National Quality Forum

Moderator: Measure Developer Maintenance
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Operator: This is Conference # 19860766

Operator: Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please standby.

Melissa Marinelarena: Hi, everyone. Welcome. This is Melissa Marinelarena, the senior director for the cancer project. I'd like to welcome everyone. I would also like to introduce my colleague Jean-Luc Tilly. He works on other projects that he is helping me today to present some of the work that he's been working on with this prioritization criteria.

Very quickly, I just want to turn it over to Karen Fields and David Cella and welcome them. Thank you for leading this work. We've been together now I guess about a year and a half and we haven't met probably in over six months but I'd like to thank you both and turn it over to you to say some words.

Karen Fields: Good afternoon and welcome. This is Karen Fields. We are excited to have everybody joining us today for our first of several planned off-cycle activities.

Today, Melissa and Jean-Luc had volunteered to go back to one of our favorite topics which is prioritizing quality measures and gap so that we can start to understand NQF strategic plan and focus for the future and so that we can improve our portfolio.

I know out team has talked about this multiple times but I think it's very critical that we really start to get more active rather than passive about new measures development. So I look forward to today's conference and David.

David Cella: Well, I just want to add my welcome to everyone and thank you for joining the call. I -- the only thing I would add to that to Karen's introduction is to remind everyone that at the last meeting when we were face to face as a committee, there was some general agreement around the need for more outcomes measure over process measures and in particular a desire to see more outcome measures that rely to some extent at least upon patient reported information.

So with that, in the back of our minds, let's go through the presentation that Melissa and Jean-Luc have provided.

Melissa Marinelarena: Great. Thank you both. So very quickly, I'll go over the agenda. I'm going to provide a very quick overview of the off-cycle activities which is what we call this webinar I think in the e-mail that I had sent originally a few months ago said we would be having another webinar in September as well. So this is off cycle because we don’t have any measures to review. So I'll give a quick overview of that.

We'll -- Jean-Luc will also provide the -- he's going to give an introduction to the prioritization criteria. Him and Helen Burstin have been working on this and our (John Bernaugh) and Helen is on the phone. Hi, Helen, welcome.

Helen Burstin: Hi, everybody.

Melissa Marinelarena: She's going to be on until 2 o'clock. And then we're going to do the NQF cancer measures and gap prioritization exercise. This is a pilot that we're doing. We did it with palliative care and then I'll go through and explain how we came up with the categorization. And then we'll do the public member comment and we'll talk about next steps.

So very quickly, just wanted to do a quick roll call to see who is here with us. Gregary Bocsi?

Gregary Bocsi: Yes, here.

Melissa Marinelarena: Great. Brent Braveman? OK. Joanne Buzaglo? OK. Jennifer Carney?

Jennifer Carney: Here.

Melissa Marinelarena: Steven Chen? OK. Crawford Clay? Matthew Facktor?

Matthew Facktor: Yes, I'm on the call. Thank you.

Melissa Marinelarena: Hi, Matthew. Martin Fleisher? OK. Shelley?

Shelley Fuld Nasso: Hi, I'm here.

Melissa Marinelarena: Hi, Shelley.

Shelley Fuld Nasso: Hello.

Melissa Marinelarena: Jennifer Harvey? Brad Hirsch?

Brad Hirsch: I'm here.

Melissa Marinelarena: Hi, Brad.

Brad Hirsch: Hi.

Melissa Marinelarena: Jette Hogenmiller?

Jette Hogenmiller: Here.

Melissa Marinelarena: Hi, Jette.

Jette Hogenmiller: Hi.

Melissa Marinelarena: Joseph Laver? Leonard Lichtenfeld? OK. I know Leonard is going to be on. Jennifer Malin? Jodi Maranchie? Ali McBride? Benjamin Movsas?

Benjamin Movsas: Hi, this is Ben.

Melissa Marinelarena: Hi, Ben.

Benjamin Movsas: Yes. Hi, this is Ben.

Melissa Marinelarena: Hi.

Benjamin Movsas: Hello.

Melissa Marinelarena: Diane Otte?

Diane Otte: Hi, Diane Otte. I'm here.

Melissa Marinelarena: Sorry. Hi.

Diane Otte: Yes. Thanks. No problem.

Melissa Marinelarena: Beverly Reigle?

Beverly Reigle: Yes, I'm here. Thank you.

Melissa Marinelarena: Hi, Beverly. David Sher?

David Sher: Hi, I'm here.

Melissa Marinelarena: Hi.

David Sher: Hi.

Melissa Marinelarena: And Danielle Ziernicki? OK. Is there anybody…

Jodi Maranchie: Hi, this is -- yes, this is Jodi Maranchie, I just joined.

Melissa Marinelarena: Hi, Jodi.

Jodi Maranchie: Hi.

Melissa Marinelarena: Is there anybody that I didn’t call that is here? OK. Then we will go ahead and move on. I'm just going to do a quick overview of the off-cycle activities so then we could get started on the exercise that we talked about.

So this is just an example of potential off-cycle activities and it could be a number of things including reviewing some measures. Some projects are reviewing maybe a couple of measures. We didn’t have any measures to review for cancer.

But some things we may be doing with the -- including a big NQF policy or process. There are a lot of updates that we're not going to be doing that here just in the setting measurement priorities and you can read all of this.

We are going to be doing this prioritization exercise based off of the work that Jean-Luc and some of the other team members have been doing. And I -- we felt like this was really step as some of the work that we have done in the conversations that this committee had had and it will be a really good step to improve the cancer portfolio.

So that being said, I'm going to turn it over to Jean-Luc and he's going to go over the prioritization criteria.

Jean-Luc Tilly: All right. Thanks, Melissa. And so good afternoon everyone and thanks for working with us today on this prioritization exercise. This is actually just our second time running this exercise. We try it last week with palliative and end-of-life care committee.

So I think just starting of a kind of research subject for us and definitely let us know what kind of tweaks we can make to the process as we go through. I'm just going to briefly walk through the rationale for this new strategic priority here at NQF, introduce our objectives, the criteria we're going to use to prioritize measures and gaps and the high impact outcomes which we're doing.

So first up on that slide here, you'll see the National Quality Strategy which is to say the triple aim on your left and the six National Quality Strategy priority fund on your right. Although our CDP work that you’ve worked on in the past takes this priorities into account, we want to go out a little bit further than stated existing paradigm. But we are primarily, your, working from that.

This schematic here describes NQF new strategic plan and how prioritizing measures fits into that. In the next few years, NQF is going to assume a kind of greater leadership role in measurement science and driving quality improvement through measurements.

