National Quality Forum
Consensus Standards Approval Committee (CSAC)
Measure Evaluation Meeting (Fall 2021 Cycle)
Tuesday, July 26, 2022

The Committee met via Videoconference, at 10:00 a.m. Eastern Time, Melissa Danforth, Chair, presiding.

Present:

Melissa Danforth, The Leapfrog Group; Chair
Dan Culica, MD, MA, PhD, Texas Health and Human Services Commission
Dana Cyra, MA, CPHQ, Inclusa
Kevin Kavanagh, MD, MS, FACS, Health Watch USA
Rebecca Kirch, JD, National Patient Advocate Foundation
Kelly Nedrow, JD, American Federation of Teachers Nurses and Healthcare Professionals
Laura Pennington, Washington State Health Care Authority
Jeffrey Susman, MD, University of Texas Medical Branch

NQF Staff:

Dana Gelb Safran, ScD, President & CEO
Elizabeth Drye, MD, SM, Chief Scientific Officer
Tricia Elliott, MBA, FNAHQ, Senior Managing Director
Matt Pickering, PharmD, Senior Director
Mike DiVecchia, MBA, PMP, Director
Paul Farrell, MSHQS, BSN, RN, CPHQ, LSSGB, Director, NQF
Beth Flashner, MHA, Manager
Tamara Funk, MPH, Director
Mary McCutcheon, MPP, Analyst
Kim Patterson, Executive Assistant

Also Present:

Dale Bratzler, DO, MPH, OU Health; Primary Care and Chronic Illness Standing Committee Co-Chair

John James, PhD, Patient Safety America; Patient Safety Standing Committee Co-Chair

Rebecca Smith-bindman, MD, University of California, San Francisco

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Proceedings

(10:00 a.m.)

Dr. Pickering: Welcome, everyone. This is Matt Pickering at NQF. It's a pleasure to convene you all again, especially our CSAC members today, July 26, 2022. This is the Consensus Standards Approval Committee or our CSAC. This meeting is to evaluate the Fall 2021 Measure Evaluation Cycle, so there will be a series of measures that the CSAC will evaluate today as well as listen to some of the proceedings that happened with our respective standing committees. We have co-chairs that will be present as well as our CDP directors in addition.

Again, thank you all for your attendance as well as our CSAC members as we get into our proceedings today, but before I do, we'll go to the next slide. I did just want to offer an opportunity for others to provide their welcoming remarks to this group as well.

First, I would like to hand it over to our CEO, Dana Gelb Safran, to provide her welcoming remarks to the CSAC for the proceedings today. Dana?

Welcome & Review of Meeting Objectives

Dr. Gelb Safran: Thanks so much, Matt. Good morning everybody and welcome. I'm really pleased to have the opportunity to spend a few minutes with all of you this morning. As Matt's outlined, the primary discussion topics today will be an overview of measures being reviewed as part of the Fall '21 cycle including recommendations from the CDP Standing Committee.

In reviewing this agenda, I am reminded of the extraordinary amount of effort and time and preparation that goes into these meetings on the part of the committees, on the part of the committee co-chairs, the CSAC members, the staff, the CSAC co-chairs. And as a former CSAC member

myself from 2013 to 2017, I do understand the critical role that CSAC plays and just wanted to offer my sincere appreciation to each and every one of you and, of course, to our CSAC co-chairs and to the staff.

There has been quite a lot of work that the team has been doing to continue to evolve, streamline, making more efficient and just make more effective our measure review processes. I'll share that, you know, I'm almost at my one-year anniversary and my role here at NQF and one of the things I spent quite a bit of time on in my early weeks was about 100 interviews with stakeholders to learn what they had to say about NQF, but in particular what they had to say about the consensus development process and what works about it and what could be better about it. Through that, you know, I heard quite a lot about ways that we could streamline things and improve things, including in the role that CSAC plays and the role that our Scientific Methods Panel plays and the way that those groups work together with our CDP committee.

The team since that time has also done quite a lot to meet with measure developers, with standing committee members, with measure stewards, Scientific Method Panel, with you the CSAC to really round out their perspectives on how to stream line and improve the CDP process. One of the changes has been the implementation of the consent calendar process that's being used today as well as the use of a CSAC discussion guide that consolidates hundreds of pages of CSAC meeting materials into one document that, for this cycle, as I understand it, is less than 20 pages. So that, I hope is making a big difference, but you'll hear more from the team over the course of the day about the kinds of changes being implemented and we will look for your ongoing engagement with us and feedback to us as we continue to improve upon this process and the overall process for endorsement and maintenance of measures.

We are so proud and humbled at the opportunity that we have had for over two decades to lead that process on behalf of CMS and for the country and, at this moment in history, where measurement has never been more critical and central to healthcare from the work in value based payments to commitments around improving health equity to ongoing efforts to reduce avoidable harm, none of this possible without measurement and without advancing to a next generation of measures.

So our work here is so extremely important and I thank all of you sincerely for all that you do. Missy Danforth, thank you for your ongoing leadership and chairmanship/chairwomanship of the CSAC. Let me turn it back to you, Matt, and thank you all.

Dr. Pickering: Thank you so much, Dana. I also echo a lot of Dana's remarks to the CSAC and thank you all for your time and attention as always to this work, especially with how we're engaging you moving forward in new areas of efficiency, such as looking at this consent calendar process. So thank you all very much.

Before we begin, I'd like to also turn it over to our Chair Missy Danforth to provide some welcoming remarks as well. Missy?

Chair Danforth: Thanks, Matt. Good morning, everyone. I want to start today by thanking the NQF staff. They've done really an incredible job, I think, taking feedback from this group and other stakeholders and you're going to see a lot of that in what Dana described today and how we're going run today's meeting.

I'm also going to thank you in advance for your patience. This is our first time trying this new consent calendar format and I think we've done a lot of prep work to make sure it goes smoothly, but thank you in advance for your patience as we work through in real time any bugs. We are missing today the greatest co-chair, my wingman, John

Bulger, so he can take a much earned vacation in Europe with his family. Hopefully, it's not too hot. But we are so grateful for all of you who are able to make it today and for your time today. Thank you so much. Thanks in advance for your patience, like I said, as we go through this new format.

I'm going to also close with an apology. I have a very annoying ceiling fan that I cannot get out of my camera. I am working today out of my house in Maine that does not have air conditioning and for some odd reason, we're also going through a heat wave and so it's about 86 degrees in my house today. I tried it without the fan this morning, couldn't do it. I'm going to try throughout the day to keep the fan out of the camera, but apologize in advance if anyone is getting dizzy staring at it, but I hope you understand. It was like that or literally just sweat pouring down as we move through the agenda today.

So, welcome, thank you, very excited to try this new format today. I want to turn it back over to Matt to explain how this is going to work.

Dr. Pickering: Thank you so much, Missy. Appreciate you attending and hopefully staying somewhat cool where you are. I also just wanted to check in. I saw Kevin Kavanagh, you had your hand raised briefly. Did you have a question or were you just --

Member Kavanagh: Oh, that was just to comment to point out that being down south, 86 is not a heat wave.

Dr. Pickering: Kevin, I hear you, I'm in Florida and 86 would be nice.

Member Kavanagh: I just wanted to clear that up. I'm sorry.

Dr. Pickering: Thank you, Kevin. I appreciate that, thank you. And, again, thank you, Missy, for those

comments as well as Dana.

We're excited to roll through this meeting with you all today. So, we'll go to the next slide no hesitation here. Just a few housekeeping reminders for folks, again, using this WebEx platform has video and audio capability. It's not new to everyone on this call. We do kindly ask to put yourself on camera when you're talking. It would be a little bit more engaging. There will be times where we're going to be taking the slides down and having just our little Hollywood Squares up on the screen so we can all participate and engage within this work. So, please go ahead and do that. Also, keep yourself on mute if you're not talking. This just prevents any further background noise as Missy has mentioned with her fan, which Missy, we didn't hear anything, at least I haven't about the fan.

We do have the chat box as well and the raise hand feature to be recognized. We will keep an eye on the raise hand as well as the chat if you so wish to use those as I mentioned with Kevin Kavanagh as I just did.

There will be some meeting breaks so we do have a lunch break scheduled around noon. We will keep to the reconvening at 12:30, the reason being is just because we also have folks that will probably be attending, developers, members of the public during the time slots we've allocated so even if we break a little early, we may get more of a lunch break than already planned. We will still convene at 12:30 and we'll see if we need to squeeze another break in the afternoon as needed.

Member and public comment opportunities, so there is and always the opportunity for members of the public to comment, both at the end of the meeting so a comment of the overall proceedings, but we also have opportunities for the public to have comments as we're going through the measure discussion. So before the CSAC makes any decisions

or final remarks, there's a consideration of the public comments as well for each one of the measure discussions we'll be having today including the consent calendar.

So, if you are experiencing any technical difficulties you can always reach out to us. If you're using the chat feature you can reach out to NQF staff directly or you can e-mail the project box and we have members of our team monitoring that as well if you have any technical difficulties, but thank you. We'll move right along to the next slide if we could.

So here's our agenda for today. So we've done some welcoming and an overview of what we'll be doing today. We'll then go into the role call and disclosures of interest and so we'll go through that and then we'll determine if we have quorum at that point and then we'll review the CSAC procedure and test vote for the proceedings today. That includes the consent calendar as well as the non-consent calendar discussions.

We'll also then roll into the consideration of that consent calendar and see if there is any discussion from this CSAC. Again, the CSAC was provided an opportunity in advance of this call to review the measures on the consent calendar to see if there were any concerns based on the criteria for the consent calendar and we'll review all of those during that discussion.

We then will have the lunch break, like I mentioned, reconvening at 12:30 sharp, 12:30 Eastern that is, and then we'll go into discussion and voting on the non-consent calendar measures. Those are the ones that did not meet all of those criteria that we'll talk about here around the consent calendar measures. Then lastly, if any measures are pulled from the consent calendar today, they will be slotted into a reserve time slot at 2:00 p.m., 2:00 to 3:00, to discuss those measures and if there are no measures being pulled from the consent calendar,

we will cancel that time slot. Then public comment would move up and then we will adjourn with next steps.

Going to the next slide, I will now go into the roll call and disclosures of interest for today. So, going to the next slide, thank you. Oh, sorry, roll call here for the team. We also have this great team, the NQF staff, that have been working behind the scenes to get everything ready for today as well as working with the project teams to get everyone ready to go for today's proceedings. You can see Elizabeth Drye, Tricia Elliott, myself Matthew Pickering, Mike DiVecchia, Beth Flashner, Mary McCutcheon and Kim Patterson. Thank you for all of your work as always behind the scenes. It's a lot of effort to get the meetings together.

We'll go to the next slide and we'll then go through roll call. So, again, thank you all for your attendance today.

Roll Call & Disclosures of Interest

Today, we'll combine introductions with disclosures of interests. So, as a reminder, you received two disclosure of interests forms from us. One is an annual disclosure of interest which goes out every year just getting any potential conflicts of interest generally and then we also have another form that's more specific to the measures that we are evaluating today in this current fall 2021 cycle. In those forms we ask a number of questions about your professional activities and today, we'll ask you to verbally disclose any information provided on either of those forms that you believe is relevant to this committee's work. We are especially interested in grants, research or consulting related to the committee's work today.

Just a few reminders, you sit on this group as an individual. You do not represent the interests of your employer or any one who may have nominated you for this committee. We are interested in any

disclosures both of paid and unpaid activities that are relevant to the work in front of you and finally just because you disclose does not mean you have a conflict of interest. We do verbal disclosures in the spirit of openness and transparency.

Now, I'll go around our virtual table starting with our committee co-chairs. I'll call your name and please state your name, what organization you are with and if you have anything to disclose. If you do not have any disclosures, please just state that I have nothing to disclose to keep the conversation moving. If you experience trouble unmuting yourself, please just raise your hand so that one of our staff can assist you.

Okay, going down the list I'll start out with Missy Danforth.

Chair Danforth: Good morning, everyone, Missy Danforth from The Leapfrog Group and I am an active member of the Technical Expert Panel for three of the adult CT dose measures that we'll be discussing today so I will be recusing myself from those measures. Thanks.

Dr. Pickering: Thank you, Missy. And those would be Measures 3633e, 3662e and 3663e. Thank you. John Bulger, we know that he's not in attendance today. Dan Culica?

