations where if the family uses the plan I'm speaking...

Female: Right.

Male: ...of pediatric, you know, then it works.

If the family tosses the plan in the trashcan on the way out of the building...

Female: Actually doesn't...

Male: ...it won't. It's really sad and amazing that it comes down to something as simple as that.

Female: Yes.

Male: But wasn't it ((inaudible)) that requires more than just a plan? It requires the plan plus a continuity piece?

Female: Yes and that's exactly it's a follow-up. That's the data that suggests...

Male: Yes.

Female: From our, you know, getting a patient back into care is really the crowning point. It's the education. I mean we've actually provide daily education classes for the patients that are being discharged.

So they have to go to class or give them a ticket. I mean we've put a lot of steps in place but I, you know, Kevin I agree with you. I think the issue is it's more about the follow-up and getting into a medical home that then manages that care.

And you're seeing that patient within a week...

Sai Nimmagadda: Hello?

Female: ...discharge.

Kevin Weiss: Yes absolutely.

Sai Nimmagadda: Hello?

Female: Yes?

Male: Yes.

Female: Someone ((inaudible))?

Sai Nimmagadda: Yes hi this is Sai calling from Chicago. And I can give a little bit of history of this measure when we first put it out five, six, seven years ago.

You know, our thoughts were to actually have, you know, institutions thinking more about what they were doing with this measure instead of just, you know, going through check boxes in all these.

It was meant to be more of a transitional plan from inpatient to outpatient, talk about the triggers, talk about the follow-up care, talk about, you know, controlling medications and things like that.

So, you know, even though that the measure may appear on the surface to be a checkbox idea here at least it starts a dialogue in which patient ((inaudible)) they start to hear about follow-up visits, they start to hear about, you know, primary care involvement.

So, you know, all in all I think that there's been some measures regarding outcomes and, you know, and like showing that this may not change the outcomes.

But it's really hard to like gauge how much effort was put in to, you know, addressing this trigger, addressing the controllers, addressing...

Male: Yes.

Female: Right.

Sai Nimmagadda: ...other areas there.

Male: Right.

Male: Yes that's part of issue. I think we'd all...

Female: Yes.

Male: ...agree this is a really important part of the management but, you know, there are a lot of moving parts here and...

Female: Yes.

Male: ...now it’s likely that there is going to be substantial variation in the content and the quality of...

Female: Right.

Male: ...the discharge instructions and the teaching that's given.

Female: Right but...

Male: And it's very difficult to get a handle on that.

Female: Right. And I think on the average length of for a pediatric patient is less than two days now for asthma in our hands. That makes it tough to get all the training in.

Sai Nimmagadda: Right but at the same time, you know, when you've got a diabetic in your institution you put the time work in to, you know, get that newly diagnosed patient educated and, you know, along the same lines there.

So this, you know, this measure is really I think it could be brought up to a higher standard if we just start to, you know, tease out those individual ones. They get an appointment?

Female: Right.

Sai Nimmagadda: Yes. So was that appointment, you know, given a number to a physician or was it just a or a generic phone number to a clinic where there's really no doctor identified and time set up for, you know, for follow-up, so...

Male: Right.

Sai Nimmagadda: ...I think you can take it to like the next level. But I don't think we should throw it under the bus quite yet just because outcome shows us it may not be perfect and try to change, you know, performance measures.

Female: Yes and I don't mean to be too provocative here I just want to make sure that I we give the pros and cons to this. And I think it is there...

(Crosstalk)

Female: ...we're we all agree that needs to continue.

You know, we have tried to take some steps to make this more meaningful for our population. And we're - and we don't have any data yet but we're working on it but I do think a follow-up is the biggest piece that we should be all working on...

Male: Right.

Female: ...they have a medical...

Male: Yes.

Female: ...their going back to then you can answer those questions for the family. And, you know, we're trying to look at some models of, you know, a phone call the next day as well as maybe a home care nurse for half of the patients getting out, so...

Sai Nimmagadda: Right.

Female: ...I think there's a lot of work that can be done. But how to make the systems across the, you know, the nation be able to adopt this is going to be not an easy thing.

Sai Nimmagadda: Well I think it's a start. And it's also puts them at a as a level now where they are thinking about these other additional...

Female: Yes.

Sai Nimmagadda: ...treatment measures for asthma. Instead of just saying here's a piece of paper, here's your oral steroids, here's your, you know, beta agonist, and like leave the door without really addressing everything else that, you know, needs to be addressed. And it starts there I think and it starts with what we're doing.