So you'll see some similar aspects of our work in there where we endorsed measures, quality measures for federal programs as part of the MAP process, gathering feedback with our new feedback tool and accelerating development of new measures through the Incubator.

Prioritizing measures and gaps works as part of that by, you know, contributing to the endorsement aspect of our work helping us prioritize the right measures to endorse, figuring out which are the most important and on the Incubator side. It means prioritizing the gaps that we want to address for it and allocate resources in those areas.

So this work is all founded in a kind of environmental scan that our colleague Helen Burstin and…

(Off-Mic)

Jean-Luc Tilly: …over the course of the half year. I mean, as you know, there are variety of excellent frameworks out there that’s prioritizing measures and identifying which should help us in priorities. So Helen lead our work that -- all of the national and international efforts in that space and it came out to about 12 criteria that were shared by all.

And by working with our Consensus Standards Advisory -- Approval Committee, the CSAC collecting survey feedback from NQF members and from some standing committees and from the (net work) groups, we narrowed it down to it about four.

These are the four that you see on the screen in front of you. So the first is -- the first criteria and it's -- we want measures that are outcome focused which, of course, means outcome measures. But then also process measures that are very proximal to outcomes where you can be sure better performance…

(Off-Mic)

Jean-Luc Tilly: … that is pointed to. The second criterion is improvable and actionable. So really two things here. The firs a performance gap already part of our endorsement process which are measures that are tapped out, then also evidence that are strategies that you applied to and improved performance in those areas.

So the third criterion then is meaningful criteria to patients and caregiver. So again, two parts. The measures are person centered that we're measuring things that are important to family caregivers and then also the results are understandable to the same patients and caregivers and can be used for them to make vision for that work they're caring.

And then finally, we're looking for measures that support a systemic and integrated view of care. So measures that can be applied across several settings to different providers across different conditions.

Now along with these four criteria, we wanted to articulate what we're calling high-impact outcomes or what all of our measurements should be enforced. So you'll know there's some pretty close alignment with the…

(Off-Mic)

Jean-Luc Tilly: …strategy we report to then I'll just read out from the slide. We're looking to improve the functional status and wellbeing, patient experience, including care coordination, preventable harm, prevention and quality behavior, total…

(Off-Mic)

Jean-Luc Tilly: …needed care and then finally equity of that care. And now something that Helen actually created which I think really helped kind of articulate…

(Off-Mic)

Jean-Luc Tilly: …in the translation of the kind of scientific terms. You know, term like functional status like they're like alienating on a patient that could better, you know, how you're getting better. Give me a moment to take a look at this here.

Yes, other examples might be continue health –staying healthy. That's what we think in terms of prevention. So now finally to organize kind of this confluence we just described, I will put them into a kid of hierarchical framework. So right at the top, the high-impact outcome, the goal (we're all) working towards.

And below that just the driver measures that we can be sure we'll have a direct involvement on these outcomes. The priority measures that either roll out into driver measures or in some other way or contributing to work distally to the high-impact outcome.

And finally the quality improvement lowest level measures that might not be appropriate for using accountability program are very…

(Off-Mic)

Jean-Luc Tilly: …but likely not (sustainable). So I'll go through each of these levels and sequence. So the first layer to talk is the high-impact outcome. So we're just driving hopefully across the (minute) but with complete set.

Next the -- we're calling the driver measures. So we expected this will actually be relatively scarce. These are really the most important accountability measures that we think will drive high performance on the outcomes we're charting so these are broader measures that can be applied to several different settings and conditions that could be comfortable in measures, you know, across the United States.

So then directly below that, you have priority measures. So these are measures that need the criteria but from one reason or another aren't limited to a particular condition or setting. So they're contributing to improvement and the (high skill) of that outcome and might even be, for example, a component or the driver I've been mentioning.

And this is really the way the prioritization exercises is going to be the most helpful to us. I think it's, you know, we want to identify what the ideal driver measures look like but then also choose around them just in the portfolio. Identify those that should really be called priority.

You know, with the segment measures that we endorsed already in the cancer portfolio would involve reflecting into the priority measures area, (improved) measures but we also wanted the driver measures there…

(Off-Mic)

Jean-Luc Tilly: And then finally, just to have that last bubble, we have quality improvement measures. So, you know, there's many thousands of QI measures that are out there. Many or most of it will never be in NQF for endorsement. You know, I think about some of the priorities there, some of the opportunities for standardization so we're all kind of moving and using them.

So the process for applying this framework to the measure set in (a given) portfolio is, you know, we've already walked through several steps and right here we're kind of that second to last step, the applied criteria scoring to existing measures.

So we haven't formulized the scoring criteria as of yet. We want to try to process a little bit more organically at first and I think you will see this as an attachment from Melissa, kind of that first crack at sorting these measures into their different areas.

And so the next, I'll walk through kind of an example using total harm. So clearly on this diagram, you can see a kind of conceptualization, it's the total harm high impact outcome and all the different components that go into it.

So, you know, we're talking about follow-ups and surgical complications, infections and (first drug) events really just sort of the universe that makes up harm. And then just in that one area, hospital-acquired infections, NQF has 13 measures that broadly speaking in, you know, our criteria of priorities but they're setting our condition specific just, you know, kind of broader, composite or national indicator to watch.

Now applying that framework to the pyramid, you know, we can see that total harm with high impact outcome right there at the top or kind of hypothetical composite of hospital-acquired infections would be the driver measure we'd like to see (with the) strong indicator of progress towards the outcome.

Not the whole picture but (towards one of) the outcome. That could be broadly applied across the variety of different setting. You know, and then an example of priority measure and there are many of these (CLAPSE) prevention in the hospital setting.

And then, you know, one of the ways you work on it, of course, hand hygiene, there are many, many hand hygiene measures. You know, so there -- maybe there's also an opportunity for standardization to work towards that same goal.

All right. So I hope the example was helpful but I'll stop anyway for questions and ask also Helen maybe to add key (tasks).

Helen Burstin: No. I think that sounds great. You know, I look forward to people's feedback. Again, what we're going to ask you today really is about is thinking about what would be those measures within the cancer domain that you think would be important to drive toward those pop-out comments that we list about, but Melissa will walk you through that exercise. Thanks.

Jean-Luc Tilly: Great. So were there any questions from any committee members? Fantastic. I get you read your material very closely. So I'll turn it over to Melissa who will walk you through kind of the specifics to the exercise.

Melissa Marinelarena: OK. So you received several attachments from me. They included -- it's things that you’ve seen before but just organized different. And I see, Len, you are on the phone, can you hear us? You're probably on mute, but I…

Len Lichtenfeld: Can you hear me?