Member Culica: Hi, Matt. It's Culica.

Dr. Pickering: Culica? Apologies, Dan.

Member Culica: No worries, no worries, no worries. Good morning, everyone. I hope everybody's fine. My name is Dan Culica. I'm with the Medicaid Program in the Health and Human Services Commission in Texas in Austin. I have nothing to disclose.

Dr. Pickering: Thank you so much, Dan. Dana Cyra? Dana Cyra? I see, Dana, you're on the WebEx, but

can't hear you. Maybe have one of our team members reach out. We'll circle back to Dana. So, Lisa Freeman, you can see those on the screen. Her name is inactive so Lisa has reached out to us just recently in the past 24 hours and, unfortunately, has resigned from the CSAC due to some personal issues so she won't be on the call today and won't be on the CSAC moving forward, so she is now inactive. Kevin Kavanagh?

Member Kavanagh: Kevin Kavanagh from Health Watch USA. I have no pertinent conflicts of interest with the metrics which are being reviewed. Thank you.

Dr. Pickering: Thank you so much, Kevin. Rebecca Kirch?

Member Kirsch: Good morning. Rebecca Kirsch with the National Patient Advocate Foundation based in Washington, D.C., but I'm here at the beautiful North Carolina shore today. I have a Technical Expert Panel position on a couple of the measures being discussed today where I will recuse myself, otherwise no other conflicts.

Dr. Pickering: And thank you so much, Rebecca, and those measures are 3666, 3665, which are two measure on the consent calendar and then 3667, which is a PCCI measure not on the consent calendar. Thank you, Rebecca. Laura Pennington?

Member Pennington: Hi, I'm Laura Pennington. I'm a Quality Measurement Improvement Manager with Washington State Healthcare Authority, which is the Medicaid organization and I have nothing to disclose.

Dr. Pickering: Great, thank you, Laura. Ed Septimus? Ed Septimus? Okay, I think he told us he was not able to attend today. Jeffrey Susman?

Member Susman: Yeah, I'm Jeff Susman. I'm Senior Associate Dean at the University of Texas Medical

Branch in Galveston and I have nothing to disclose.

Dr. Pickering: Thank you so much, Jeff. And Kelly Nedrow?

Member Nedrow: Hi, I'm Kelly Nedrow. I'm the Senior Director for Health Issues with the American Federation of Teachers, Nurses and Health Professionals and I have nothing to disclose.

Dr. Pickering: Great, thank you so much. I'm going to circle back to Dana Cyra. Dana, are you on line now?

Member Cyra: Can you hear me now?

Dr. Pickering: Yes.

Member Cyra: Okay, yes, I'm online. I'm Dana Cyra. I work for Inclusa, Incorporated, which is a managed care organization in Wisconsin and I'm also a family caregiver. I have nothing to disclose.

Dr. Pickering: Great, thank you so very much, Dana, and everyone. Just to confirm with the numbers that we have today, unfortunately, we are not going to have a quorum for all of the measures today. So that means that offline voting is going to have to occur after the meeting. We are able to vote on one measure due to no recusals of that measure. That one measure is 0097, that is the last measure that we have in discussion currently today. There are no recusals on that measure and given our numbers, which we're looking at 80 percent to be quorum for voting, we dropped below quorum for the other patient safety measures and the PCCI measures. We would need eight people and we dropped below that number with the recusals that we have with Missy and Rebecca.

In addition, when we're looking at the consent calendar measures, Rebecca is also recused from two GPC measures in the consent calendar, so that means that those two measures would have to be

voted on separately by the CSAC because of quorum. However, the other measures that are on the consent calendar there are no recusals so quorum is maintained so we can discuss those measures and if there are no objections, those measures will move forward as endorsed.

So, again we do not have quorum for all of the measures today. The only measure we have quorum for today is 0097, which will be voted on on the call today if quorum is maintained. The other three measures for patient safety, we do not have quorum because of recusals, so those measures will be voted offline. The PCCI measure we do not have quorum because of recusals so we will have to vote on that measure offline and the two GPC measures in the consent calendar, 3666 and 3665, will also be voted offline due to recusals and those measures not having quorum today. Therefore, the other measures in the consent calendar will still be discussed and if no objections from this group, we'll move forward as endorsed.

Any questions from this group before we proceed?

Member Susman: What is our denominator in quorum today?

Dr. Pickering: Right, so in total we had 11, as you can see on the screen --

Member Susman: Right.

Dr. Pickering: But with Lisa Freeman being inactive that drops us down to 10. We have an 80 percent quorum number, which is eight people to discuss the measures. However, with the recusals of Missy and Rebecca, our denominator drops from 10 to nine. So when we do 80 percent of nine, it's 7.2, so that means we would still need eight people to vote, but with Missy and Rebecca recused, we are dropping below that eight number.

Member Susman: Thank you for the explanation.

Dr. Pickering: So, one more time, that means 0097 we have no recusals for from this group today present on the call, we can vote today if we still maintain quorum with everyone here on that measure. The other three patient safety measures and the one PCCI measure that we were looking to discuss and vote on today, would have to be voted offline. We can still discuss those, discuss the issues. The CDP directors and the co-chairs will still share their perspectives, but we will be voting on those measures offline.

In addition, the two GPC measures in which Rebecca is recused, 3666 and 3665, will be voted offline out of the consent calendar. The other measures in the consent calendar can still be discussed and if no objection will move forward as endorsed since there are no recusals on those measures and we maintain quorum for those measures today.

Okay, let's go ahead and proceed. We still will do a test vote. We're doing a test vote again because of 0097. Earlier this morning, you should have received a Poll Everywhere link so as we're going through the procedures today, you can go into your e-mail. It should've been sent this morning to find that Poll Everywhere link. Please do not share that link to anyone besides yourself as this is a voting link for the measures. So, as we proceed and we get to the test vote screen, there will be a test vote question just to make sure everything is up and running for your Poll Everywhere link, but you should've received that this morning so you can take a look in your e-mails.

I'll go ahead and keep going to talk about the proceedings today. So we go to the next slide. We talked about the consent calendar process and so earlier this year we convened the CSAC in an advisory meeting to talk through a lot of areas of efficiencies and improvements that can be implemented for this fall 2021 cycle. One was this consent calendar process in which we are trying to

move measures that do not have any issues or have a super majority in the overall suitability for endorsement vote from the standing committees into a consent calendar in order to focus the CSAC's discussions and proceedings today on measures that have potential process issues or areas where the measures are a close call for voting if you will, for further consideration of this CSAC to make sure that processes were followed and criteria were applied appropriately.

So we thank the CSAC very much for their willingness to roll through with this consent calendar process and thus, we are doing that for this reduced measure cycle. So as you saw in the materials we have 13 measures for this cycle, so this is an opportunity for us to pilot these types of processes, so thank you to the CSAC for their willingness to pilot this.

The consent calendar includes only measures that were recommended for endorsement by the standing committee and they meet a series of criteria that are on slide 12, but also page four of the Discussion Guide. So a measure must meet all of those criteria in order to be on the consent calendar. Again, that's a super majority of overall suitability for endorsement vote of greater than 80 percent. So that means only measures that are recommended for endorsement are on the consent calendar. Those measures that are not recommended for endorsements are not on a consent calendar and those measures that are less than that 80 percent overall suitability for endorsement votes are also not on a consent calendar.

Those non-consent calendar measures will be discussed and voted on separately by the CSAC as measures that did not meet one or more of those criteria that I've mentioned that are on page four of the discussion guide or on slide 12 of the deck today. The consent calendar process allows the

CSAC to focus discussions and consideration of those measures due to concerns or issues that have been identified and those concerns or issues would map back to those key consideration criteria and ultimately reflect issues related to the Consensus Development Process.

Going to the next slide. So the consent calendar was shared with this CSAC in advance of this meeting so prior to the meeting for your consideration and review of those measures given all of those criteria, again that we'll go through here in a little bit. The CSAC was given five days to request to pull any of those measures from the consent calendar and have a rationale based on the key consideration criteria not being met. So again those key consideration criteria are found on page four of the Discussion Guide as well as slide 12 of this deck.

Any request from a CSAC member must be submitted to the NQF staff or CSAC chairs to pull a measure and if a measure is pulled for discussion, NQF would have notified the developers as well as the standing committee co-chairs and project teams of the measure being pulled and the CSAC member requesting to pull that measure would have served as lead discussant. I can say that as of today, none of the CSAC members have requested to pull measures off the consent calendar in advance of this meeting. However, if a measure was to be pulled for discussion along with that rationale, we would update the materials and reflect any changes and re-send those materials back out to the CSAC; however, like I mentioned, no measures were pulled from the consent calendar so the measures listed there are what was originally sent out to the CSAC. Again, no measures were pulled leading up to this meeting.

Going to the next slide, so here are the key consideration criteria for inclusion onto the consent calendar and, as discussed, measures will not be

discussed if they meet all of these following criteria. So they are included in this consent calendar if they meet all of these criteria, so they will not be discussed separately.

They must receive an 80 percent or greater passing vote on the overall suitability for endorsement. So like I mentioned, that's a supermajority so that is an endorsement vote approving endorsement so they must receive that supermajority vote. They also must not have any process concerns that have been identified that may have affected the endorsement decision. So any process concerns that may have affected the endorsement decision that must not have occurred in order to be on the consent calendar.

Also, no reconsideration requests were received on that measure either by the standing committee, like during post comment considerations or by the CSAC as it's another opportunity for developers to submit a reconsideration request for CSAC consideration. I am going to also report that no reconsideration requests were also submitted to NQF or this CSAC in advance of this meeting.

The standing committee also accepted the Scientific Methods Panel rating. So this criteria, there's no overturning of the SMP's decision related to the measures that were evaluated this cycle. For number five, no new information received through public comment that was not available or discussed during the Standing Committee's measure evaluation meeting which is conflicting to the Standing Committee's recommendation. So, no new information was received through public comment that conflicts with the Standing Committee's rating or decision making on a measure.

Also, measures are included in the consent calendar if they are not pulled for discussion by a CSAC member. So, again looking at the measures in advance of this call, no CSAC members pulled a

measure so thus, the measures in the consent calendar have also not been pulled by a CSAC member.

And lastly, no additional concerns identified that require CSAC discussion and this is based on the CSAC decision making rationale which is posted online and readily available for anyone's review, but those rationale also include mentions of just consistency and evaluation of measures as well as just being consistent with the CDP process. Any further questions on this before we move forward? Okay, we'll go to the next slide.

So during the meeting, so today, for the measure evaluation discussions today, the NQF project staff, myself included, will first provide an overview of the measures on the consent calendar, noting any measures that were pulled for discussion prior to the meeting. The CSAC chair or vice-chair, which in this case will be Missy, will then ask if any CSAC member wishes to pull a measure for discussion, giving another opportunity today if you wish to pull a measure off the consent calendar.

The CSAC member that wants to pull a measure must present clear and compelling rationale for pulling the measure which must relate to the key consideration criteria, which we've previously discussed and it's also on page four of your Discussion Guide. The CSAC member wishing to pull it will also become the lead discussant for that measure an allocated time slot today which is again reserved for 2:00 to 3:00 p.m. So if you wish to pull a measure and you have clear, compelling rationale as to why it didn't meet one of those criteria that we went through just in the previous slide, it would be moved to a 2:00 to 3:00 p.m. hour for discussion and the CSAC member who wished to pull the measure will be the lead discussant for that measure and discussing any issues during that time period.

So the CSAC chair or vice-chair after all of the discussions are heard will then ask the members of the public if they have any comments on the measures within the consent calendar. And going to the next slide, if quorum is present, the CSAC chair or vice-chair will then ask if there are any objections to accepting the Standing Committee's endorsement recommendations for the measures on the consent calendar.

So, again, this is not a vote, it is an approval of the consent calendar through no objection. If no objections, and it just takes one member, the recommendations are accepted and no voting on endorsement is needed. So those measures again, being endorsed from the Standing Committee, if no objections the endorsement will stand and CSAC endorses those measures on the consent calendar. And, again, just a reminder it's only 80 percent or greater passing votes for overall suitability beyond the consent calendar so it's only measures that are endorsed from the Standing Committee.