Female: Right. Well I'm just I'm echoing some of my colleagues I think from across the country too, you know...

Reva Winkler: This is Reva. I just want to mention that we've seen similar measures like this and this discussion is fairly repetitive.

A couple of the issue with having a measure that just did you give them a piece of paper is generally again people have a sense that this is very much a check boxy kind of thing and they've - we've all seen the papers on the floor outside the trashcan.

Female: Right.

Reva Winkler: And so I think that what we're looking for is to see these measures evolve into something more robust that really talks about the educational component.

Did the patient, you know, understand have we've even assessed their learning capability, their language ability, their health literacy, are all of those things taken into consideration when you hand them the piece of paper and expect them to act on it?

And so just I think you're going to find that simply handing folks a piece of paper with information on it is not the kind of measure we need to move away from that into something much more robust.

Sai Nimmagadda: I agree (Christine). And maybe breaking this thing down into, you know, two separate measures or, you know, more like splitting this up possibly...

Reva Winkler: Right.

Sai Nimmagadda: ...looking at this down the road. I agree with that.

Rubin Cohen: So just very quickly this is Rubin again. Just to take this to the next step. The British have done this in COPD. And there's a very nice article in the (thorax) where they have a nurse practitioner calling the patient's after discharge and checking their medications, if they have any problems of the medication.

And they have achieved exactly the nurse practitioner call when she called what the response was. And I can email you that article and some of this can be adapted to exactly what you're talking about in asthma.

So it's not just the transition but actually have a follow-up call within there but have a nurse - an equivalent of a nurse practitioner in England.

So this was done through the National Healthcare Service in England for COPD. What they did they actually did take it to the next step which is what we're talking about right now.

Female: And I think that would be very interesting. I agree totally. I think that's, you know, we're trying to do that here.

And again that's what seems to make of the difference is that personal outreach, did you get your prescription filled...

Rubin Cohen: Right exactly.

Female: ...did you get that subscription filled, what are the barriers to getting it filled, and how can we make sure that you come back in and see us, you know, in the next week or so?

Again not too soon because the kids still on steroids so it doesn't make a difference but in time enough so they can internalize this so it's not too late to reinforce it.

Sai Nimmagadda: Correct, correct.

Female: Right.

Sai Nimmagadda: And, you know, when you think about triggers and there's like...

Female: Right.

Sai Nimmagadda: ...it's just meant to get people to think about. But I agree...

Female: Yes.

Sai Nimmagadda: ...if there's and the next step which is follow-up with that call with...

Male: Yes.

Male: ...that patient that is very important.

Reva Winkler: Yes. This is Reva. I think we're going to have to move on to the next manager but I would us the committee members to really think seriously about whether the measure as written, not as you wish it would were or what it in the future, but as written and currently exists whether it meets the criteria.

You mentioned things around evidence, we've mentioned things around some of the precision of the specifications. So I would really ask you to strongly consider the requirements of the criteria.

All right then we need to move on and our next measure is 548 Sub Optimal Asthma Control. And this measure comes from the Pharmacy Quality Alliance and I think this was yours?

Rubin Cohen: Yes this is mine Rubin Cohen. So basically again asthma is an important problem and so on and so forth.

So what this one specifically looks at poor asthma control and it's using two rates to look at this poor asthma control.

One is the frequent use of the short acting Beta-Agonist that they defined over a three month period.

And then once they identify the rate that in section one that our people are using a lot of short acting Beta-Agonist in a three month period how many of them do not have controller medication?

And this the idea as these rates would indicate an overutilization of a rescue medication, the short acting Beta-Agonist's and those subjects would need an additional controller medication.

And from hearing the discussions before on the other measures I - anything that we've said would probably apply to this one in one form of another.

There was actually a fair amount of controversy on this one in terms of the quality of the data.

The quality of the data wasn't bad. Mostly it rated high and moderate but in terms of usability and feasibility down the line.

Female: Thoughts from other committee members?

Kevin Weiss: Kevin here. The literature as I understand it with regards to frequent use of Beta-Agonist's was not built on a 90 day window. And that's why I ask some help from colleagues who may know the literature or at least remember it better than I do.

But it was actually measured over a period of one or two years. And based upon that there was a pretty strong evidence that persistent use of short term inhaler reliever without some controller has clear risk for morbidity and mortality.