Melissa Marinelarena: Yes.

Len Lichtenfeld: Can you hear me?

Melissa Marinelarena: Great. Yes.

Len Lichtenfeld: OK. I was not…

Melissa Marinelarena: I know you were dialing in.

Len Lichtenfeld: Well, I was on the computer. I thought it was going to be webcast so I was on the computer and I was just talking in here but I'm on the phone now so…

Melissa Marinelarena: OK. Great. Welcome. I know you're going to come. So, yes, so you received the document that we had reviewed during our in-person meeting which was the sort of the framework of the measures by cancer type.

And then I gave you a spreadsheet. We gave you the description of the measures. I have the measure title, the description numerator/denominator. So it's a lot more specific which will help with this exercise that was what I used.

And this draft document, so this -- I think one of the lessons we learned from the palliative care exercise was it was helpful to have the work sort of already -- sort of the pre-work done for the committee because it's a lot of information to grasp and then have you sort of refine it and agree or disagree with this.

So what I did was went ahead and took the measures from the cancer portfolio and put them in as either priority measure or a, you know, internal QI measure and again, I don’t think that that is really finalized yet but it was just to get a picture of where our portfolio fit within this criteria.

So as you can see, the objective for today's webinar is to each identify the highest priority measures from the cancer portfolio and the priority gap using this criteria that will have the biggest impact on the driver measures and outcome measures.

I think this will also be helpful in getting rid of that long list of gaps that I found dating all the way back to 2008 and sort of let's clear this slate and then identify what is the highest priority in gaps and then we can move forward from there.

You go to the next slide. So this is an example, it's the same where it sort of demonstrating that Jean-Luc showed a while ago with the triangle but I sort of looked at the other way.

So this is where functional status wellbeing would look like with the functional status being the outcome measure on the left, the, you know, couple primary driver measures, I just put that in for visual and then we would have our cancer specific priority measures and then some QI measures on the right side that would be fit in into the cancer specific priority measures.

So this is what it would look like. If we go to the next slide, so that top row this is actually what we have. So based on what I found in the portfolio, there were no measures that fit under priority measures or internal QI measures that would actually improve functional status or wellbeing that are cancer related or cancer specific measures.

And the way I categorized them was on this spreadsheet there is -- under Row K, there's non-condition specific and they're already tagged as either their coordination or disparity sensitive basis. So instead of me trying to determine where they fit, I just use these categories which I believe they aligned with the National Quality Strategy. So I just went with that.

So today, in part of the work for the committee would be whether you'll agree with that or not. So I'm going to turn it over to Karen and Dave right now to facilitate the discussion on functional status and wellbeing and to talk about priority measures and QI measures.

Karen Fields: So, Melissa, this is Karen, since we don’t have any, do we want -- do you want the group to talk about some examples or -- please give me a little direction.

Melissa Marinelarena: Yes. So the first question is is the committee agree that out of our portfolio that none of the measures are in fact functional status or well-being measures?

Karen Fields: OK. OK.

Melissa Marinelarena: And then if you do agree, then what are some priority measures that are related to cancer that would improve functional status or wellbeing.

Helen Burstin: And maybe I could just jump in for one quick clarification, this is Helen. Thanks for that question, Karen. So quite a way to think about this as well is addition to trying to prioritize among the measures we have, a big piece of this exercise is also identifying the gaps.

So you may not be able to identify a specific measure but we'd love you to identify a measure concept. Just the key area that you think that general measure focus you think to be important in which patients. And some of these goals would be to say what are then the top gaps in cancer care that we want to try to ensure gets filled.

Karen Fields: OK. Thank you for that. I -- since this is our first part of experiment…

Helen Burstin: Yes.

Karen Fields: …the criteria is the first question. So I guess my first comment is patient reported outcomes will -- and measure -- soaks through in patient reported outcomes will likely lead us to the opportunities that where we start to measure functional status in a meaningful way although obviously, there's other ways to measure functional status.

So I'm thinking of some work that's being done right now in prostate cancer where measures are being developed to look at the patient's functional status following surgery in a patient-reported strategy. So I think the more we can encourage patient-reported outcomes that focus on patient-reported outcomes and measures that focus on that, the more will be likely to get to true functional status.

Other areas where I see some development going on are in the areas like lymphedema and breast cancer patient's post-op and so I'm sure that the group can brainstorm or may have some knowledge on areas where then we can encourage measures. So I'll stop and let David add to that.

Melissa Marinelarena: Thank you, Karen. Hi, David. David, are you still on?

Karen Fields: If we lost him which sounds like we may have, anyone from the group have any thoughts or ideas? Because I had already read through Melissa's assessment and I agree, I don’t think we have anything that comes close to measuring it. But I don’t know that there's a lot of development out there. So what does the committee think?

Beverly Reigle: This is Bev Reigle. I know one of the things that we've been looking at really along the lines of what you said, Karen, in about pre-rehabilitation is sort of piece looking at very much in the cancer area especially in lung cancer.

And then certainly having measureable tools to determine has a person actually, you know, profited from it or benefited from it in terms of outcomes from maybe being deconditioned or whatever. So there's a piece of that that’s going on and certainly from a lymphedema piece, there's some new work being done on actually subclinical detection of lymphedema and the outcomes of that in terms of if you're catching it or actually detecting it prior to any clinical signs.

So it's primarily bioimpedance spectroscopy but at any way, there are things out there I think we could look at and then cancer rehabilitation in general has become -- has been around but it's I think becoming far more important and screening tools related to that and then the outcomes so functional outcomes that go along with that.

So I think I don’t know if this is along the line or if I'm even talking in the same thing but that’s something I know that’s going on and certainly in the survivorship area.

Karen Fields: Right. I think those are excellent examples, Beverly.

David Cella: Hi, this is Dave CElla. I apologize for not being heard. I was -- I switched over to my computer in the webinar but apparently the microphone doesn’t work when you dial in to the computer so I came back on the phone.

Melissa Marinelarena: Thanks, Dave.

David Cella: So I've been listening all along and I agree those are some good thoughts. If I could throw out a couple of ideas about this -- what I think might be a good way to approach the top of the pyramid or triangle and then the working down from there is something we have to, you know, we'd have to get more specific on.

But I think when we're talking about the top of the triangle, I think it's going to or at least for me, it's been most helpful to not think in terms of specific questionnaires or patient-reported outcomes or even other outcomes so much as to think about, you know, what is it that the -- that patients would understand and that clinicians would understand and all of us would understand.