If quorum is not present, CSAC members will vote offline on each measure under review for those measures which quorum is not met. As I stated, Rebecca Kirch is recused from 3666 and 3665. Those two measures will be voted separately offline by the CSAC and if there are no objections to the consent calendar measures, the other measures will move forward as being endorsed, except for 3666 and 3665, which would have to be voted on separately outside of this meeting.

Going to the next slide, so the non-consent calendar measures. So there are measures that did not meet all of those criteria so they are pulled for discussion and review by the CSAC. Following the consent calendar discussions and after we come back from our lunch break, the CSAC will then proceed to review and vote on the measures that require discussion as they do not meet any of those criteria, one or more.

For these measures, the respective NQF team and the co-chairs will also provide an overview of the measure, highlighting the issues of why it's being pulled for discussion by the CSAC and the Standing Committee co-chairs will share their perspectives. Then the CSAC will have the opportunity to ask any clarifying questions through lead discussant and discussant discussions before moving to a vote on each measure separately.

The CSAC will be asked if they wish to uphold the Standing Committee's recommendations or accepting the Standing Committee's recommendation to either endorse or not endorse a measure or do not accept the Standing Committee's recommendation and return that measure back for further consideration by the Standing Committee. So this is the outcome of the votes that the CSAC has normally done in the past.

Going to the next slide. Now measures being pulled from the consent calendar during the meeting today. So, again, we're going to discuss the consent calendar measures. If a member wishes to pull with a rationale of why it didn't meet one or more of those criteria, that measure will be moved to an allocated time slot today, which has been allocated from 2:00 to 3:00 p.m. today.

So measures that are pulled will be slotted into that time slot and for each pulled measure, the respective project team staff, the director of the team overseeing that measure and the Standing Committee co-chairs will again present the measure, the issue that the CSAC member has called attention to. The Standing Committee chair will provide their perspectives.

The CSAC chair will then ask the member who pulled the measure to lead the discussion on those issues. They will then open it up to see if the other CSAC members have anything to discuss and then the Standing Committee co-chairs will provide any

responses to relevant concerns and then they'll be moving to a vote.

Following those discussions, each measure that is pulled will also have a vote and the vote again is to accept the Standing Committee's decision or turn it back to the Standing Committee.

Moving to the next slide. So now we're going to do a test vote, again, because we are still able to vote on 0097. Please locate that Poll Everywhere link and we'll go ahead and do this test vote and I'll turn over to Mary and Beth to run through that.

CSAC Measure Review Procedure and Test Vote

Ms. Flashner: Good morning, everyone. Mary will be pulling up the Poll Everywhere, so our question today is do you prefer tea or coffee and your choices are tea or coffee. If you don't drink either, please choose one so we see you know how to vote.

I see seven, we're looking for eight. Is someone having trouble finding the link? Take your time, we're running slightly ahead. Eight, I'm seeing eight votes. Mary, please close the poll. Coffee is the big winner today, so six prefer coffee and two prefer tea and that would be a passing vote if this was a vote on a measure, but please enjoy your coffee and tea.

Any questions about voting?

Member Susman: Are you sponsored by Starbucks?

Ms. Flashner: No, unfortunately not. Dr. Pickering: No, and we probably could give everyone Starbucks coffee for our meetings. All right, great, I think we can close that down. It looks like everyone is up and running on that, so fantastic.

Just before we go into our consent calendar discussions, I just want to make sure, does anyone have any other questions related to how this is going to run today? Okay. Great thanks, Missy, and thank you all.

So, we'll go to the next slide. Again this is now talking about the consent calendar measures that are in the Discussion Guide.

Ms. Flashner: Matt?

Dr. Pickering: Yes?

Ms. Flashner: This is Beth. We are running a little bit ahead of schedule and we had told the developers, members and co-chairs that this would start around 11:00, so I'm not sure if we still want to --

Dr. Pickering: Yeah, I think we can keep going. We'll discuss the consent calendar measures and we may have to take a break obviously for the lunch period. So just for everyone, as you can see on the bottom of the slide here, after the consent calendar discussions, as Beth has raised, we've informed our co-chairs of our Standing Committees and developers about this consent calendar discussion happening at this time if they so wish to attend.

However, we would then be sharing the outcomes of the consent calendar discussions via e-mail to those stakeholders informing them of the final outcome. So that being if measures are not pulled and that 2:00 to 3:00 hour be canceled or if measures are pulled, which measures they are and what the rationale was, we'll share that out with them so they know to attend that 2:00 to 3:00 hour, if needed. Again, if nothing is pulled, we will inform the stakeholders that nothing is pulled from the consent calendar and those measures are moving forward as endorsed and that the 2:00 to 3:00 hour will be canceled and public comment will be moved up.

So, we'll proceed to go through the consent calendar today and go through that process of discussion and if there's no objections and if not, we will move forward and we'll break for lunch with maybe a longer lunch than what we had allocated,

but we just wanted to make sure we had enough space for everyone to discuss, ask questions if needed, but then we'll break for lunch and come back at 12:30. Thanks, Beth.

This is just an overview of the consent calendar and for those following on in the Discussion Guide, that is now going to be page five. Page five in the Discussion Guide lists both consent calendar measures and non-consent calendar, but as a general overview here on this slide, the total number of measures for Fall 2021 was 13 measures. Again, this is a reduced number of measures cycle.

The reason for that was because NQF was also receiving a lot of e-mails and responses from developers seeking if they're intending to submit measures for Fall 2021 still recognizing the issues and the difficulties of data and resource allocation to support measures, maintenance endorsement due to COVID-19. So, NQF working with those stakeholders recognized that this is still an ongoing issue. We reached out to other measure developers asking if this was still an issue that they are grappling with and thus the responses were a resounding yes and also requesting to move measures to a different cycle. NQF did a lot of work to move measures from Fall 2021 to future cycles that will be coming down the pipeline and that's why we have a reduced number of measures this cycle.

This also gave NQF an opportunity to pilot these new processes, such as this consent calendar approach with a reduced number of measures, but this is why we have 13 just so CSAC is fully aware of this. Ten of those measures are new measures and three of those measures are maintenance measures. The consent calendar, again, those measures meeting all of those criteria that I stated previously. We have eight measures. Six of those are new and two of those are maintenance.

And as just one more reminder, all of those measures have been recommended for endorsement with an over 80 percent threshold rating, so they recommended overall suitability for endorsement with more than 80 percent of the Standing Committees in favor of that decision, recommending that.

For the non-consent calendar measures, meaning they did not meet one or more of those criteria, there are five measures. Four of those are new and one is maintenance. As far as measures being pulled for discussion, again prior to the CSAC meeting so in that five-day review of the consent calendar measures, no CSAC member requested to pull a measure for discussion today prior to the meeting.

As I mentioned after discussions today, we will send out an e-mail to developers and Standing Committee co-chairs to let them know the outcomes of the decisions on the consent calendar today. So, Mary, if we could just go to page five of the Discussion Guide, we could see those measures fully listed there. There we go, thanks, Mary. As you can see this is the consent calendar. You have really the measures in the consent calendar on this tealish blue left column where as the measures not on the consent calendar are on the right column.

You can see of all the GPC, or the Geriatrics and Palliative Care, measures all of those measures reviewed by that Standing Committee are on the consent calendar. They meet all of those criteria that we previously reviewed so there's a supermajority here. No process concerns identified. No overturning of any SMP voting. No reconsideration requests, etc. All those measures are listed there, there are three new measures. Same thing for surgery, so surgery only had one measure come through this cycle because we did have a reduced cycle, but that measure also met all of the criteria and thus being on the consent

calendar.

For Primary Care and Chronic Illness, there are two measures that are on the consent calendar. One being new, one being maintenance and there's one measure not on the consent calendar and that's 3667.

In addition, you can see a little one next to that title of 3667 in a bracket. That is to map back to the key consideration criteria so stakeholders, our CSAC members, but also others who are looking at this Discussion Guide can see which criterion was not met for this measure. In this case, this measure did not meet the 80 percent threshold and thus why it's included in the consent calendar.

Moving to Patient Safety, of the measures reviewed for patient safety, only two are on the consent calendar and one is maintenance and one is new, where we have four not on the consent calendar. We have three measures that are very similar just at different levels of analysis. So you can see 3633e, 3623e, and 3663e and it's a lot of numbers being a mouthful. You can see that those are all new measures, same measure, different level of analysis and you can see the criterion or criteria that were not met and that's why they're included on the non-consent calendar list.

So for that first measure, one and two, one again is not meeting the 80 percent threshold. It still could be recommended for endorsement, which in this case it is recommended for endorsement, it just did not meet that 80 percent overall suitability for endorsement vote by the Standing Committee.

Then you can see number two, on all these other measures, there are some additional concerns that have been identified that require the CSAC's review and consideration.

Lastly, 0097 you can see here also did not meet criterion one and criterion two. And this measure, if

the CSAC does recall, was not fully evaluated by the CSAC back in Fall 2020, you can see that little asterisk under the table here indicating that it was originally evaluated in Fall 2020. It was not brought to the CSAC's consideration for endorsement or non-endorsement. However, it was informed to the CSAC that this measure did come through in the cycle, but due to voting errors on validity, it was not going to be considered by the CSAC during Fall 2020. Instead, it would be moved to Fall 2021 once those voting errors had been adjudicated and it was brought back to the Patient Safety Standing Committee this past cycle.

Our project team, our director, Tami Funk, will go ahead and disclose that further when we get to that portion of the meeting today, but just holding it out here, this measure again was originally evaluated in Fall 2020, had some voting errors that were identified feeding up to CSAC, thus it was not fully evaluated by CSAC, but the plan to bring it back to CSAC was and CSAC did agree to this plan on bringing this measure back for Fall 2021 CSAC. Like I said, we'll go through that when we get to that discussion today, but that is the only measure that we'll be able to vote online today.

The other measures, we will be voting offline and for the consent calendar measures, the two GPC measures 3666 and 3665, will also be voted on separately and the no objections discussion will happen for the other measures remaining on the consent calendar. Sorry I'm stating that a lot, I just want to make sure we're all getting it and it's sinking in.

So with this, what I'll do now is provide this overview of our consent calendar, I will now turn it over to Missy, who will facilitate the discussion and provide any thoughts on the consent calendar list and go through this process and see if anyone wishes to pull a measure for discussion later on today.

Keep in mind that if you do wish to pull, it must map back to those key consideration criteria, must be a clear rationale as to why in order to pull it for the discussion from 2:00 to 3:00 p.m. and you, as a CSAC member, wishing to pull it would be the lead discussant. Missy, over to you.

Consideration of Candidate Consent Calendar Measures

Chair Danforth: Thanks so much, Matt. So before I actually ask the question about pulling measures from the consent calendar, I want to first ask my CSAC colleagues if they have any questions about the criteria for including measures on the left side of this chart that Matt just outlined that, again, are on slide number 12 or any questions in general on both the new process that Matt just outlined.

I think he did a great job in providing a lot of detail, but I do understand it's a lot of information and it is the first time we're trying this new process today. So, I'm going to pause for a second just to see if anyone has any questions about the criteria for these measures that they met to be on the consent calendar or any questions about the process that we're about to start.

Member Culica: Missy, it's Dan. I have my hand up, but I have just a quick question. I'm sure that Matt covered in his wonderful presentation, but just to be sure, for the voting for the measures that we will be voting today and next offline. I don't remember what is the percentage to pass.

Chair Danforth: Great question, Dan. Matt, can you review that again?

Dr. Pickering: Yes, for CSAC the passing vote on a measure is 66 percent, so of those voting today for passing the measure it must be more than 66 percent of the voters voting to pass the measure, it's 66 percent.

Ms. Flashner: It's above 60 percent.

Dr. Pickering: Oh, excuse me, it's 60 percent, Dan. So, 60 percent to pass the measure.

Member Culica: Thank you.

Member Susman: Sixty percent is our passage rate for most things at the committee level, correct?

Dr. Pickering: Yes, well for the committee level it's 66 percent.

Member Susman: No, it's 60, 60 percent, isn't it?

Dr. Pickering: No, sorry, yes 60 percent, I apologize, 66 percentage is going on in my head. It is 60 percent at the committee level, 60 percent for this group. I apologize for that confusion.

Member Susman: Okay, no problem.

Chair Danforth: Yes, so the one that we'll be voting on today hopefully if everyone can stay on for the full call, to pass we'll be looking for like five out of eight since our denominator is eight today, but again, when we vote online, the number required to pass will change because we are expecting additional people to be able to vote online, but that's a great question, Dan. Anything else before I get started? And, again, please don't hesitate if you have a question because I do realize it's a lot of information.