The fact that they've turned this into a 90 day measure I don't know if the literature moves itself would be justified as interpreting itself to - I'm not being very cogent here but I'm not sure that the literature really translates into this shorter window.

So thoughts of my colleagues who may know that...

Rubin Cohen: No I understand what you're saying. I guess I looked at it in a way is 90 days you don't want to wait a year or two to find out these patients asthma their over utilizing their short acting. I guess that's the way I looked at it, not from the literature point of view.

Male: Yes I think that would probably generalize to the time period if you're talking about three canisters. I mean that's 600 puffs, 300 uses.

Female: Right.

Male: So if someone got a prescription from their pharmaceutical mail in with - and got three dispensers and but wasn't given a controller and that person had just a mild exacerbation for maybe, you know, and was using it for about four or five weeks would that be would that be bad care or good care?

Male: Yes that would be...

Male: That's a good point.

Male: Now that you bring the issue up there is again to go back to your phrase a misclassification bias. I mean even...

Male: All right.

Male: ...you know, patient these for a to prevent exercise induced bronchospasm in some of those patients request, you know, several prescriptions at once based on insurance coverage so there would be a misclassification here.

Male: Yes I think that's a very good point because the mail order pharmacies usually they'll give you 90 day supply which will be...

Male: That's right.

Male: ...three canisters whether you use them or not.

Female: And they're pushing towards that too.

Male: Yes. That's another that's a good point that's a very good point actually.

Female: Your thoughts or concerns about this measure? In general the folks that responded are rating it reasonably well...

Female: Yes.

Female: ...on all of the criteria. Kevin I think you did have some concerns.

Kevin Weiss: And my concerns were first is can you interpolate the literature which doesn't really look at 90 days to say that there's a health outcome associated with a 90 day risk particularly with this denominator?

I want to be mindful if this was a severe group or a moderate persistent group, but as I recall from this measure and you can help me a little bit closer, they took a pretty wide swath at...

Male: Yes.

Kevin Weiss: ...the denominator here.

And so they're getting a lot of mild intermittents here who really just have, you know, a little bit of an exacerbation that requires a little bit of symptomatic relief for a few weeks.

They probably will be given a better deal in terms of copayment if they go through the mail order.

So I it just feels like the 90 day window may be too short for this denominator. We might be picking up a lot of, you know, this other stuff that is being - it doesn't relate in the literature to bad outcomes if you don't give a controller.

Female: Right. And you can think about an exercise induced asthmatic, you know, ((inaudible)) that would, you know, use quite a few plus he had a flair, a significant flair that's maybe the, you know, pneumonia or something and you're kind of lumping the patient in their as well.

Reva Winkler: Do we have anybody from the major developer with us?

Female: I wonder if they could speak to I'm looking here where it's currently being used?

Male: Yes I was just going to say that in the Indian Health Services. And I'm wondering if they're using the QI measure? I'm wondering what kind of data improvement they've come up with?

Female: Right agreed.

Reva Winkler: Katie we have anybody from PQA on?

Katie Streeter: I haven't seen them on the Webinar yet. So at this point I don't think we do.

Female: Okay.

Female: It says that it was tested unless I misread that wrong somewhere with NCQA, is that true?

Male: I'd have to look at that again actually.

Reva Winkler: Do we have anybody from NCQA still with us?

Ben Hamlin: Yes this is Ben.

Female: Yes.

Ben Hamlin: I think it was tested...

Female: Yes.

Ben Hamlin: ...but it was a one off that was not part of our usual asthma so I can't speak to that test because I wasn't involved in it.

But I believe we did work with them at one point to develop a tested measure but I think it was a one off projects.

Female: Yes it says initial testing in 2007 and 2008.

Male: Yes here it is yes for multiple health plans and NCQA right.

Reva Winkler: Okay. Well we can certainly get to the developer and pose the question which is you're looking for current data and impact and trend data, correct?

Female: That would be helpful.

Male: Right. Yes.

Reva Winkler: And maybe any analysis of unintended consequences?

Female: I think that's the biggest point.

Male: Right.

Male: I'd also like to see some literature that supports this 90 day window having without controller having risk the same that the longer term because I - unless I remember that literature wrong it really is one year, two year data on averages.

And I just don't know that it translates back into the 60 day risk, I mean 90 day risk of not using a controller for particularly with the denominator of this many mild intermittencies.

I just feel like there's a disjuncture between the literature of what they're trying to do which is very good and what the literature supports in terms of the use of anti-inflammatory meds.

Female: Okay.