And so I just -- I mean, that sort of good one but I was thinking at -- for that top of the pyramid idea something like the proportion of patients who after adjuvant therapy returned to their normal functional level. You know, because to me that's a realistic goal for adjuvant treatment is to be able to get through the treatment and then either go back to work or get back to your child care responsibilities or whatever it is.

And how you define that and how you manage really if we didn't worry about that just yet that might be -- it might make it easier to come to some consensus around what belong to the top of that pyramid.

Helen Burstin: Yes. Dave, this is Helen. Hi. That's a great suggestion. I think for the top of the pyramid, we just try to think very globally across all conditions and all areas what would be the top things we want to drive measures towards. I think that sounds like a great outcome measure for cancer and a great gap. But the top is really more the level below…

David Cella: Yes. This might even be the next level down, right.

Helen Burstin: Excellent. Yes. Exactly.

David Cella: Right.

Helen Burstin: Maybe in some ways you could make the analogy also the work (even Basta’s) had in (GAMMA) of looking at symptoms monitoring as another way follow-up kind of capturing some of that with increased survival being the ultimate outcome as well as (improved symptoms).

David Cella: So maybe part of the discussion can be, you know, is an idea -- all ideas are good ideas at this stage of this kind of process. But there's an idea of something that, you know, rises to the top because, you know, it sounds like the process is set up mostly to kind of think top down even though it's bidirectional and they all relate to one another. But if we can get some clarity on the top and that’s the aspiration, it might be a lot of guess and then kind of work on from there.

Helen Burstin: Yes.

David Cella: So something even broader than return to normal functioning might be, you know, just, you know, living well with cancer however, you know, however that’s defined.

Helen Burstin: Yes. Great.

Shelley Fuld Nasso: This is Shelley Fuld Nasso. I really like that idea of returning -- somehow returning to normal functioning. I think that’s so important. And I think maybe that’s a little easier to measure.

I mean, I know here we're talking more about ideas more than the feasibility of it. I mean, I also really like the idea of living well with cancer but that just seems a lot more amorphous. But if you get back to normal function, I think that could be really powerful.

Melissa Marinelarena: Thank you. Does anybody else have anything they would like to add?

Jodi Maranchie: Hi, it's -- hi, this is Jodi Maranchie.

Melissa Marinelarena: Hi, Jodi.

Jodi Maranchie: So it would seem to me and I think the comment earlier about patient reported really matching up here is that the outcomes we can measure are performance status symptom score. Would you go so far as to say remission rate or is that beyond our scope? And something more concrete might be percentage of days out of the hospital.

Melissa Marinelarena: OK.

Karen Fields: I think those are excellent suggestions and I think that the other think that we'll note is that some of our -- many of the measures that exist now fit in to multiple categories because some of the things you also describe are going to the preventable harm and complications category or into cost even.

But I think that one of the things that will remain hard for us to measure is remission rates or survival rates as readily if we think about something that is a primary driver or national driver. But I think those are the ultimate functional status and should be our aspirations.

Melissa Marinelarena: And I think for cancer when I was putting this together is difficult because there's many different types of cancer and do we prioritize the types of cancer as one cancer higher priority than others or, you know, do we come up with this general cancer measures like in general returning to normal function is probably a little easier than trying to determine returning to normal function after XYZ cancer which what I had trouble with.

And then you'll see because we have several measures for breast cancer and colic cancer and then there's small chunk of hematology measures and then the rest are just sort of symptoms that they were sort of difficult to work with. So that will be something else that, you know, we'll ask you to think about and work through as well.

Does anybody else have anything else to add and, of course, I can, you know, you have a document. You can also throw in your ideas and send them back to me and I can come up with a different format for you to provide your feedback to this and this is ongoing work for us as you think of other stuff.

Shelley Fuld Nasso: Melissa, this is Shelley again and I think that, you know, while you may want, there may be some cancer-specific measures or type of cancer-specific measures that, you know, returning to regular functioning applies to everyone.

So I think you’ll get a bigger bang for your buck by doing something like that if -- I mean, again, if you can figure out the right way to measure that. But I think that’s just, you know, it's so impeccable for patients because it's really how they live their lives and I think it's, you know, it has to be more than just remission rate because like for example, I'll give you one.

My uncle finished treatment a year ago for head and neck cancer and he's, you know, but as far as his doctors' are concerned, everything is fine with him but he's not at normal function. He's back to work but he still have the feeding tube and still can't eat.

And so like how do you make sure that gets captured because I don’t think he has -- would count as returning to normal function but you just can't look at return to work because he's at work but he does not have his life back by any means yet.

And so I would think, you know, but that's what patient care about. So that’s what we need to, you know, figure out how to measure. That’s why I really like that idea so much because it would capture that.

Melissa Marinelarena: Right.

Jean-Luc Tilly: I'm sorry, actually with the palliative and end-of-life care committee, had also singled out return to normal function as being kind of the primary driver in this category so (the limit there).

Melissa Marinelarena: Yes. That’s great.

Helen Burstin: And that sits under survivorship also and they all I think blend well together.

Melissa Marinelarena: Great. Thank you. Does anybody else have anything, say would like to add? OK. Thank you. That was great.

Jennifer Carney: Hi, this is Jennifer Carney. Can you hear me? I was on mute. Sorry.

Melissa Marinelarena: Yes. Hi, Jennifer.

Jennifer Carney: I was trying to say one last thing I agree with everybody, I just like to add too one of the I think him impact outcomes that would be -- that I think is so relevant especially in the present and based on all the topics presented at our ASCO meeting, there was a lot on total cost versus low value care or access to care.

It would be so nice to address that. I think that’s a real big gap that we have and maybe if there's a way. You know, I know that for metastatic colon cancer where we have some outcome measures already but if there was a way to have find or add or look at those total cost and value of care, there's a…

Helen Burstin: Yes.

Jennifer Carney: …group meeting that -- I mean, a study that’s looking at financial toxicity of patients with metastatic colorectal cancer. But it would be so great if we could add the total picture to everything, you know, that quality with the cost.

Melissa Marinelarena: Yes and that is one of the high impact areas down towards the bottom so we will talk about that and we can include, you know, we can -- there's a lot of gaps in that area and this -- in cancer. So that is coming up next. But, yes, thank you.

Karen Fields: So, Melissa, just to summarize, it sounds like the committee felt that they were a lot of different kinds of examples of functional status and wellbeing and so you're going to capture those ideas.