Member Susman: So, Missy, this isn't perhaps an issue about the new process which I think is great to pilot and try out and will help streamline things, but we're getting relatively small numbers now at CSAC and I wonder if now or sometime later on, you can talk about what the intent is. It seems like we've really slimmed down here and I worry that we don't have the breadth of perspectives that we should have at CSAC or as people are unable to attend, we get down to a pretty small number. Thanks.

Chair Danforth: Yes --

(Simultaneous speaking.)

Dr. Pickering: Missy? Oh sorry, Missy. I was going to add, Jeff, great comment and we do recognize that. So after today, I mean obviously we meet with the CSAC on strategic meetings, we would like to do sort of a debrief for lessons learned as well as to think about what's to come in the pipeline ahead.

Because that will be a number that the CSAC is more familiar with and so we want to make sure that through this pilot, are there other things that maybe we need to consider based on the CSAC's perspective related to the criteria related to just the process itself that maybe the CSAC would have liked to see something this way versus this way.

A reduced number of measures, Jeff, you're right, this is not really the full perspective of what we would normally see; however, it does provide us that opportunity to pilot this and also for the CSAC to really dig in and see if there is a way to improve the criteria or the process moving forward for the measures that we've --

(Simultaneous speaking.)

Member Susman: Just to clarify, I'm not talking about the number of measures that --

(Simultaneous speaking.)

Dr. Pickering: Apologies.

Member Susman: I was talking about the number of CSAC members.

Chair Danforth: Got it, yes.

Dr. Pickering: Sorry, members not measures, got it. Okay.

Chair Danforth: Yes.

(Simultaneous speaking.)

Member Susman: I mean you know it's Zoom, whatever, how can you hear. But yeah --

Dr. Pickering: It's Missy's fan really.

(Simultaneous speaking.)

Member Susman: My sense is we've gotten to such a small group that I worry that we're no longer as represented as we should be and that we have an increasingly small number, I mean in this case, we could have five to look at it or approve a measure, which seems to be getting pretty slim.

Dr. Pickering: And great comments, too, Jeff, thank you. We do recognize we are today with the quorum issues and we certainly will be looking to see how we can increase the size of our CSAC or ways that we can make sure that we don't run into some of these situations moving forward, but appreciate the comments, Jeff. It is something that for NQF we continue to think about how we make sure that our committees are representative and we do have quorum, especially given where we are currently in this virtual environment. Thank you, Jeff, for your comment.

Chair Danforth: Yes, thanks so much. Okay, I don't see any additional hands up. I just did my scan that means that, as I suspected Matt and the entire team did a great job laying this all out for us, so I will now ask the magic question, are there any CSAC members that would like to pull a measure from the consent calendar. Again, you're looking at the left side of that table in that teal blue column. Okay, I see no hands. I see nothing in the chat, so I will move us on.

Dr. Pickering: Before we move on, Missy, sorry, we do public comment to see if there's any members from the public. So, once more if there are any members of the public on the line, you now have

the opportunity to provide any comments to the measures on the consent calendar, which are those measures on that left column as Missy has said. You can raise your hand and we will recognize you in the order that we see your hand raised. Okay, no comments. Missy, back to you.

Chair Danforth: Okay. I then because there are no objections, the measures will be confirmed to have CSAC endorsement and, Matt, will you announce the measures that are endorsed?

Dr. Pickering: Yes. So, thank you all very much for your consideration of the consent calendar measures.

As a reminder, those measures that are endorsed now, I'll start from the bottom up. For Patient Safety, NQF number 0689 and NQF number 3636 will be endorsed. Primary Care and Chronic Illness or PCCI, NQF number 3661 and NQF number 3332 will be endorsed. Surgery, NQF number 3639, also receiving endorsement and for GPC just the one measure 3645 receiving endorsement.

Again, due to Rebecca's recusal for the other two measures, NQF number 3665 and 3666, will be voted offline by the CSAC through a SurveyMonkey that will be sent out later for the CSAC's review. For those on the call today, the CSAC members on the call, just keep in mind your votes hearing that you had no objections when you get that SurveyMonkey for 3665 and 3666, since you had no objections you would just vote to endorse those measures and that will satisfy that survey item.

Okay, well fantastic, with that we are ahead of schedule, quite a bit ahead of schedule. We just wanted to make sure we had enough time for folks to go through the consent calendar, have some discussions as needed, but it's great to see that the process pretty well. We will break for lunch at this time. We are now at 11:00 a.m. Eastern. Our lunch is at 12:30, so we will give an hour and a half lunch

just because we need to reserve that time for other stakeholders to be in attendance in the afternoon.

So, hour and a half we will convene back at 12:30 p.m. Eastern. NQF staff will be sending out e-mail confirmations to those stakeholders, develops and Standing Committee co-chairs notifying them that the 2:00 to 3:00 o'clock hour will be canceled and public comment will be moved up.

One last thing before we let you go, if at any point in time later on in the afternoon, you have need to step away for anything, please just let us know. You can message the team directly through Teams Chat or send an e-mail to us just so that we can continue to monitor our numbers because we still have to have quorum for 0097, which is later on in the afternoon. It's the last measure being discussed and we also need to monitor numbers just to ensure that we have enough to have the call today. So, just please let us know in advance if you need to step away and if you know the time, that would also be helpful as well to let us know the time you will need to step away and return.

Kevin, I see you have your hand raised. Do you have a question?

Member Kavanagh: Well, a comment. If possible why don't we move the measure that we have the quorum for up first to make sure that we have a quorum and get that measure voted upon?

Dr. Pickering: That's a great suggestion, Kevin.

Member Kavanagh: We may not be able to do it, but you've got an hour and a half to contact people and, you know, that way at least we'll get that one done.

Dr. Pickering: That's a great suggestion, Kevin. Does anyone from the CSAC have any objections to that approach?

Chair Danforth: No, that's a great idea. Thank you, Kevin.

Dr. Pickering: Okay. No guarantee. So what we'll do is reach out to our Project Team for that measure which is the Patient Safety Team and then we'll have to reach out to the subsequent co-chairs and developers to see if they are able to attend, but we'll circle back when we get closer to the meeting time at 12:30 or announce that decision at 12:30 when we reconvene. Thank you, Kevin, for that suggestion.

Any other comments or questions?

Ms. Flashner: Matt, we've had a couple of additional people during the call. Would you mind just repeating what the outcome of the consent calendar was for those individuals?

Dr. Pickering: Sure. So just for those have joined the call. The CSAC has completed their consent calendar discussion and review. Since we had recusal for two of the measures in the consent calendar, 3666 and 3665, those two measures we did not have quorum for so those two measures were not considered in the consent calendar and they will be voted on separately offline due to not having quorum for those measures due to a recusal.

For the remaining measures in the consent calendar, those measures were not pulled for discussion, therefore, there were no objections from the CSAC on those measures and those measures will move forward as being endorsed as of today. So, thank you, Beth, for mentioning that.

One last call for any questions. Okay, we will reconvene at 12:30 p.m. Eastern sharp. Thank you all very much and we'll be doing our end to start following up with directors, co-chairs and developers. Thank you all. We'll see you soon.

Chair Danforth: Thanks, everyone.

(Whereupon, the above-entitled matter went off the record at 11:01 a.m. and resumed at 12:30 p.m.)

Dr. Pickering: It's 12:30 p.m. on the Eastern side. We're going to pick back up and continue on. Mary, if we can go to the next slide.

I just want to welcome everybody back to the CSAC meeting today. Again, this is the CSAC for the Fall 2021 Measure Review Cycle. As discussed earlier today when we did a roll call, just wanted to let those who are attending know that we were not able to achieve quorum on a series of measures for review today with CSAC. The measure that we do have quorum for and thus will be voting on today, is 0097. It's the only measure that we have quorum for voting.

As far as the other measures not on the consent calendar list, those will be discussed today by the CSAC as well as presentations from our CDP directors and co-chairs for those measures, but those measures will be voted offline.

In addition, we did go through the consent calendar measures and there were two measures also that we did not have quorum for. Those measures were NQF number 3666 and 3665. Those two measures were for the GPC Standing Committee. Those two measures will also be included in offline voting. Again, we didn't have quorum for those considerations; however, this CSAC agreed to move forward on the consent calendar for the other measures, which those measures remaining were endorsed earlier this morning through the consent calendar process.

Lastly before we go into now the non-consent calendar measures, we were able to move things around within our agenda, again trying to keep to our quorum numbers. We're moving 0097, which is the one measure we have quorum for and will vote today to be the first measure up for discussion, that's with the Patient Safety Standing Committee.

We will then follow those discussions with the remaining Patient Safety Standard measures, which are the three eCQMs. After the conclusion of those discussions, we will then move to the remaining measure which is for PCCI, the Primary Care and Chronic Illness measure, which also we will discuss for consideration.

Lastly, before we go into all of this, I just wanted to remind folks that NQF is a non-partisan organization, so out of mutual respect for each other, we kindly encourage that you make an effort to refrain from making any comments, innuendos or humor relating to, for example, race, gender, politics or topics that otherwise may be considered inappropriate during the meeting.

While we encourage discussions that are open and constructive and collaborative, let's all be mindful of how the language and opinions we have may be perceived by others. With that, we can proceed.

Are there any questions before we get started into our first measure discussion? Okay, so again the first measure we have up is 0097 with the Patient Safety Standing Committee. I'm confirming that John James, one of our co-chairs, is on as well, but we will also have Tami Funk presenting, but I'll turn it over to Missy, just to sort of tee it up and then we'll go to Tami. Missy?

Chair Danforth: Okay, hi, everyone. Thanks so much, again, for coming back. We are going to be talking about one measure from the Patient Safety Standing Committee. Tami is going to review that so thank you so much, Tami.

Ms. Funk: Okay, good morning, everyone. I will review our first Patient Safety measure, NQF 0097, Medication Reconciliation Post-Discharge.

This is a maintenance process measure developed by the National Committee for Quality Assurance. This measure is being discussed right now because

it did not receive 80 percent or greater passing votes for overall suitability for endorsement and there was a process concern identified that may have affected the endorsement decision.

This measure was first evaluated for maintenance by the Patient Safety Standing Committee during the Fall 2020 cycle and the reason it's coming back to the CSAC for Fall 2021 consideration is due to a voting calculation error. So during the initial measure evaluation meeting, the measure votes for validity were incorrectly calculated resulting in it being stated that the measure passed on validity when, in fact, the validity vote totaled a consensus not reached decision. The error was not discovered until after the post comment call, but prior to the Fall 2020 CSAC meeting and at that point it was too late to be rectified as a part of that cycle.

During the Fall 2020 CSAC meeting, the Patient Safety Team and the co-chairs recommended and the CSAC agreed that the measure should retain endorsement until the Patient Safety Standing Committee could discuss and revote on validity and subsequently overall suitability for endorsement. This occurred during the Spring 2022 Cycle Measure Evaluation Meeting that occurred last month, in June of 2022.

NQF 0097 was discussed on June 28, 2022, as part of the Spring 2022 Cycle, but just for validity and then overall suitability for endorsement. The Standing Committee had a discussion on validity and revoted and passed the measure on validity and then also passed the measure on overall suitability for endorsement. During that discussion, the Standing Committee agreed that the validity testing showed positive correlations with related measures at a statistically significant level. The Standing Committee highlighted that the developer had also conducted face validity testing where the Technical Expert Panel agreed with the measure's intent.

The Standing Committee inquired about how medication reconciliation was assessed by the measure and the developer clarified how the measure assesses medication reconciliation and how it should be documented and then responded to another concern about whether medication reconciliation was actually a surrogate of whether it was just performed or whether any discrepancies were actually detected. The Standing Committee had a long discussion about who performs medication reconciliation and how those various roles address and remediate any issues that are found. The Standing Committee noted that medication reconciliation is actually a very complicated process and so it may be more effective to create a second measure related to the reconciliation accuracy itself.

The members overall noted that medication reconciliation and the measure in particular do drive actions by clinicians to assess medications which are helpful in clinical care and the Standing Committee passed the measure on validity and subsequently on overall suitability for endorsement. I'll now invite our Standing Committee co-chair, Dr. John James, to share his perspective on this measure.