Male: So I mean I think a couple of things then from what I'm hearing is the trend is very important. It's not 90 days that are continuing to renew the prescriptions for a longer period of time using just short acting Beta-Agonists without control or therapy.

And other people have used it. The Indian Health Services QI what kind of data and what kind of use have they got out of it?

Reva Winkler: Okay that'd be great. We'll get to the developers and ask them to see if we can provide that information for you for the meeting.

All right anything else on this measure or can we move on?

Female: I would just say that the Indian Health Services probably more close to Medicaid where they don't have to have a 90 day versus commercial plans so...

Male: So that's true.

Female: Apples and oranges a little bit.

Male: Yes.

Reva Winkler: Okay. Great anything else? All right so next measure is 620 asthma short acting short acting Beta-Agonist inhaler for rescue therapy. This is from Active Health Management.

This is a percentage of patients 2 years or older with asthma who have a refill for short acting Beta-Agonist in the past 12 months. And Rubin I think this one's yours?

Rubin Cohen: Yes but this one is looking to exactly what you said. The idea of being a short acting Beta-Agonist have been shown to control asthma and if patients are - have these medications, are filling these medications and doing this properly could prevent emergency room visits, could prevent physician visits.

So there is nothing here about controlling therapy. It's simply looking at people with asthma accessing their short acting Beta-Agonist for relief.

Reva Winkler: Is if we look at the ratings submitted generally they look reasonable and most people generally rated this high on for the important criteria. Kevin you had some concerns? Did we lose Kevin?

Female: Let's see is this one very similar to 36?

Female: Yes.

Male: Thirty six also has controllers.

Female: Okay. Okay this one's specific.

Male: Thirty six is the one that deals with moderate to severe persistent asthma and having a prescription for a what they call a preferred therapy which is a controller.

Female: Okay.

Male: And this is a short acting Beta-Agonist.

Rubin Cohen: Right. It'll have had a refill.

Kevin Weiss: I have to tell you I apologize, Kevin here. I was on mute and I was talking to myself which is...

Rubin Cohen: Okay I've done that several times actually.

Kevin Weiss: This is the short acting one right?

Rubin Cohen: This is the short acting one right it’s refill over was it a one year or a two year period?

Female: One year.

Rubin Cohen: One year right looking at using this medication refilling this medication with the idea of prevention for ER visits and physician visits and just using the short acting Beta-Agonist alone nothing else.

Male: I had a concern about the - is this sending the right message I guess was the one that I was looking at ultimately.

Female: Right exactly.

Male: And, you know, this is this and I guess I'll just leave it there since everyone said exactly.

Male: Well it is standard of care but nonetheless it's not associated with improved outcomes like...

Male: Right.

Male: ...controller...

Male: Correct...

Male: ...kind of thing.

Male: It could actually end up causing risk creating risk for populations.

Rubin Cohen: I mean according to them there 2011 data so that’s the recent data 42% of asthmatics from data beta did not have any rescue therapy available in the past one year.

So I guess if you look at it from their small window not the a picture...

Male: But from the...

Rubin Cohen: ...patients need their rescue inhalers.

Male: Except for the denominator that they used...

Rubin Cohen: I think it's all asthmatic.

Male: ...you all (expecting) you need to. I think this is the one where they - the denominator included people who may not, you know, that yes they have to come in once every year for at least an office visit. I think that was it if I have it correct.

But it didn't say that I mean you could have a person who just came in whose asthma is not really active that they just note on the record asthma because, you know, the person...

Male: Yes carry through.

Male: And does that person necessarily need to have that, a short a acting inhaler if in fact they're coming through with that mild aversion?

So it there's a issue here of this broad denominator I think that concern me and the message that it's sending which is to press for what is really relatively easy to get.

And I don't know that there's any evidence that getting a short acting reliever is a difficult problem in any health system.

I haven't seen that literature that there's a gap in that. Am I...

Rubin Cohen: I mean all I can hear I don't know, but they're saying 42% of their asthmatics did not have any rescue therapy.

Male: But is that a denominator issue or...

Rubin Cohen: No, no, no that's gap they identified.

Male: Yes I understand. I guess I'm trying to say is that 42% could a big chunk of that the people who didn't really need one because they...

Rubin Cohen: Sure, sure yes.

Male: And they were just coming in just...

Rubin Cohen: Exactly.

Male: Yes and...

Rubin Cohen: ((inaudible)) control there. Yes they were doing something else.

Male: Yes.