But I guess when we put them into big categories -- our big categories were what were meaningful to the patients and then also other things related to specific outcomes like survivorship or functional status from a return to work or other kinds of categories. Is that -- when you -- is that what you want the group to finish as well which is basically what we're giving you are definitions of something we value as functional status?

Melissa Marinelarena: Yes.

Helen Burstin: I'm sorry, yes, I just like to add, Karen, that’s a great question and I think our thinking is those criteria might help you hone in on what you think would be the higher priority. So of the outcomes we've listed which would be highest, you know, potentially most meaningful to patients and caregivers, which should be most likely the cross settings and reflect integration of care, which should be most likely to be actionable?

You know, with that (lens) once we -- one Melissa and the team put it together helps us identify which ones we should really try to prioritize to get filled.

Karen Fields: OK.   Well, I -- thank you because I think as we go down the list that we're hearing is we'll have a lot of cross-cutting measures…

Helen Burstin: Yes.

Karen Fields: …and maybe we'll reserve the right to come back up to functional status if we have some more ideas so.

Melissa Marinelarena: Absolutely.

David Cella: Yes. Language is so important here. I don't remember what I said when I first threw that idea out there but I should have said return to normal functioning because, you know, I think if you even get a little bit that much more specific and say functional status, it does mean very specific things to some people and then you'll have apples and oranges being compared.

But normal functioning is more patient centered in my mind because it's what normal for that individual patient and one person may not get back to their former physical capacity or capability but can get back to normal functioning because of the nature of the, you know, what's normal for them. So it probably should be at that top of the pyramid. Again, it should be something that's not too prescriptive.

Karen Fields: Yes.

David Cella: Could I explain…

Karen Fields: Although we're thinking patient centered…

David Cella: Yes. Yes.

Karen Fields: …in this category.

David Cella: Right. So let me -- I wonder if I could just share -- Helen, I assume this is OK, the experience so far with the MS Incubator project.

Helen Burstin: Sure. Absolutely. I think it's a good example. Yes.

David Cella: Yes. So there's an example where I think that, you know, the neurology culture is a little different than the oncology culture but the American Academy of Neurology is -- we're doing some work on an incubator around PROs and multiple sclerosis.

But the American Academy of Neurology is putting together an outcome measure that reads something like the proportion of patients who have better quality of life one year after your index start date, better or maintained I think. So it's a numerator/denominator where the numerator goes people who one year later, their quality of life is either is good as or better then when you started with them.

And that’s it. They then go on to say, you know, you can use the MSQLI or you can use neuro quality or you can use the (FEMs). So you can use any accepted measure of, quote, “quality of life" in neurology. They don’t prescribe that. They just want to make sure you're using something that allows you to track how many people you're maintaining or improving upon. And that to me is also like a top-of-the-pyramid kind of aspiration.

Jette Hogenmiller: I would certainly -- this is Jette. I would certainly agree. Obviously, we need to be focused on patient centered from their perspective which maybe kind of a Likert analog scale or what have you. Am I kind of hearing the group say that we need to potentially submit different thoughts about this measure as well as potential measures that exist and the component of it might be at least worth looking at and reviewing to see if it fits that person-centered aspect or kind of what's the to-do to get us moving forward?

Melissa Marinelarena: Well, there may not be measures that exist. So like Helen said, you know, coming up with measure concepts. We will put all of your thoughts, summarize it and then start to put them back into one of these tables or diagrams and then the next step would be to prioritize those.

So what do we want to focus on since, you know, funds are limited? So what do we want to focus on? What will really drive functional status out of all of these things? You know, you may want to refine this once you see them again and we work with them and, you know, as the team here also is working with the criteria as well.

But I'll -- we work this and send it back to you and get your thoughts and if you think of something else in the meantime then send it to me and I'll share with Jean-Luc and Helen and (John) who's not here today. And if…

Len Lichtenfeld: This is Len. Can I ask you -- can I ask a basic question and maybe I'm reflecting my own ignorance but I'm going to ask you anyway. In this process, we're discussing a number of items that are interesting, are important, worth knowing. But may not reflect the actual quality of care that's being provided to that individual. Neuropathy in the (use of solid platforms) that occurs. It's not preventable. The use of drug maybe perfectly inappropriate.

You know, is the goal here to use measure -- to look at measures that reflect the quality of care or is this to get measures that just tell us about the cancer experience because those are two different endpoints?

Jean-Luc Tilly: So, I mean, I think ideally the measures we think that would capture both. The second criteria for prioritization is improvable and actionable which the (AID exec) what you are saying. You know, we don't want to just capture a phenomenon that clinicians don't have any (pull over).

Len Lichtenfeld: Right. So I think then there has to be very much part of the consideration especially in the conversation that we've been having and I'm not sure that -- I'm just not certain that that's where we're heading.

So I think that point you just made is important. It has to be actionable where we can make a difference and I think that that filter has to be present as we have this discussion (moving things along).

Helen Burstin: Yes. That's a really important question. This is Helen again. I think our feeling is we want to get a sense of what would be the higher priority things to measure and improve upon.

Not all of them will necessary be used for accountability although it could be that the initial accountability measure is are you actually being able, you know, can you assess whether somebody's function has returned? I mean, I think some of this is we got to walk before we run here, not to be too functional here.

But, you know, what would be most important to measure as we start thinking about care through the patient lens, through the caregiver lens, through the clinician lens. If you could really say, OK, I'll this process measures may not really be giving us a reflection of what is good, you know, good care from the patient and the clinician's perspective, what might we move towards understanding, there might be a gradual approach to how those measures could be used.

Len Lichtenfeld: And then, Helen, I appreciate and understand that. So the next question I'm going to ask is we're here having a conversation, some of us represent patient advocacy. Are we actually going to reach in to the patient community and ask them the question as part of the parallel, part of that process what is important to them so we have some sense or maybe some validation (of the medical uses) or is that too broad – is that too broad to do as part of this program?

Helen Burstin: We'd be delighted to think about ways to do that and in fact the work Dave we're sharing with you on MS that we've been doing recently is doing exactly that by going to an online platform and getting perspective on -- from thousands of patients for example of what's most important to them.

So we'd love to think about ways beyond having, you know, some of the patient advocates on the call who are so important to our process. But ways of getting directly to the frontline would be something we'd love to think through with all of you.

Len Lichtenfeld: OK. That would be something I think would be important to do if we can and I think we can so -- for things for further discussion. Thank you.

Melissa Marinelarena: Thank you.

Karen Fields: Well, so if the group ready to move on to the patient experience category next because that will -- we may need to come back to any of the categories at any time. So I guess my first comment is now that we had a little bit of this discussion and I'm understanding a little bit more about the direction that NQF staff and strategy wants us to move in, I'm wondering about this next category.