Dr. James: Thank you, Tami. The background on this measure is pretty colorful, but I think the committee went through the appropriate processes to resolve issues that sometimes came up after the meeting was over. One thing that gave some of us a little bit of confusion was the term reconciliation.

Going in, I would have thought that would be reconciliation of the need for the medications against the list of medications that actually exist as the patient is discharged. In fact, what it is, is a list matching. Is the list at discharge the same as the list picked up by wherever the patient was discharged to?

So, the Patient Safety Standing Committee thinks strongly that the developer needs to come forward and work on something that we might call genuine reconciliation which is to get a team together and ensure that the right medications are being given to the patient to optimize their care, not just list matching. So thank you, Tami, that's all I have to add.

Chair Danforth: Thanks, Tami. Thanks, John. On CSAC, the lead discussant for this measure is Rebecca Kirch. Rebecca, do you have anything additional?

Dr. Pickering: Oh, sorry, Missy. I think it was Jeff Susman --

Member Susman: I think you're wrong.

Chair Danforth: Oh, I'm sorry about that Jeff.

Member Susman: No problem. So first of all, I do think it's even more colorful than presented. In the Fall of 2020 as I understand, the evidence was categorized as consensus not reached, but actually failed evidence with an N of 23 individuals. There were 34.7 who passed along with the validity where they had said it was passed, but it was actually consensus not reached.

Then in June 4, 2021, there was a revote on evidence after considering comments and it achieved a 64.7 percent with the bar of 60 percent and recommended for endorsement 19 of 23 or 82.6 percent. Then, another error caused a revoting on validity and June 28 has been presented. It did pass on validity with 12 of 16, 75 percent endorsement, the same 75 percent.

There were a lot of process issues and I'm sympathetic to the challenge that NQF staff had to determine quorums and voting and pass rates, but it's somewhat distressing that in this measure we've kept revoting and revoting and eventually it passed,

which gives me concern about things just basically regressing to the meeting. Whether that should in some way influence the ongoing maintenance measure in this case or not, is I think almost secondary to this issue of how many times do you have a measure go up for a consideration before you say, my God, this is really getting to be a problem, particularly given the measure failed fairly significantly on evidence the first go around.

The comments and the subsequent discussion which Dr. James has presented I think was very mixed. The idea that this is simply a check box, if you will, that says yes I did this and that's sufficient from an administrative data set or looking at the records and being able to say, yes I did this, that's enough without looking at the appropriateness of medications or, in some cases, the multiple changes that could occur in medications from discharge to 30 days after. I think, as Dr. James has indicated, prompted the committee to urge CMS to come up with or NCQA, I guess, is the originator with better, more nuanced measures.

The other concern and I was a little bit puzzled, maybe Dr. James could shed more light, is that a JAMA article was referenced about the ability of reconciliation to change outcomes, but the cited article actually showed in elders that there was no influence, no positive statistical influence, on outcomes.

So, while this is a measure that feels good and people certainly have argued that until we get something better, it's the best we have and helping people to get some initial information or data, I worry about, given our breadth of profile, that we pass oh, well this will be okay until we come up with something better. That said, the measure did pass albeit with 75 percent in its final iteration and the process imperfections or problems were adjudicated and, you know, I'll leave it for the committee to decide is this a measure that should be used at a

plan level for accountability.

Chair Danforth: Thank you so much, Jeff. John, I can see you thinking. Do you respond to any of Jeff's comments before I open it up to the rest of the CSAC members?

Dr. James: Yes, I would. Thank you, Missy. I hate to talk process here because I'm just kind of new to this as a co-chair. But I think in the end when we have a measure like this that is flawed, but widely used and does in the mind of many experts make a difference, but it needs to be made better, that the NQF needs to make it very clear that if this measure comes back in three or five years and there are not substantial improvements shown, it is a non-starter.

One of our roles, I think, on NQF panels and committees is to force improvement and we need to take that responsibility seriously and push these measure developers, perhaps out of their comfort zone, to make them make these things better so that we aren't just kind of going through the motions, as Jeff said, we are actually testing these things in our mind to see where they can be made better. Thank you.

Member Susman: And if I might, I think in my experience on the Standing Committees at CSAC, there has been no ability to set parameters around improvement in measurement. We're stuck with the measures we get, okay I understand that, but I agree totally, John, that we should be able to take to task developers and have some accountability to address concerns that CSAC and/or the committees have had and expect a turnaround over a reasonable time and to see some addressing of the flaws or imperfections. I don't see that built in our system right now, which I think is a real detriment to improving quality of care overall. I'll get off my soap box.

Chair Danforth: No, thank you, Jeff, and thank you, John. That was a really helpful dialogue and, Matt,

just a note that might be helpful when we regroup as CSAC is I think, I don't know, several meetings ago, we actually when Iona Thraen was still co-chair for the Patient Safety Standing Committee, there was a conversation about doing some review of competing measures.

Because now there are many different medication reconciliation measures, both at the facility level and the plan levels. I don't know that we ever heard where that ended, but it may be helpful to try to find where that conversation went and bringing some of those updates back to this group, just given this conversation.

And, Matt, I'm actually going to let you facilitate the next couple of minutes of dialogue from CSAC. I'm going to go shut my door. I'll be right back.

Dr. Pickering: Sure, Missy, thanks. Great comments from Missy. There has been work done previously related to medication reconciliation and looking at different types of measures for this. I will remind the group that any sort of competing measure discussion, according to our policies, other medication reconciliation measures must come through at the same time in order for a competing measure discussion to be held.

There has been some work looking at different measures for medication reconciliation in which the NQF staff have engaged the Patient Safety Committee a few cycles ago, but again, there needs to be two measures that would be considered competing to come through the measure evaluation cycle at the same time to be evaluated as competing measures, but it's a good comment to take back as well for when other medication reconciliation measures come to the Standing Committee and subsequently to the CSAC, especially if we're doing it at the same time.

Member Susman: Matt, one of the challenges is to close the loop on these discussions. I would say in

the past, while I think the staff is certainly well intended and there's been a lot of change in leadership, most of these discussions never come back to the level in which they're raised. It would be fine just to say no, we can't do this or we've considered this, but it's not possible, but I'd say 90 percent of the time, maybe even 100 percent of the time, this sort of conversation dies in a vacuum and I think that's a real opportunity for improvement overall at CSAC.

Dr. Pickering: Thank you for the comments, Jeff, taking those into consideration as well, I appreciate that. Missy, are you?

Chair Danforth: I am and I apologize. Okay, I'm sorry, Rebecca, actually just put a question in the chat. Is medication reconciliation ever considered to include de-prescribing as an action of meds review that has accountability in any complementary or competing NQF measures. I don't know if even anyone on NQF staff could answer that on the call without doing a little bit of research.

Member Susman: I mean certainly don't some of the geriatric measures look at appropriate prescribing/de-prescribing, if you would?

Dr. Pickering: Missy, I see Mary Barton, who's from NCQA on the call and she has raised her hand. I will say that normally the CSAC there's no formal role for developers related to CSAC discussions. I do see that Rebecca's question is really specific to potentially what's included or maybe excluded in this measure, so if the CSAC wishes to hear from the developer, I believe Mary Barton from NCQA who has her hand raised now, is able to address any of those questions.

Chair Danforth: That would be great, Matt.

Member Susman: I mean I think it's simple. This is just a comparison of what was prescribed on discharge and noting that you reviewed that and

prescribed in the reconciliation to home or the other venues that are prescribed.

Member Kirsch: I'm just reflecting a little more on what Dr. James explained about the Standing Committee's discussion and what they thought reconciliation might mean versus what it does mean for purposes of this measure, so I'm just trying to get a better handle on just from the patient perspective comparing lists doesn't deliver more quality care.

You know, making sure that people are taking the right medications does and I'm just trying to understand how that conversation of the Standing Committee then translated to let's go ahead and approve this. It may be because of the discussion we just had, but there are limitations on we have to take the measures that we have, but I heard Dr. James explain that the Standing Committee itself discussed what does this really mean and I may have misunderstood that.

Chair Danforth: Sure, so let's actually do this. Rebecca, I think that is a helpful comment and clarification. I would ask Mary Barton, because she is here, to be able to just answer that one specific question and then as a reminder, following that it would be great to just get any additional comments, questions or concerns from CSAC members but, Mary, if you want to go ahead and unmute yourself and address Rebecca's question that would be wonderful.

Dr. Barton: Thanks so much. There's a lot of flexibility right now in what constitutes an appropriate medication reconciliation and I feel your pain because I think that this is an area that we would love to have a higher bar measure and really look at the changes that are made or possibly look at the indications and the medications.

Really there are a lot of ways that this could go and be more rigorous, but for today, with the data that

we have this is the best step and, unfortunately, this measure is not yet at 95 percent, so I feel like we're kind of trying to go step wise here.

But for sure a deprescribing conversation is completely appropriate to have in the context of a discharge from a hospital when you're staying, whether it's here's this thing you've been on for 10 years, but you actually don't need to be on it on any more or because we're adding these three other meds; that's entirely appropriate.

I do want to just make a plug for another measure that NCQA has recently designed, which is for deprescribing of benzodiazepines in older adults, because the Beers criteria recommends that older adults should not be on benzodiazepines and we, rather than saying nobody should be on them, we're trying to take a point of view that there are some people who already on them and so they should be tapered safely and make that move towards discontinuation in a tapered way.

But that's not the measure that's under discussion today, sorry.

Chair Danforth: Thank you, Mary. Okay, any additional questions, comments, concerns specifically from my CSAC colleagues? Doing a face scan. Okay, seeing none, but I have some notes from Jeff, Rebecca and others for some follow on. I am going to ask Beth to actually come on now oh I'm sorry, actually I'm going to see if there are any public comments. So no additional comments from CSAC members. I'm going to pause and see if there are any public comments.

Dr. Pickering: So any member of the public can raise their hand if you're using the WebEx feature, I believe there's a star six feature to take yourself off mute. If you have any comments related to 0097 for the CSAC's consideration, now is the time to do so.

Chair Danforth: I don't see any, Matt.

Dr. Pickering: Neither do I.

Chair Danforth: Okay. At this point then, I am going to turn it over to Beth to come on and give us all instructions for a vote. Thanks, everyone.

Discussion and Voting

Ms. Flashner: Hi, so we're going to vote on this measure. Mary, if you can pull up the Poll Everywhere that would be great.

Dr. Pickering: And as that's being pulled up, I just want circle back to Dan's original question around what constitutes passing. So it's greater than 60 percent of those voting need to vote in favor to uphold the Standing Committee's endorsement, so greater than 60 percent of the votes coming in. Sorry, Beth, go ahead.

Ms. Flashner: CSAC members, please select your vote for NQF 0097, Medication Reconciliation Post-Discharge. Your choices are to uphold the Standing Committee's recommendation to endorse the measure or you can do not uphold the recommendations instead return it to the Standing Committee for reconciliation. Looking for eight votes, I see seven votes. If anyone is having difficulty -- I see eight votes. Mary can close the poll and share the results.

On this vote for 0097, seven CSAC members voted to uphold the Standing Committee's recommendation to endorse the measure. One CSAC member voted to not uphold the recommendation, instead return it to the Standing Committee for reconsideration. Therefore, 0097 is endorsed. Thank you very much and I believe I turn it back to you, Matt.

Dr. Pickering: Yes.

Member Susman: Could I just ask a technical

question here for a moment?

Dr. Pickering: Sure, yes.

Member Susman: How long will the endorsement last since this was back in '20 that it was originally considered and there was all of the comments that we've had about the measure?

Dr. Pickering: Great question, Jeff. So since this has now officially been endorsed with the CSAC approval of the Standing Committee recommendation, this measure will come back in, in its normal cycle from Fall 2021, which would be in the three years or three to four years. That's when the endorsement would be maintained for this measure.

Now there are opportunities to pull the measure off cycle, so out of those three or four years, that would be if the measure substantially changes. So if the recommendations are substantial enough that there's a change in the results for instance, or there are new specifications that come out that shape the measure, that would pull the measure outside of that three or four year cycle to come back to Standing Committee earlier.

In addition, if there is an appeal received or if there's a member of the public that wishes to have the measure pulled off cycle due to new evidence that has come to light. That may also be where the measure could come back either to the Appeals body after this CSAC meeting or out of cycle out of that three to four years, if there's new evidence that a member of the public submits to NQF for the Standing Committee's consideration, that could impact the original voting that occurred from the Standing Committee.