Female: I mean in pediatrics it would be that they have intermittent asthma. That's how we would class it.

Rubin Cohen: Correct yes. And maybe not even very active intermittent asthma.

Female: Correct.

Male: And, you know, just this comes up in a couple of these measures I was going to ((inaudible)) that.

You know, we sample quite a bit. And somebody who had, you know, mild to moderate intermittent asthma might just have the samples that we had given them in the office.

Though the reality is we'd of given them a script they might not have filled it because they were using it so infrequently. I'm just pointing out why those numbers might have been a bit skewed.

Male: Yes the sampling would clearly be more of an issue with this measure.

Rubin Cohen: So that was an enthusiastic. But I'm not sure what other people seem to be more enthusiastic than I was.

Female: Yes I said yes as well even though my numbers are in there but I - with some hesitation.

Rubin Cohen: I think there was...

Female: Sure.

Rubin Cohen: ...more hesitation on this one than probably most of the other ones.

Reva Winkler: This is Reva. One of the comments I keyed off of was somebody said that the use of the rescue medications were not associated with improved outcomes?

Male: By themselves?

Female: No it's appropriate.

Male: By themselves it's not, no.

Female: Yes.

Dr. Bani Vir: This is Dr. Bani Vir (Kippermass) Health. Can you all hear me?

Female: Oh great. Hi Bani great.

Dr. Bani Vir: Hi. I've been trying to respond but the line was not open. This measure is really directed at ensuring that anyone with asthma regardless of severity have access to at least one inhaler.

It's not suggesting that an inhaled inhalers or short acting inhalers are going to treat asthma that is persistent or improve the long term care if they are indeed need in need of a long term medication.

What it's trying to address is that everyone should have a rescue inhaler handy even if they have mild or asthma that flares up maybe once every year it would certainly lead to dire consequences should they not have a rescue inhaler at their home or on them at the time.

And we're looking to sort of decrease the number of not only emergency room visits but urgent care visits as well when if the patient should just need a quick burst of relief before getting into see their primary care doctor that they have that available to them.

Female: In fact one of the comments that we received during the commenting period asked about that.

And we responded with that exact statement that it's in looking not to alleviate or not to respond to the overuse of short acting inhalers but really address the fact that everyone should have at least one available to them.

Female: Is this - may be heresy. Is there a way to describe this a little differently because I didn't know that you say that I feel a little more comfortable?

Female: Right. And that's exactly what is described in the measure descriptions.

Male: I have to think about the literature here because if one looks at the bit of epidemiology that's done of people coming to emergency rooms and looking at the medicines they're on it's usually in the 90% in terms of the fact that they're coming in with relievers, so it's not as though people bring up in emergency rooms aren't don't have relievers...

Female: Well I would like to defer to our local subject matter expert on asthma Dr. Anne Showden. He's going to respond to that.

Dr. Anne Showden: Yes hello everyone. So, you know, as I look at the literature that's available I mean if you look at the literature that's actually out there you're looking at how the, you know, how well is your asthma controlled not so much do you have a short acting Beta-Agonist available and it's kind of unethical to do a study like that because every study we look at uses the number of refills to assess how well their asthma is being controlled.

Now I would sort of beg to differ a little bit. I think that there is benefit to this measure in terms of having the inhaler available if need be even if you're Stage I.

If you're allergic to cats and you get an asthma exacerbation the same thing with (Abupaton). I mean if you have an allergy to peanuts and you go out to eat you want to keep the (Abupaton) with you.

So I look at from that standpoint. I mean the literature, you know, there's indirect evidence that this measure will be of value number one.

And number two I mean looking at our own data there was 42% of, you know, of members did not have rescue inhaler therapy in a year.

Male: Did not have a prescription to send.

Dr. Anne Showden: I'm sorry?

Female: Well additionally I'm sorry to interrupt you AJ but we - it's not just that a prescription was not just sent.

We allow for completion of this measure it's not only through claims data for prescriptions but also through information from the HIE in for patient derived data and provider feedback.

Male: HIE?

Male: Yes electronic medical record.

Female: Electronic medical record health information exchange.

Female: Right, health information.

Male: Yes and then to Dr. (Rodney)'s point, you know, patient derived data which we feel, you know, sort of increases the accuracy or the sensitivity and specificity of the measure and also provider feedback.

Female: All right any other thoughts on...

Male: Yes this to me the literature that I know that has looked at people who, you know, who randomly come in to an emergency rooms or come to hospitals or near fatal asthmas they almost invariably all have Beta-Agonists.