My -- this -- when we talked about the patient experience and we think about it the way it's described, most of the measures that are put in to these categories are really more about what's the appropriate therapy delivered to the appropriate patient or was it delivered in appropriate time.

That seems a little less about experience or even shared decision making. So for example, you have -- you're HER2/neu positive. You should get trastuzumab and I don’t know if that’s -- what I would call a shared decision where educating a patient but it's actually really an appropriate therapy for that patient to get compared to should I get a lumpectomy versus a mastectomy because both of those outcomes are similar.

And so I guess I want first to hear from the group if or how we want to define that patient experience question and then a little bit more from the group about do we think this fit into the category. And before we -- I move to that, maybe, Melissa, give us your thoughts about how you put them in this category. When I initially saw this from you, I understood it but now with our conversation, I understand it a little bit less.

Melissa Marinelarena: Sure. So again, the next category is patient experience and because I broke it up into different categories. So the first one is breast cancer only because I guess there's a chunk of breast cancer measure.

So I -- again, this is the visual where we have based on experience on the left, that’s the high-impact outcome, you know, the driver measures are yet to be determined. And then I took -- I categorized the priority measures based on what I thought was -- let me start with the measures on the very far right.

I did some notes by -- those are like more of the documentation measure. So anything that was, you know, documentation of a past -- and it's kind of hard to see if you can go into the next one. But those were the ones that were more documentation, more -- they're all process that those documentation of.

The other one, the ones that I identified as priority were a little more proximal of the outcome and again, this is just what I just drafted and put together. So this is what…

Karen Fields: Yes, I mean, I think I -- when I reviewed this before, I've got it. I'm just wondering if we understand the definition of patient experience we all want to be on the same page with that because now that I'm hearing our discussion and really starting to understand what you're looking for, I'm wondering if this is a different category altogether which is appropriateness of therapy which doesn’t –isn't really reflected in any of these categories.

Melissa Marinelarena: Right. So under patient…

Karen Fields: But I defer to the group.

Melissa Marinelarena: So quickly, under patient experience, it includes care coordination and shared decision making. So like I said, the spreadsheet that I sent under Row K, there's non-condition specific and some of these measures are tagged as care coordination, that’s how they ended up under patient experience.

So this is the question of the committee, do you agree that these are in fact patient experience and/or care coordination measures? So again, I -- instead of me trying to decide if they were, I went by what based these measures have been tagged by before.

Karen Fields: OK.

Melissa Marinelarena: So the committee is that is your job or, you know, the task before you is to determine if these are patient experience…

Karen Fields: OK. So let's open it up to the group and -- for comments and thoughts.

Melissa Marinelarena: And again, these are by breast. I thought it was easier to, you know, since we have these different types of cancers so I did breast first.

Karen Fields: No. I wanted -- what I want to tell you, I think it's logical. I think it's laid out well. I just -- my question is for the group, does the -- what our definition of -- and our understanding of patient experience, care coordination, shared decision making, do these fit in to that category? So I'd love to hear some more comments.

Melissa Marinelarena: And if you need more information about the measures in the spreadsheet, let me know and I can read it to you and it might make that a little clear on how they ended up where they did.

Helen Burstin: You know, it might be helpful, this is Helen again, for you to explain, Melissa, why would you put them there? It's a little bit of a reach. Is the idea that they would be reflective of having had a shared decision making conversation because in and of themselves, they're not classically measures…

Melissa Marinelarena: No, they're not.

Helen Burstin: …that reflect the patient experience. Right. So maybe give us a little more…

Melissa Marinelarena: Right.

Helen Burstin: …logic there would be helpful.

Melissa Marinelarena: So I am not sure how these are tagged in QPS if it's (DAP) has done or measure developers. But for Measure 219, post-breast conservation surgery irradiation, it is tagged as care coordination and disparity sensitive.

So 219 is actually -- we just go down to the very last category. I also put it under equity of care because it is disparity sensitive but that is why because it says it's under care coordination. That wasn’t something that I chose because I thought that would be a little -- I don’t know that I would have an explanation for. I don’t -- I wouldn’t have there -- I wouldn’t put it here.

Helen Burstin: Yes. Either I.

Karen Fields: Yes.

Melissa Marinelarena: Right. I wouldn't put any of these here.

Helen Burstin: I agree.

Melissa Marinelarena: But at some point, these were tagged as this. So, you know, they passed and here it is. Do they -- are they care coordination or a shared decision making?

Karen Fields: So let's -- do you want to go -- well, first of all, general comments from the group or ideas or thoughts because I think this one actually could be care coordination but the next one isn't. It's you either get the drug or you didn't and it's the standard of care that you would. So did the patient get the best standard of care when necessarily be coordination and shared decision making is not two equal choices for patient to consider?

So rather than talk about the individual metrics right now, does -- any general comments from the group? And, David, any comment?

David Cella: No. I don't have an additional comment on this, Karen.

Len Lichtenfeld: This is Len. I'm going to once again weigh in with trepidation. I think, you know, maybe we'd put off a little bit because if we witness the patient and said the patient experience, this would not be on any patient's list.

Like you said, where at care coordination measures, we need to understand that care coordination particularly that radiation therapy question, yes, we can understand the disparities but that factors are real issues if you go to the second level of thinking question (beyond) question.

So I think the issue of patient experience, this would not reflect when most patients or many of us would consider a patient experience measure. But if you broaden it -- so that's -- it's a definition issue and we're sort of trying to -- we're sort of put stuff in the patient experience that I think the hesitation that I'm hearing is because that doesn't -- it just doesn't fit together.

Care coordination is measurable and it's now coming in support but, you know, you really have to stretch to get into the saying – (that a patient would consider part of their experience). Whereas a discussion about mastectomy versus lumpectomy.

That would be very important part of the patient experience and did they get an adequate explanation good explanation of that decision? Do they have role and an opportunity to understand their options? They, you know, understand the implication of that decision and the necessity of that decision. That's what -- that's the different types of measures that's not on here.

Melissa Marinelarena: This is Melissa and this is a question to Jean-Luc and Helen. Do we look at patient experience separate from care coordination and shared decision making or do you see this as one and the same?

Jean-Luc Tilly: Yes. It's…

Male: I'm sorry, go ahead.

Helen Burstin: I was just going to say I think already it was just patient experience broadly including the reflections on key issues like shared decision making and care coordination, but I think the lens was really the patient experience.

Melissa Marinelarena: OK.