So otherwise it would come back through in the next three or four years depending on the cycle.

Member Susman: I just think that four years for a measure that's been in question since '20 is rather a

long time to go for something that everyone agrees is not optimal, but I'll say no more.

Dr. Pickering: Thanks, Jeff.

(Simultaneous speaking.)

Dr. Pickering: Oh, sorry, John, did you have anything final?

Dr. James: So can this committee ask for a shorter return time or is it up to the Standing Committee, the Patient Safety Standing Committee or NQF itself? Who makes the call?

Dr. Pickering: So, a lot of process questions today. So to answer your question, John, the CSAC is able to send a measure back to the Standing Committee which would go back in the next upcoming cycle. That's one immediate way for a measure to be reconsidered, but there needs to be rationale as to why and usually points to any process issues or other potential issues that are under the CSAC's purview. However, in this case, that did not happen as you can see the voting score is listed here, which is 88 percent passing. So that's above the 60 percent threshold.

Another way, John, like I mentioned is if a member from the public wants to submit that this measure should come back for early maintenance review due to new evidence that's come to light or any potential unintended consequences as a result of the implementation of this measure that could be considered by NQF and the Standing Committees for consideration of whether or not the measure should come back for early maintenance review.

Lastly, we have an appeals period and any measure that is upheld as being endorsed goes through a 30-day appeals period after the CSAC meeting in which case any member of the public may submit to appeal the measure or its decision from the CSAC in order to be officially reconsidered. Those are the

options.

In this case, where we find ourselves today is that this measure has maintained endorsement and moving forward it will go into the appeals period and outside of that, if no appeals have been received, it will come back through in the next three to four years, unless there's an early maintenance request that would constitute a Standing Committee review of the measure.

I want to keep on moving so we keep to our agenda here. Now we're at 1:00, so thank you, Missy. Missy is now recused for the next series of measures up for discussion, so thank you as well, Jeff, for being the discussant of this measure.

We'll now move to the remaining three measures up for discussion within the Patient Safety Standing Committee. You can see those listed there. Those are the three eCQM measures. Same measure, different level of analysis and so Tami as well will be leading out this discussion.

Our lead discussant is going to be Rebecca Kirch and we also have additional discussants as Kelly Nedrow and Kevin Kavanagh for these measures. So, Tami, I'll turn it over to you.

Ms. Funk: Great, thank you, Matt. The remaining three measures that are listed in front of you for the patient safety discussion today, these measures NQF 3633e, Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults at the clinician level; NQF 3662e, Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults at the clinician group level; and NQF 3663e, Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults measured at the facility level. These are three new eCQMs and they are intermediate outcome measures and they were developed Alara Imaging and the University of California at San

Francisco.

These new measures were evaluated by the Patient Safety Standing Committee and all three measures were recommended for endorsement. They are not included in the consent calendar as they did meet criterion number two, which identifies whether there were any process concerns that may have affected the endorsement decision. In addition, NQF 3633e did not meet criterion one, as the overall suitability for endorsement vote was 78.9 percent passing.

These measures were reviewed by the Scientific Methods Panel and the SMP passed all three measures on reliability and validity. During their measure evaluation meeting, the Standing Committee recommended all three measures for endorsement. During the post-comment meeting, NQF received two public comments that applied to all three of the measures.

One comment applying to all three measures was in support of the Standing Committee's recommendation and additionally requested the development of an exclusion criteria for overuse. The developer provided a public response addressing this request and clarifying why this is not necessary based on the construction of their measure and stating that the comment actually reflects a fundamental misunderstanding of the measure.

The second comment also applied to all three measures and it was in opposition to the Standing Committee's recommendation restating concerns from a pre-evaluation comment that had been submitted and stating that they didn't feel the Standing Committee adequately considered that pre-evaluation comment in the original measure evaluation meeting.

The Standing Committee discussed this comment during the post-comment call. While the NQF measure review process was followed, in

reconsidering this comment several Standing Committee members had concerns that their review may not have been thorough enough due to lack of expertise among the committee members since the radiology expert on the committee was recused from discussion and voting on these measures.

One Standing Committee member noted that when a professional society comments on a measure, it should be strongly considered; however, this same member also stated that they thought all the issues were well considered during the original meeting and that the overall vote for endorsement should stand. It was also noted that many comments in support of the measure were also received at the time of this original comment before the measure evaluation meeting.

The committee suggested that in the future, for similar technical measures on very specialized subject matter, a Technical Expert Panel might be convened to help review some of the measure's nuances, similar to how the SMP reviews, but subject specific.

The Standing Committee was given the option to vote on the following three options. First the Standing Committee could agree that the measures met all the NQF criteria and vote to stand by their recommendation to endorse the measure. Second, the Standing Committee could revote on the measure's endorsement or on a specific criterion based on a credible rationale that criteria were not met or, three, the Standing Committee could vote to postpone further review and NQF could create a Technical Expert Panel to provide additional expert feedback to the Standing Committee.

The majority of Standing Committees present, which was 11 of 14 members or 78.6 percent, voted to uphold this recommendation to endorse the measures. Therefore, no subsequent votes were held and the Standing Committee's recommendation

to endorse all three measures stands.

I would now like to invite the Patient Safety Co-Chair, Dr. John James, to share his perspective on these measures.

Dr. James: I think, Tami, you did a great job of describing the events that led up to where we are now, thank you. I think it reflects my feeling that the incorrect process, while it's perhaps a bit laborious, is very thorough and we followed it and we listened and we got different opinions on the committee. Most of us weren't experts in this kind of area, but we listened hard to the experts who talked to us, both pro and con and we ultimately decided by a large majority that this was fit to be endorsed. So there's not much to say beyond that, except that we really did do, I think, due diligence with this one and by the way, the other two measures did pass the 80 percent that you guys are using today to put it on a separate pile.

With that, I'll pass it on.

Dr. Pickering: Great, thanks, John. Thank you very much, Tami. So at this time, I'll welcome our lead discussant, Rebecca, to provide any additional remarks based on her summary of these three measures.

Member Kirsch: I appreciate it all, such a nice hug. I think we all needed that at this time of day. I can be brief because the deliberations, the discussion as outlined were very thorough. And what I particularly appreciated from the patient and caregiver perspective in what the Standing Committee even talked about social risk factors and whether there's impact there, which is very important for us to keep seeing happen as CSAC has talked about and the MAP Committee has talked about the importance of equity in deliberations as we look ahead for NQF.

I think in particular they discussed a great deal around the harmonization, could these three

measures somehow be condensed and the developer had acceptable answers around the importance of attribution across the three different care quality areas that were distinct. So, I did not detect anything that would cause us to upend what the Standing Committee suggested, so I'll defer to my other discussant, my co-discussants, for any other comments.

Dr. Pickering: Thanks, Rebecca. Kelly or Kevin, any additional comments or thoughts?

Member Kavanagh: Yes, I've got some if I could go on.

Dr. Pickering: Please.

Member Kavanagh: I'm somewhat concerned about these measures and whether or not the validity and the specifics of the Medical Society's concerns were taken into consideration for these metrics. The previous discussion nor the information provided by NQF actually truly delineated what these concerns were and I had to do some research myself. I do feel that they are valid concerns in that these measures, if not thoroughly discussed by the committee and understood by the committee, have the potential of possibly doing harm.

The reason is in the discussion when they talk about these measures are actually talking about the type of test, etc., and you need to focus on that, that is really code for when you measure radiation with CAT scans, you're really talking about the number of slices used. The CAT scanners, from my understanding, are pretty much comparable to radiation delivered and after you adjust for patient factors, which I believe these metrics do, you're then left with how many slices do you order? What is the distance between the slice? This is the major driver in dosage. If you double the number of slices you will either see a wider area or you get a much better image quality and are able to better pick up lesions.

So this is what they mean, it will possibly drive the type of test that's done. There's no control that I could see in the denominator for number of slices or distance between the slices and if indeed you have a metric that's just measuring radiation and you are now financially incentivizing people to lower radiation and the best way they can do that is to limit the slices, you may have the unintended outcome of creating lower quality testing and having lesions missed.

Now I didn't obviously hear all the testimony or go through everything, but that's the key question and what disturbs me is that with NQF with the presentation of the Standing Committee, and what's presented so far, no one has really talked about that. Does the denominator need to take into account number of slices so that we get out of image quality types of concerns or does it not have to do that. Otherwise, you're dictating really the type of CT that you're getting.

Of course, you also have the with and without contrast CT where you just double everything doing a separate test that maybe isn't even needed. So all of those are, I think, major concerns and I'm really wondering if the Standing Committee actually considered the comments, because the comments weren't really written in an explicit way to explain these factors. They seem to be more global terms that could be overlooked by the Standing Committee.

But, in view of a metric that could cause potential harm or unforeseen outcomes, I think if the Standing Committee has mentioned they didn't have the expertise in reviewing this, I really think they need to reconsider and get the expertise and do a more in depth look at the metric. That's my overall comment on this. Thank you.

Dr. Pickering: Thank you, Kevin. So, just confirming and maybe we can go back to John on this one,

after we hear from others on the CSAC, but just confirming that the concern is really that the comments received really get considered by the Standing Committee. So the comments that were submitted, did they really get fully evaluated and considered by the Standing Committee noting some of the concerns that were in those comments.

Member Kavanagh: That's correct and if they actually understood the comments, the impact and whether or not the denominator should or should not be changed to look at number of CT scan slices that are being ordered and getting that out of the measurement. As I said, I think it's too superficial. I don't think they've addressed the comments. These are professional societies and the radiologists I've talked to readily understood the problem and this is in a situation where there is actually no standardization of types of tests.

Every patient is different and a lot of times it depends upon the ordering physician. So that's the concern.

Dr. Pickering: Thank you, Kevin. So before I go back to John on that one around how the comments were considered, I'll see if our other co-discussant, Kelly, if you have anything to add before I open up to the CSAC overall?

Member Nedrow: I noted, of course, from a non-clinical perspective some of the same things that Kevin brought up. If the goal of the measure is to reduce patient exposure to radiation, and this is coming from a non-clinical perspective, the concerns that come up for me are if low image quality is a possibility then having to have additional testing, which is additional exposure to radiation, is a concern as well as additional costs for patients due to having to have multiple procedures or images taken. But those were my points that I noted.

Dr. Pickering: Great. Thanks, Kelly. Anyone else

from the CSAC wish to provide any additional comments related to these three measures and what's been discussed thus far?

Member Susman: One question or concern and I saw it on one of the measures that is on our consent calendar that I was engaged with, is having the appropriate and robust technical expertise on a panel. I think for things like RT where some pathology markers and such that we saw in the primary care, there is not as broad and robust technical expertise as I might in any case.

I'll just reflect on the consideration of the pathology markers that were considered in our primary care group. You know, primary care doesn't usually consider that sort of stuff and we can certainly consider some of the aspects of a measure, but there were only two or three individuals who really had any technical expertise whatsoever and it wasn't like you could just read up on it right away and try to figure it out.

I guess the bottom line is maybe there needs to be some process to add additional technical experts when we consider something that is very specialized like RT exposure for CT so that the very people who might have the expertise have to recuse themselves and then we get into this whole question of were the technical issues considered adequately. That's my only comment.

Dr. Pickering: Thanks, Jeff. So a comment here, again, on the technical expertise needed for the Standing Committee and make evaluations on these measures, which as Tami summarized, this was a discussion that the Standing Committee had and also even further determined through a vote on how they would like to proceed given the concerns that were discussed within the Standing Committee. They voted to proceed with endorsing the measures as they have reviewed them.

Anyone else from the CSAC have any additional

comments before maybe turning it back to John for any remarks on these issues? Okay, so John, I guess the comments you have been hearing around how the Standing Committee really handles the comments that have been received for these measures and really some of that technical expertise area of concern, do you have anything you'd like to respond to related to those comments?

Dr. James: Yes, I would. Thank you, Matt. Kevin, I think I understand your comment and if I understand the way all this works and, of course, my knowledge is limited, but if you put in a request for a high density, that is a lot of slices, CT scan the radiation is going to be higher and so that the idea that you have to independently deal with the number of slices versus the overall radiation dose, I think is not necessary. That is, the number of slices is reflected in the overall dose. So you might want to rebuttal on that. By the way, Kevin, it's good to see you. I haven't seen you for a long time.