And so I think that the 40% you're seeing in your data is really potentially a large portion of individuals who have had a diagnosis of asthma that's being carried forward on their record that's relatively inactive particularly since the way that you're defining asthma in your denominator you've got about as wide a net as you can.

And so you're going to have a lot of those individuals who have intermittent mild asthma who are not active.

Male: Would you not agree whether you have intermittent or mild asthma that you should have short acting rescue therapy available to you? That's the only point of measure?

Male: Yes well the answer it's sure you should have that based upon the guidelines. The question is is this a - is the gap that you're seeing which is this 40% a real or perceived gap?

And if it's a perceived gap because of the fact that you're getting a lot of people with inactive asthma then it would be putting a measure in play when in fact there isn't a gap that needs to be fixed.

And so that's the question is it's incomplete in terms of what those 40% look like. And it would be a nice though I don't know if you can easily do it is sample into that 40% and see how many of those are actually active asthma at all.

Female: Agreed. And while we are of course limited to technology being what it is right now we do our best to be to have a highly specific denominator.

While you may refer to it as casting a wide net we definitely try to drill down and identify asthmatic very specifically looking for the presence of an asthma diagnosis at least in the past one to two years.

And we're not satisfied with just one diagnosis. We're also looking for an overlap of with office visits, refills with medications, or the presence of patient data in the past 12 months indicating that they indeed have asthma.

Reva Winkler: Okay any further discussion on this? We have one more measure after this one. Does everybody feel that their issues have been raised?

Okay all right then let's go on to next measure which is a new measure 1876 Optimal Asthma Care.

This is a composite measure with an all in one composite measure that has three components to it. Kevin I believe this is your measure.

Kevin Weiss: Thank you. This is a really intriguing measure. I think many of us on the call might be looking at it and saying, you know, is this what we need?

And I think heard on the call earlier and I know that a number of us really liked the idea of trying to move towards composite measures.

And what they've tried to do in this one is to try and look at several components. And in doing so I think that they're on their way to what might be useful activity.

Now this is a measure that's actually in play and being used in Minnesota. So with that little bit of background I think just briefly kind of walking first through the issue of importance I don't think that any of us had any problem with that and it clearly is addressing important issue the same way others are as David Lang suggested at the very beginning of this call. So do we need to spend any time on that issue of importance?

Male: No I don't think so, you know. I think we're good.

Kevin Weiss: So then we would go into the - I'm switching here to sorry. I'm going across...

Reva Winkler: The reliability and validity.

Kevin Weiss: Reliability and validity thank you. Reliability and validity, oh Lord. So from what I could see from the reliability is that they've done a lot of testing of this measure and it seems to be pretty robust.

They've also been - they've done auditing of the measure through sampling processes that they have to do to get particularly a survey piece of it.

And the only question that begins to emerge for me is on the reliability. And so and it's the issue that comes up with composite measures.

And that is when you have three different elements and you put them together and they're measuring three very different constructs within an illness structure are you measuring independent constructs? That's important because otherwise you're double measuring?

And I think that this does meet that definition because the three different things that they're measuring feels like they're different constructs.

But the next question is is are you - are they equal in weight enough that and are they appropriately used so that they can actually combine them into the composite score?

And then the final piece is is how does the scoring done, and is a scoring done in a way that actually continues to represent this composite or not?

So I think the problem that needs to be looked at here in this measure which is at least in my mind identifies three very nice independent constructs in this concept of Optimal Asthma Care is the one around the control survey.

And so I think if just to spend a moment or two on that one is that they use a series of several control surveys.

The control surveys are patient oriented surveys that are asking questions that are looking to see if the symptoms are well controlled and that the patient's feeling okay with their asthma.

These are recommended by national guidelines and there's a little bit of literature that supports their use.

Now if one looks at the surveys and actually goes to the source documents of the publications - and I - to the - try to benefit this group I took that extra step.

And what you see is these surveys were developed in specialty practices. They were part of a large national survey work being done within the asthma community which was being done to try and build up a survey that could be used in that community.

And that's a good thing. And they show good construct - and repeat reliability and validity as measured against physician opinion of how the patient's doing.

The question then becomes is when you plop it into this environment as the composite and use a cut point that was developed in that environment into a different population do you change the performance characteristics of that survey?

And I think at best one can say is you don't have complete information to know. My guess is this since they're using such a broad denominator here that they've dramatically changed the population and enough so that the population where this - these surveys were tested in really reflect the - the population that they're applying it in this measure.