Jean-Luc Tilly: Yes. I'll add that in the palliative committee deliberation of last week, you know, the shared decision making was certainly called that as (belonging) in this and then there were also, you know, discussions around measures of comfort with decisions being made, patient family engagement, you know, the (CAP) process survey which was brought up, you know, the kind of measures that come out of that instrument I think is a good fit for this scenario. It's always about advanced care plans, documenting care preferences and things of that nature.

Jodi Maranchie: Yes. It's just like the others though -- I'm sorry, this is Jodi. It ultimately comes down to patient perception of their participation in care coordination.

So I don’t know how you would get at this anyway except patient -- by surveying the patient.

David Sher: This is David Sher, I'm radiation oncologist. I had to step away at the very beginning to see a patient. But I'm going to ask a very stupid question, I admit it upfront it's a stupid question.

But any kind of measures relating to actual cancer outcomes, controls, survival, you name it. Where does that fall in the high-impact outcomes sort of rubric here? Is that -- because it seems that, you know, these are measures that are going to reflect ultimately in and of itself like measures as currently written on cancer outcomes even though you can develop (labor intensive mechanisms) -- very useful for the patient experience care coordination.

But the actual measure itself, they're getting to a survival outcome, you know, using hormonal therapy and (sensitive) in breast cancers and so on. Does that not exist in the sort of the categories and we're trying to fit their round peg in this global testing or is it just an understanding…

David Cella: Yes --I'm sorry.

Helen Burstin: Yes. I'm sorry, this is Helen again. I mean, I think it's something we would have expected to be at the top and we'll need to just -- I mean, again these are helpful views through cancer that we want to make sure we modify as we kind of look to this framework for cancer.

David Cella: This is Dave. I mean, correct if I -- if I got it wrong but I've been thinking of that, you know, these four levels of the pyramid at the top being things like do patients live longer? Do patients live better? Are patients getting the right treatment?

And then when you go down the list, you know, there are things that you can do that you that you should be doing to help ensure that patients live longer. Those tend to be more -- I mean, the outcome measure of survival but there are a lot of process measures that presumably feed to that top of the pyramid.

And do patients live better is the one -- the one that's kind of lacking in terms of available measures that all levels of the pyramid. Are patients getting the right treatments? That's -- that’s part of the living longer but maybe it's a separate thing. Do patients have a good experience of care, you know, is it a good place to get treatment? That might be at the top of the pyramid.

So, I'm thinking very general terms at the top of the pyramid that might not ever -- at least not the first time through, might not have an actual performance measure type that's, you know, that’s all of that.

Helen Burstin: Right. I think that’s exactly right, Dave. I think in our mind, that first -- that first prior area wouldn't -- wouldn't encompass that as well but we need to be more -- more clear in our language, particularly in this area.

Karen Fields: You know, Helen, this is Karen. I also think that we're limited in another way which is these are definitely process measures. And, you know, did an action occur and it has not direct -- it's not a direct outcome measure. It's an, obviously, a desirable measure and I think maybe that's where the gap is.

The gap is ultimately these might speak to the patient experience or coordination of care because, certainly, a surgeon a rad onc and a patient educational and the shared decision making has to occur to get radiation in a timely fashion after surgery.

But since this is simply a process measure, it's not going to be able to be reflective of that and I think when you look at both internal and external list, its reflex -- our biggest gap which is not enough outcomes measures and more process measures. And that -- maybe that's where we're stuck today.

Helen Burstin: I agree, Karen.

Melissa Marinelarena: This is Melissa. So we can -- I see where we have a, like, another step and, you know, if we look at the diagram the way it's pictured differently, there's another step before these measures between the driver diagrams and we need to talk about, like, priority measure level one and then these -- which would be our outcome measures and then these here could be priority measures level two that we'd feed into the outcomes.

Helen Burstin: Yes. And that may be a better way for us to think about this. And then I think we can -- by looking at the list, all of us can agree, these are focused around therapy decisions or documentation of therapy decisions or, you know, pathology around therapy decisions.

And so they're a lower priority because of their limitations as process measures. But they're ultimately to an improved patient experience because and improved outcome is an improved patient experience.

Melissa Marinelarena: OK. Is there anything else on patient expenses? So, pretty much the same for colon cancer.

We go to the next one. There aren't as many here but it was -- it's pretty much the same thing and I use the same -- I use the same concept here, how they were tagged in that spreadsheet.

Again, I don't agree but it wasn't Melissa's opinion. If you like my opinion, I will happily give it to you. But we can -- I can rework this. We can put in another level, like I've said, you know, so level priority one and then we could still look at this and see if these measures that we have now will feed into some outcome measures around colon cancer.

And, you know, we can talk about what kind of ideas -- what kind of measures we want or the higher-level measures for -- again, that will be the same for colon cancer around patient experience.

Karen Fields: I would ask Helen and the group if there really should be another high priority or high impact measure category which is -- because they're still valued to the right therapy was given at the right time or, you know, in the right -- you know in the right situation.

As just a quality measure, it's not -- it's a completely different standard but like the next category, we can look at total cost and high value care where for two new negative patients shouldn't get a therapy, we know that's expensive and dangerous. So, it's easier to categorize those but, again, that's still the right therapy at the right time. I'm just wondering if there's an overall measure category that might be missing in the list.

Jean-Luc Tilly: Right, Karen. As Helen had said, we had thought of the countermeasures as moving into that -- that first, you know, the functional status of well-being and the outcome that we talked about and that, you know, having a good outcome on -- under treatment is kind of a presentation to having good well-being having those -- those drive towards that as an outcome.

But I think you're right (that in our) presentation that not entirely clear, certainly. So, you know, that's (something) to think about for us.

Karen Fields: OK.

Melissa Marinelarena: So, you know, to consider this as a separate high impact outcome or just be clear about it being…

Male: (Inaudible)

Melissa Marinelarena: …functional status.

Jean-Luc Tilly: …wellbeing. Yes.

Melissa Marinelarena: OK. OK.

Karen Fields: Anybody else from the group? Any other opinions from the group? Because I -- I don’t know that we want to -- I know we want towards better patient -- better outcomes, better patient involvement and shared decision making but I don’t know that we want to move away from appropriate therapy at the appropriate time as a standard.

I just -- we want our systems to be farther along than that. But, you know, as more and more expensive therapies come along, we're still going to have to ask is that -- was that the appropriate therapy at the appropriate time and we'll never be able to get away from that category of quality measures, I think.

Melissa Marinelarena: And it might fit into -- we might think about if it fits in to any of the other categories or it could fit into more than one category. I mean, does it fit into preventable harm and complication? Maybe access to (native) care, equity of care? I could -- you know, I could see it making an argument for those different -- high impact outcomes.