MemberKavanagh : Well, thank you. Well it is reflected in the overall dose and that's why controlling the dose will drive how many slices you have and the fewer slices, the less clarity of the image you will have.

Dr. Pickering: Right.

Member Kavanagh: You know, I've experienced this quality with CT scans on ear work, on the temporal bone where we need a very high quality image. I couldn't get the radiologist to give me enough quality image so I could see the inner ear structures for surgery. We ended up doing, I think, two or three CT scans on the gentleman. So, you know, you put in a financial incentive on top of that, you're going to drive down image quality and that's the adverse effect. If you drive down image quality, you're going to miss things. You know, if you take a slice once every 5 mm, you're not going to be able to pick up small lesions or have the needed

resolution for surgery.

Dr. Pickering: Thank you, Kevin, for that level of detail, appreciate that. Sorry to cut you off on that one. Just a reminder that sort of the issues here are really looking at how the Standing Committee really addressed the comments or considered those comments as was summarized by Tami and John, and just the consideration of that technical expertise.

So reminder that readjudicating a lot of the Standing Committee decision making would not be under the purview of the CSAC; however, just the consideration of those comments and how that factored into the evaluation is what is being considered today as well as that technical expertise. Thank you very much for that. John, do you have any other comments you'd like to add?

Dr. James: Yes. I would like to respond to the comment that Kelly raised. We did worry, if that's the right word, about the concern you raised about having to do repeat scans because the resolution was too low because you used too low a radiation dose.

Okay and when we ask that question, the developer cited the study where only about 11 percent of the time was a repeat scan necessary when this measure was applied. Now, I don't like that, but that tells me that it's being done pretty well, that the radiologists are picking a dose of radiation that is at the threshold for the quality of scan they need, that is, the number of slices if you will, and the risk that it's going to have to be repeated because they don't see what they want to see.

I might also point out that there's such as a thing as an incidentaloma and sometimes you find what you probably shouldn't have found because it really isn't making any difference, but that's the technical side. I don't want to go there, but I think we really did go through the process of discussion and engaged the

people as best we could that we felt knew what was going on. It is an ongoing issue did we have enough expertise available to really look at this measure.

Member Kavanagh: John, if you have to repeat 11 percent of your CT scans in an optimal setting, that's pretty high.

Dr. James: I agree, Kevin.

Member Kavanagh: You know and that's in an optimal setting of universities that have top notch people that aren't financially driven. You add a financial incentive on top of that. I mean 11 percent is high. These are expensive tests that have radiation exposure.

Dr. Pickering: Yes, thanks, Kevin. Thanks, John. I want to see if Tami, the Director of the Patient Safety Standing Committee has any additional comments to add and then we'll do one final round of CSAC comments and discussion before we open it up for public comment, which I know the developer of this measure is on the call and most likely has some comments to share for the CSAC.

So, Tami, do you have anything you'd like to add?

Ms. Funk: Thanks, Matt. I just wanted to note in response to these concerns also that we took steps in the subsequent cycle, Spring 2022, to call in additional subject matter experts to help the committee when recusals were a potential issue on nuance concerns. Just from a process concern (audio interference) for future reviews to resolve them, but again, that doesn't apply. The Standing Committee reviewed the comments in their own discussion on their own and made the decisions and stand by their endorsement decision.

Opportunity for Member and Public Comment

Dr. Pickering: Thanks, Tami. Any final comments from the CSAC before we open it up for public

comment? Okay. All right, thank you. Public comment is now open so if any members of the public would like to provide comments to these measures and the discussion being held currently on these measures by the CSAC, now is the opportunity to do so. You can raise your hand and we'll call in order as we receive them. I see Rebecca Smith-Bindman, you have your hand raised. I believe you are representing the developer, is that correct?

Dr. Smith-Bindman: I am. Thank you for the chance to speak. I am a radiologist and epidemiologist and I've been a faculty member at UCSF for 25 years. For the last 15 years, my primary area of research has been in quantifying the radiation doses used for CT scanning and identifying ways to appropriately reduce excessive doses. I developed a measure with my team and the three measures that you review today are all essentially the same with a different level of attribution.

I want to first correct that 11 percent number that was just spoken. We shared results from two evaluations. One, we prospectively evaluated the eCQM across 16 hospitals, one large outpatient radiology group and in that testing data, we assembled 50,000 CT scans from those organizations.

In those 50,000 CT scans, a small fraction, less than one percent, I think it was 0.3 percent, were deemed as having poor image quality. A very, very small number of actual scans. The 11 percent number is a number that was evaluated as part of our measure. We created a test set of images, 750 CTs assembled from a dozen institutions and for those we assembled a lot of low dose exams, because we did a radiology reader study.

In that set of 750 CTs that were evaluated by 125 radiologists, in that test set assembled to be over-representative of very low doses where we thought

there could be a quality issue, that's where the 11 percent came from, but in real practice, it was a fraction of one percent.

I want to help you understand the quality gap that lead us to create the measure. Around 90 million CT scans are performed every year in the U.S., meaning the equivalent of one in four Americans is imaged with CT scanning each year. The measure will impact a significant portion of the U.S. population. We developed this measure because we observed an extremely variation in the radiation doses that are used for CT scanning. The doses that are used for particular types of scan, for example, an abdominal CT to evaluate a patient for right lower quadrant pain. This is bread and butter radiology. The doses that are used for that vary tremendously depending on where the patient goes for the CT. Meaning one patient might get a dose of three millisievert and three millisievert is the equivalent amount of radiation that's typically received as part of annual background exposure in the United States from the sun and earth. So, you could get a dose of three millisievert. You also could go to a different institution for the same symptoms and get a dose of 30 millisievert or even go to another institution and have a dose of 100 millisievert all for the scan done for the same reason. So, three, 30, 100 for the same scan and my evidence of this is based on analysis of 15 million scans that my team has assembled from across 160 hospitals.

The variation in the dose is not driven by patient factors, such as how large the patient is or why the scan is being done. Yes, you need different doses for different indications, but that is not what drives the variation, nor is it driven by the type or age of machines, but rather by local decisions that are made about the details of the machine settings. It turns out that slice thickness per se is not an important parameter, but the number of phases is, the mAs/kVp are.

I want to make clear that again patient size, the indication for scanning and the machine all influence dose, but they don't drive the variation. The variation remains after accounting for these factors.

I also want to emphasize that appropriately dosed scans can be obtained in all patients and all machine types, which my team has demonstrated in an NIH funded randomized control trial across 100 hospitals. Providing audit feedback to imaging facilities about their doses can achieve meaningful and standardized dose reduction without impacting image quality. The measure is provided in such a way that it will give feedback the same as that was given in our trial and there is currently no evidence that image quality is a problem.

I mention that as part of our radiologist reader study where 125 physicians rated the image quality of selected exams from a low dose and this was not a big problem in actual practice. A small fraction of one percent of scans in testing were weighted as having unacceptable image quality, but 33 percent of doses exceeded the maximum that we established as part of the measure. So there's a large safety problem with radiation dose and no image safety problem with image quality.

We are super aware of the potential for any measure to lead to unintended consequences and we are also aware of concerns that have been expressed about our approach for measuring image quality. I want to emphasize that this measure is not primarily intended as a robust measure of image quality, but to ensure a minimum level of quality that correlates with physician satisfaction. The measures used by CMS will be closely monitoring image noise and other measures of image quality during the process of assembling data, and we'll be very sensitive to any signal that there's a problem and we'll revise the measure if it turns out we need to make changes.

I wanted to tell just you one more thing about our approach to developing the measure. We systematically set forth principles that we thought were important for making a state of the art measure and I think this will answer a concern that was raised about the choice of how to stand, whether you get the scans that you want and appropriate image quality.

First, the measure covers all body regions and all types of scans including high-dose exams, multiple phase that are needed for certain clinical questions. Second, the primary focus was on dose, but we also had it measured to account for image quality. Third, and this is the part that I think subtle, but really important, that it covers the two key process of care components that determine a radiation dose.

These include the choice of imaging protocol or in layman's terms the type of scan. For example, whether a patient with a suspected pulmonary embolism is imaged with single- or double-phase scan, this decision is made by the radiologist and then separate decisions regarding the technical settings used for the type of CT scan which are done which are at the discretion of the technologist.

Both contribute to radiation dose and in our measurement, we decide what the clinical indication was, not based on what the radiologist chose to do, but rather what the ordering provider indicated was necessary. So if the patient needs a high resolution internal ear exam, that's the criteria that we evaluate that measure and that exam would be put in a high dose category, so it would be allowed a higher dose than if the scan was done for sinus disease, where you need a low quality image to look for sinus infection.

I think I will end by just saying we engaged a very diverse and expert stakeholder group for our Technical Expert Panel including leadership from the American College of Radiology, the President and

Chief Medical Officer of Radiology Partners, one of the largest radiology groups in the nation, representation from Leapfrog, the Director of Quality Measurement at The Joint Commission, the Chief Medical and Scientific Officer of the American Cancer Society, the Executive Vice President at UnitedHealth Group, and a medical physicist who previously served as President of the American Association of Physicists in Medicine as well as the Society for Imaging Informatics and who serves as Governor of the American Board of Radiology.

This group also had representation from other specialty societies, urology, emergency medicine, cardiology, several additional radiologists and many individuals with methodological expertise in measure development, electronic health record extractions as well as reporting. So, while I appreciate there may not have been complete expertise at every level evaluation of NQF, those levels of expertise were carefully considered, the measure modified in response to the entire development process, which went over a three year period. Thank you very much for considering our measure.

Dr. Pickering: Thank you very much, Rebecca. Any other comments from the public related to these three measures, which is the same measure but different levels of accountability? Now is your opportunity to provide comments. Okay, hearing none and seeing no other hands raised. Again, as a reminder, we did not have quorum for this measure, so unfortunately, we are not able to vote on the call today. The vote will occur through an offline survey which will be sent out to the CSAC after we adjourn today.

Just a suggestion here for those CSAC members on the call today is to please jot down your decision on this measure. The questions that you will be asked are whether you want to uphold the Standing Committee's recommendation to endorse these

measures. So you will be voting on those individually in that offline survey so please jot down the numbers for these measures and your decision. Again, these measures are 3633e, 3662e and 3663e. Again, that offline voting survey will be sent out after the call, so please just keep track of your decisions.

Thank you all very much. Thank you, Tami. Thank you, John. We'll now go to our last measure for discussion today. Again, we don't have quorum on this measure either, so it'll be offline voting as well, but the CSAC will still discuss the measure and issues that will be presented. I'll turn it back to Missy, who is not recused from this measure now, to take it over from here and introduce Paula Farrell, the Director of the PCCI team.

Chair Danforth: Thanks so much. Paula, are you with us?

Ms. Farrell: I am, yes.

Chair Danforth: Okay great. Thanks so much and we will turn it over to you for a description.

Ms. Farrell: Okay, great. Thank you. So for the Fall 2021 cycle, we had one measure that was not included in the consent calendar and this measure was NQF number 3667, days at home for patients with complex chronic conditions and its summary can be found on page nine of the CSAC Discussion Guide.

The developer for this measure is Yale New Haven Health Services Corporation and this was a new outcome measure that was evaluated by the Primary Care and Chronic Illness Standing Committee.

So NQF number 3667 is not included in the consent calendar as it did not meet criteria one. The measure was not recommended for endorsement by the PCCI Standing Committee, therefore, it did not

receive 80 percent or greater passing votes for overall suitability for endorsements. The reason being is that the measure did not pass on validity, which is a must pass criteria. The measure was initially reviewed by the Scientific Methods Panel and they did not initially reach consensus on validity. The Standing Committee highlighted that the SMP's main concerns with validity pertained to risk adjustment models, measure exclusions and meaningful differences in performance.

In reviewing the validity of the measure, the Standing Committee noted that the developer conducted face validity and construct validity testing. While the face validity testing indicated that the measure may be valid, the construct validity testing found that the correlation between this measure and other measures was weak and there was a Pearson's rank correlation that ranged from 0.549 to 0.048.