And so it - and I think that leads to the outcome that we're seeing which ultimately when they applied this measure we saw only 10% of practices or thereabouts actually get optimal care.

Now in this reliability validity piece if there's a problem with that construct it will lead to results that are little bit skewed.

And I think the fact that you look at a question of whether or not the physicians in large groups of physicians in Minnesota are only getting optimal care in 10% of the time -- I'm rounding by the way -- makes you wonder whether it's the bad care of Minnesota or this measure is particularly harsh on this concept of optimal care.

And if it is being particularly harsh my guess it's happening in that survey problem of translating that original survey work into this measure.

So I think we have some incomplete information on validity that relates to the second component, the survey component that would concern me and would probably warrant some further investigation in a measure that is in the right direction.

They could have scored this differently. And the score they could have used was just a simple one, two, three if they got, you know, if documented each of the components and achieved it a yes, no as opposed to trying to make it a little bit more sophisticated scoring system.

But that they chose not to do that and they ended up with this score. And when it comes to the feasibility - should I jump to feasibility or do you want to spend a moment on what I said about validity and reliability, Reva?

Reva Winkler: So whatever what anybody in the workgroup want to comment on Kevin's thoughts on reliability and validity?

Male: Well I just think that's well thought through. I think you've gone back to the source literature on that one. You can easily see that happening.

Kevin Weiss: Let me then go on to feasibility. And so the feasibility then is we've got a measure that we at least I am predisposed to want to see move for but I'm concerned about the this issue on how they use this survey.

And you end up with this 10% or thereabouts of practices that are getting optimal care and sending off a very kind of a funky signal, if I can use the word funky in a public forum.

Because it's basically saying that a bunch of doctors in Minnesota are just not doing do care.

I would expect that the majority of the doctors are doing a pretty decent care in Minnesota and probably would have expected to see an optimal measure in the 50%, 60% range maybe the 20%, 30% range.

But being so low it makes me wonder if there's a construct in the measure rather than the problem in the care that's being identified by the measure and so that's the feasibility concern I have.

All in all seeing that this is a great measure it needs some more work to better understand it even though I know it is by what the measure developers have it in practice and they're trying to work with it.

So I'd be very curious from the measure developers perspective to see if I've touched upon anything that makes any sense to them or anyone else on the committee for that matter?

Female: Great that was really an excellent assessment of what's going on here.

Kevin Weiss: I feel like I stopped the show here. Is anyone else out there?

Male: Yes we're here.

Kevin Weiss: Well so for those reasons I really didn't feel it was ready for prime time for endorsement. It would definitely feel like something you'd want to investigate and particular for quality improvement to see, you know, is that the measure or is it the quality of the care but not ready for the accountability and putting money behind it at least in my mind's eye at this point in time.

Female: Yes I also think there's a - it's a little difficult to know the patient reported aspects of this how my times they've been the emergency room.

In some ways it makes me even more nervous, you know, (parents) tend to forget that they've been to the emergency room, so yes.

Rubin Cohen: I'm just wondering these asthma surveys are these like the Asthma Severity Score, the Juniper score, or are they're something completely different?

Male: ((inaudible)) and Asthma Control Test.

Rubin Cohen: It's what I'm sorry?

Male: Like the Asthma Control Test?

Rubin Cohen: Asthma Control Test, the ACT okay.

Female: Yes.

Male: I mean just...

Male: This posed another problem that is they're kind of because of the measures and the age groups in some cases they actually don't have measures that work well for different age groups using different measures and trying to fold them all into the same second component piece which has a little bit of measurement construct issue in terms of cross validity.

They have the asthma control and then they've got the parents version of that, but then they have a third instrument as well. So it feels like it's in the right direction but not quite right yet.

Male: Yes. Yes it's a more ambitious measure.

Male: You know your comment about not being ready for prime time is dead on on a couple of these.

And, you know, we really do and especially and those cases have got to hold it to a scientific rigor if you will that I don't know maybe even a little bit higher than some of the more seasoned measures.

There's a lot of questions here as you pointed out that are unanswered or perhaps unanswerable at this point.

Reva Winkler: This is Reva. I'm sorry I cut myself off for a couple minutes. Did we hear from the folks from Minnesota?

Female: We haven't Reva.

Reva Winkler: Okay is...

Female: I am here. We're trying...

Female: Open their line now.

(Crosstalk)

Female: Do you hear us?

Female: Yes, yes.