The developer did emphasize that the lack of correlation may be due to the other measures having smaller sample sizes and that being risk adjusted also raised concerns that the risk adjusted models have no standardized approach to address social determinants of health factors. The Standing Committee highlighted that the SMP's concerns regarding the measure exclusions, regarding low outliers and how the developer attributed them to unintended consequences of the measures construct as the measure attempts to balance days at home and other unintended consequences.

The Standing Committee also highlighted the SMP's concerns with meaningful differences in performance and the use of the measure for quality improvement purposes, specifically they questioned whether the measure can be used to identify differences in patient function or health-related quality of life and the Standing Committee agreed that these concerns were significant enough to threaten the validity of the measure. Therefore, the

Standing Committee did not pass the measure on validity.

During our post-comment period, NQF did receive two commenters that expressed support for the Standing Committee's decision to not recommend the measure for endorsement citing concerns with the measures validity. We also received three comments in opposition of the Standing Committee's recommendation citing that the measure is an important metric in managing patients at home and one that patients also care about. One commenter that was also in support of the measure for endorsements did note though that there were challenges that exist to be operationalizing the measure, including concerns about access to care and perceived lack of control to make changes by those being held accountable and the ability of claim-based measures to make effective reactive reactions and to improve care.

The developer of the measure also submitted a comment clarifying aspects of the measure and they did request that the Standing Committee provide feedback on potential enhancements to the measure. During our post-comment call, the Standing Committee did draft three recommendations for the measure developer to consider for improvements.

One, the Standing Committee recommended introducing a survey instrument or a patient reported outcome measure that would assess factors which may affect the quality of care and feasibility of care being provided at home. Two, the Standing Committee recommended that the developer focus on assessment of the measure on the continuum of care versus a specific location being at home. Third, the Standing Committee recommended that dual eligibility risk identifiers are not an accurate capture of social determinant of health factors and not all patients who are able to receive care at home are dual eligible and this could

potentially penalize a provider.

Additionally, the Standing Committee advised that there were significant policy variations in Medicaid from state to state which also impact entity-level social determinant of health factors.

So the Standing Committee discussed all of these comments that were received during the post-comment call and ultimately decided to uphold their recommendation not to endorse the measure due to the validity concerns as the Standing Committee concluded that the develops approach to risk adjustment was not sufficient.

At this point, I'd like to invite our PCCI co-chairs, Dale Bratzler and Adam Thompson, to also share their perspective on the measure.

Dr. Bratzler: Thanks, Paula. This is Dale Bratzler, University of Oklahoma. So we did do a very long, detailed discussion of this particular measure. Paula has done just an outstanding job of highlighting the concerns that were raised by the committee and the comments that we received in the post-comment meeting that we had.

I think I would boil down a lot of our concerns about the particular measure that the risk adjustment, particularly for social determinants, simply wasn't adequate to make any of us feel comfortable that days at home for chronic conditions was a measure that could be equitably applied across multiple different health settings, rural urban settings, different types of healthcare settings for patient care.

Again, the Yale New Haven team did a great job with their discussion of all the things that they had done to build the measure. Again, they used dual eligibility, Medicare Medicaid dual eligibility, as the primary evaluation of the social issues for a particular patient, but we went through a long list of other things that our committee, many in primary

care and others, that may impact the decision about whether a patient is able to receive care at home or needs to be in some other setting.

I want to point out there was a lot of confusion initially that patients who are living in a nursing home that is considered home and so they did not fail the particular performance measure, but it's all the other settings that a patient may be in that can fail the measure.

Like I said, Paula did a great job of highlighting all of the conversation. It was quite a lengthy conversation, but it really fundamentally came down to can we adequately adjust for all of the factors that may support or not support a patient actually living in the home setting.

Dr. Pickering: Is Adam on the line?

Chair Danforth: I don't see him.

Ms. Farrell: I don't believe he is able --

(Simultaneous speaking.)

Dr. Bratzler: Adam may not be available.

Ms. Farrell: Yeah, after 2:00 so I don't believe he's on the line.

Chair Danforth: Okay, Paula and Dr. Bratzler, thank you so much. For CSAC, Dana Cyra is the lead discussant. I know she is here. I will turn it over to her.

Member Cyra: Yes, I am here. I have to tell you that you know as I read this and saw the concerns, I was kind of noting some of the concerns about this which I thought there were some significant concerns, especially not incorporating the social determinants of health as a risk factor. I really, based on my personal experience, feel that dual eligibility cannot be used as a substitute for looking at social determinants of health.

I would say that among the individuals we serve, which is the home- and community-based waiver population, about 48 percent of the people we serve are elders and those are often times not people who have struggled due to any social determinants of health. They're people who have run out of their money to pay for their care or they're people who were successfully able to divest their income. So I think you just have too much variation among that population to think that you could use that as an indicator of social determinants of health.

The other thing that I thought was really concerning was actually using this as a measure of care coordination and primarily because what we're seeing right now is that we cannot get people out of hospitals or nursing homes because of the direct care work force crisis. We just can't find places for people to even discharge to in the community setting and I don't think an ACO would have any control over that. So I agreed with the committee that this was not valid, that it didn't pass the validity test and I just don't think it would be a good measure.

I have to say that I went back and I looked at the comments for this and I did see that there were a number of like disability advocates who see this as a way of sort of really emphasizing how important it is for people to be able to receive care at home. I just don't think this is the measure that's going to get them there.

Chair Danforth: Thank you, Dana. That was an excellent summary and I really appreciate your personal commentary on that as well. I think it really added some color to this entire discussion, so thank you so much.

The additional discussants for this measure are Dan Culica and Laura Pennington. I'm actually going to go to Dan first to see if he has anything additional to add. Dan?

Member Culica: Yeah, I'm here, Missy. Thank you. I would say that I consider a merit of the measure. I mean I understand the pitfalls and I think that in a way I was surprised that the only issue that has been found was with the construct validity. I personally didn't see very much of approval in that regard.

I mean there is a mention that it was evaluated by comparing with other measures and I would say that looking for the description in the manual, it says that the other NQF measure that is comparable is Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions. I know that this is the measure that has been compared to, but this one is an admission rate, while this one is days at home, so I don't see very much the similarity between the two measures. Again, there might be details that have been missed, that I obviously missed.

Other issues, I would say that when the measure is designed to look at the days at home and it actually explains that it's designed for that, but then when I look at the measure, it says the setting of care, it says post active care in patients in hospital here. So there are some discrepancies there.

Then on the issue of social determinants of health, the measure is described as adjusting for clinical and social risk factors and then when a more detailed analysis looked into and concluded that the use of dual eligibles was used as a proxy for social determinants of health, there are some discrepancies between I would say the final conclusions and the overall evaluation and what is actually written down about the measure. I would say that again I was surprised that the construct validity was the only issue that has been found with the measure, but I can see the merit of it.

I can see why it has been pushed and I can see why CMS would have liked to do that and see being

brought in, especially with this transition to accountable care now that it's embraced.

Chair Danforth: Thank you so much, Dan. Those are great additional comments. Laura, do you have anything additional to add?

Member Pennington: Not really. I agree with my colleagues that I really appreciate the intent behind this measure, but also recognize the difficulties with it and hope that the measure developers can improve this and bring it back in the future for consideration, especially as we get more sophisticated with collecting social determinants of health data.

I know we're still kind of in the early days of that in some ways and so agree that using the dual population as proxy is not as effective as I think really trying to figure out how to do this and do it well.

Chair Danforth: Okay, thank you so much, Laura. That was actually a great overview from everyone. Thank you, Dana, and Dan and Laura that was fantastic. Does any other additional CSAC member have any comments, questions or concerns? Are there any public comments? Is there anyone on the line that would like to share a public comment. Matt, I don't know if you can give those instructions again if folks are on mute.

Dr. Pickering: Sure, so thank you all to the CSAC for the consideration and discussion of this measure that's been presented. Now is the opportunity for members of the public to provide any comments related to this measure, that's NQF 3667. If you have a comment you'd like to share for the CSAC's consideration, now is the opportunity to do so. You can use the raise hand feature and we'll call on you as recognized or there's the star six option to take yourself off mute as well.

Chair Danforth: Oh, I see Mary's hand now. Oh,

Mary, did you mean --

(Simultaneous speaking.)

Dr. Pickering: Mary's on NQF staff so I think she took it down.

Chair Danforth: Okay, I knew she was, but I'm like maybe she has a question.

Dr. Pickering: Yep. Any other members of the public wish to make any comments? I don't see any hands raised, Missy, and not hearing anyone else.

Chair Danforth: No, I'm not either. So as a reminder we won't be voting on this measure today. We will be voting on this measure when we get the SurveyMonkey or the online link. Just to reiterate to uphold the Standing Committee's decision in this case would be to uphold their decision to not recommend the measure for endorsement. Okay, no additional questions, concerns? Great. I'll turn it back over to you, Matt. Thanks so much, everyone.

Dr. Pickering: Great, thank you, Missy. Thank you, Dale, as well, our co-chair of the Primary Care and Chronic Illness Standing Committee. I thank you, Paula, as well. As Missy said, since we didn't achieve quorum for this measure, voting would happen offline through that survey. As Missy also said, as part of the reminder, the question you will be asked is whether you want to uphold the Standing Committee's decision to not recommend this measure for endorsement. So, keeping that in mind, if you do wish to reverse that decision, there will be a text box in that survey that will ask you to determine why you think it should be endorsed, right? That survey will be sent out after this call.

Now that concludes all of our discussions of the measures for Fall 2021. Since no measures were pulled for discussion from the consent calendar, that hour block from 2:00 to 3:00 has been canceled. I'll ask Mary to pull up the slides once again.

Now we'll move to the overall public comment. This is for any of the proceedings that have happened today, whether the consent calendar or any of the measures that have been discussed. If any member of the public would like to voice any comments for the CSAC's consideration, now is the opportunity to do so. Like I said, you can raise your hand, we'll call in the order as we see it or take yourself off mute and share your comments. So, I'll just pause for a few seconds for public comment.

Again, last call here for the opportunity for anyone from the public to share comments on any of the proceedings that have happened today for the CSAC's consideration. You can use the raise hand feature or take yourself off mute. Public comment? Okay seeing none and hearing none, I want to thank everyone again for the proceedings today. We will go through our next steps and just remind folks of the survey before we adjourn the call. Mary, I'll turn it over to you to conduct next steps today.

Next Steps

Ms. McCutcheon: So, for our next steps the voting results will be posted in early August. This date will change a little because of offline voting. Once all offline voting is complete, this voting results document will be posted very shortly after.

We also have our meeting summary from today's meeting so that will be posted in September. Additionally, the appeals period this also may shift slightly because of the offline voting, so it will still be held in August, but those exact dates might shift by a few days there until the offline voting is complete.

Then, final CDP technical reports will be posted in November of this year. Additionally, any resources or today's materials, those are all available on our project web page, our CSAC page on the NQF website. Any additional questions or concerns, please feel free to reach out to at

CSAC@qualityform.org email and we're happy to address that way as well. Matt, I'll pass it back to you.

Dr. Pickering: Thank you very much. Before we adjourn, I also want to just thank this CSAC once again for piloting this new approach for the consent calendar. We very much are looking forward to doing some feedback on this process with the CSAC when we convene next.

In addition, want to really be appreciative and sensitive to the comments that have been shared related to other issues that have been presented to this CSAC as well as what the CSAC continues to see in which there are areas to work with this CSAC moving forward. Part of the reasoning for doing the consent calendar is to try to reduce a lot of the time on reviewing measures that didn't require a lot of discussions, to have more of these strategic discussions with the CSAC, which we are very much looking forward to doing moving forward as well.

I'm mentioning a lot of comments that were expressed by the CSAC today, but also in previous meetings as well related to things around reserve status as well as the public reporting, so those are not lost on NQF on our task list to do for the CSAC, so please know that that's something we look to engage the CSAC in the months ahead.

But thank you all very much. To the developers, to our CSAC. Missy, thank you, for your leadership and also the members of the public and the CSAC team for all of their work today. Missy, do you have any final closing remarks before we adjourn?

Chair Danforth: No, I just want to thank the staff and my CSAC colleagues for hanging in there for this pilot today. I think it actually went really smoothly, so thank you, everyone. You get like 90 minutes back to your day. I hope everyone has a great afternoon.

Dr. Pickering: Great, that's right. Thank you all very much. Have a great afternoon and a great rest of your week.

(Whereupon, the above-entitled matter went off the record at 1:58 p.m.)