Female: They can't hear...

Female: Yes.

Female: Hello?

Female: Yes we can hear you.

Female: Oh.

Female: Oh.

(Colette): Hi Reva. This is (Colette) in Minnesota Community Measurement and I'm on cell phone and speakerphone. You weren't...

Female: Okay.

(Colette): ...hearing us talking.

Female: All right (Colette).

Female: I can hear you now.

(Colette): Okay I don't know which phone she can hear me through.

Female: Oh I don't know.

Female: (Colette), we can hear you whatever you're doing.

(Colette): Okay. I'm sorry we were trying desperately to comment on as everyone's had indicated previously this is a first year measure.

It was implemented at a statewide level so every primary care clinic in our state was submitting data and we believe that we have some implementation issues in terms of the control tool and a little bit with the written action plan. And we fully expect these results to look different a year from now.

Female: Okay.

Female: All right thanks (Colette).

(Colette): Great thanks.

Female: So for the folks in the workgroup that's some response to your issues or concerns. Any further thoughts, Kevin, on this one?

Kevin Weiss: No I just would I'm - would encourage us to see them as it develops. I it does sound like that's - their picking up some of the signal noise issues and some of the other issues that you're going to get with those kinds of composites.

So go for it but it does feel a little bit premature for endorsement at the current time at least in my mind’s eye.

Reva Winkler: Thoughts from anybody else? Okay. Well congratulations. You guys are gone through all ten of the measures in a brief time.

I hope that we've been able to identify the issues that are most concerning or for which you all are differences of opinion. It provides measure developers an opportunity to respond to some of those issues.

We will be summarizing everything and this information will be readily at hand for you all, the rest of the members of the steering committee as we discuss these measures and make final recommendations.

I think the other thing for this particular group is the issue that was raised at the very beginning is we do have ten measures for asthma.

And many of them cover some of the same ground maybe with different approaches. And I think that in anticipation and preparation for the meeting I would ask the members of the workgroup to look at how these measures could or should work together and ask yourself the question of do we need all of these measures to have a good group of performance measures for asthma?

And if so which measures really provide the most utility and usefulness as well as which ones meet the criteria?

The - your briefing memo outlines sort of a way of looking at measures that are related in competing and this may even be one step further. It's do we have too many measures and if so what are the best define a good group for NQF to endorse?

So these are some of the issues we'll need to address at the in person meeting. And so I'll ask you to begin thinking about that as well.

Do we have any questions from the workgroup before we go to public comments?

Okay operator could you open the lines and see if there's anybody in the audience who wants to ask a question or make a comment?

Operator: Of course. And to our public audience today if you'd like to comment, please press star 1 at this time. Once again, ladies and gentlemen, star 1 and we'll pause for just a moment.

And I have no respondents at this time.

Reva Winkler: Great thank you. So just before we close I would encourage any of the members of the workgroup who did not submit your ratings through the SurveyMonkey tool to do so so that we can include your thoughts and ratings in with the group that we're going to prepare the summary for the in-person meeting.

If anybody on based on the discussion today wants to change any of their rating we can (arrange for you) to do that too. You can go in and just put a two after your name and re-rate some of the ratings that you previously submitted.

But I think today has been a wonderful discussion. I think we've gotten some preliminary sense of these measures the issues that are most concerning to members of the workgroup.

The measure developers have heard you. They will be present at the in-person meeting and hopefully responding to some of the questions or concerns that you've already raised.

And hopefully this preliminary discussion will allow us to focus in on the most important issues as we go through the criteria for each of the measures in our March meeting.

If there are no further questions - anything any questions about the meeting, or the evaluations, or anything from a workgroup members?

Male: Will you send out a summary of this meeting?

Reva Winkler: You bet.

Male: Thanks.

Reva Winkler: We're putting it together in about two days we'll actually have the transcript. And that's one of the easiest ways to make the summary. So yes we will.

Male: Thanks.

Reva Winkler: Anything else? Okay then I thank you very much for the work that you've put in and that you're continuing to. I look forward to meeting all of you at the March meeting. And we've completed our work on time and I thank you very much for that. And I hope everybody has a good day and again we'll see you soon in March.

Male: Thank you very much.

Female: Thank you.

Male: Thank you.

Male: Thank you.

Male: I apologize again for being late.

Male: So much.

Female: Bye.

Female: Thanks everybody.

Male: Bye.

Operator: Once again, that does conclude today's conference. I'd like to thank everyone for joining us today.

END