Karen Fields: Agree.

Melissa Marinelarena: OK. Is there anything else? Colon cancer, like I said, was the same. We'll have to think about -- if we could go to the next slide, that’s the same thing with colon cancer.

If you go to the next slide, please. So, hematology is sort of the same thing and there was one process measure that I put under the priority measures that was (more), (what did you do)?

Did you not get the treatment and then the rest, you know, was documentation. I know that -- I think that during the meeting we reviewed a couple of these measures and there was -- this was a small population. So, we’ll have to think through and I don’t know if anybody has any thoughts on this right now, you know, what do we want to do with these measures? Do we need some other outcome measures? Can we fit these into some of the categories that we've already talked about?

We can always come back to this as well and move on to some of the other categories. We can move on. And, this, we may have to come back to…

David Cella: Can I just -- I'm sorry, this is Dave. I just want to make sure. So, you're sort of populating each sort of populating the pyramid here with existing measures?

Melissa Marinelarena: Exactly. So, it's not only -- it's more -- it could be existing measures but I think what they're doing is highlighting the gaps…

David Cella: Yes. Right.

Melissa Marinelarena: …in the portfolio, right? So…

David Cella: It's a big gap in the middle, right? Yes.

Melissa Marinelarena: Right. So, they're tagged under these categories but they -- because that's -- that's how they've been tagged. And, again, do I agree? Not necessarily. But that's for you that -- you know, you're the expert in the field to decide and I think that's what -- this is doing is highlighting the gaps and, you know, how do we -- how do we fill those gaps.

David Cella: I guess, in my mind, the question is because now sort of top of bottom is left to right, it's -- if you -- if we have something that the committee is happy with on the left here which is the top of the pyramid, right, will that serve to pull up from the right, you know, from the bottom in a rational way or, I mean, I guess we're all knew with this so I'm just wondering if do we have enough reasons to think that if we -- if we get clear on the aspirations, knowing that we're -- or hoping at least that we're putting forward a set of realistic aspirations that that it will pull up the measures into being drivers and priority measures.

Jean-Luc Tilly: Yes. Part of the work of the -- of the NQF staff that we're accompanying of this, you know, we're going to come up with a lower calling driver diagram, you know, that will look currently that total harm picture that we (showed in the slide).

David Cella: Right. Yes.

Jean-Luc Tilly: So with a little more specificity in terms of, you know, what components are feeding what aspect. So, you know, from there, having clearly identified something at the top, you could use that, as you say, use that driver diagram to kind of extrapolate downwards and figure out, you know, what -- what the literature says about what specific component of clinical care are feeding these -- these drivers that we've identified.

David Cella: Because, I mean, looking at this one that you have on the screen, I think that, at least, my understanding and I don't know -- I'm sorry, I can't look at all these numbers but that high impact measure patient experience, that seems realistic. I mean, there are existing patient experience measures and the experience measure should include whether the patients perceived care is well coordinated and perceived that they participated in shared decision making, they're appreciating that it is as what's mentioned in the patient's perspective.

That seems realistic but I'm not -- I'm not seeing how these internal QI measures speak to that. And that maybe because I'm not as aware of the measures as I should be but are you saying these seven things are patient experience measures?

Melissa Marinelarena: Well, they're tagged as care coordination. So, I put them over on the right because, for example, the numerator Barrett's Esophagus is esophageal biopsy report with the histologic finding of Barrett's mucosa that contain a statement about dysplasia. That's what it's measuring. So…

David Cella: Which -- and this is not to be meant to be critical but I don’t think it has anything to do with the patient's experience. So, I'm just trying to -- I'm trying to -- I'm not sure how the patient experience drive would pull that up, what it mean that that gets communicated to the patient and the patient understands it?

Melissa Marinelarena: So that's the question to the committee. I mean, based on this measure, no. It's documentation of this.

David Cella: Yes. Yes. Yes.

Karen Fields: So, I'm also noticing that unfortunately, Melissa, you were left to look at the way the measure developers decided to present and categorize their measures. And some of that was done before these new ideas about how we would look at high impact measures.

So, they may have called it care coordination and that somebody needs to have this information to make a medical decision eventually but it's certainly not directly related to the patient experience. So, maybe we also need to go back once all of these discussions are done and ask the measure developers to recategorize their measures in the context of this new definition.

David Cella: Yes. Yes.

Melissa Marinelarena: Sure. And, Gregary -- Gregary's on the phone. You know, from a pathology perspective, if you could provide some input about, you know, what kind of outcome measure is there, a priority measure that, you know, some pathology measures, these documentation measures or reporting measures are going to be feeding into? I know we had this conversation during our meetings. So, thinking about what kind of big outcome measure, these types of measures are going to feed into.

Gregary Bocsi: Well, that's something I've been struggling with here is that you have the high impact measure of categories and you're trying to fit all the measures, I guess, into one of these categories but as you sort of suggested, it may be that the measures don’t particularly fit into any of those high impact categories as presently, you know, construed.

So, I mean, I can see how, you know, just one the face plain language tape aspect of things, you know, as you were noting earlier, as it was noted earlier that in order to, you know, basically do, initiate appropriate care and allow for the possibility of it to be coordinated appropriately, you need to have the accurate information.

And so, that might be the best fit amongst the high impact category that are -- are present here. But it may be that, you know, non -- that measures don’t necessarily fit into any of the high impact categories. I guess -- is that what you're also getting at?

Melissa Marinelarena: Right. And it might not be this -- this category but maybe one of the other ones or maybe thinking, you know, from pathology perspective, maybe coming up with a measure concept for pathology, maybe a composite. What are the most important component from a pathology perspective that are needed to give us read to this other, you know, larger outcomes. So, thinking that rather than having just, you know, multiple individual measures.

Gregary Bocsi: So, you're thinking of a different high impact category?

Melissa Marinelarena: Not a different high impact category but under the priority measures, those measures are -- we're looking for those to be outcome measures. They -

- those are the ones that are more -- that are settings specific, disease specific, so those are the cancer specific measures.

So, rather than having this individual documentation or reporting measures on the right, thinking from a pathology perspective, you know, what are the most important perspectives from pathology that you would need and maybe come up with a measure concept that would be a composite?

Gregary Bocsi: I mean, the difficult with pathology is that since many of the measures are related to the diagnosis itself, you don’t have the diagnosis until pathology has provided that for most of these. And so, it ends up being, you know, very early on in the process and it's sort of like that initial piece of information that made you eligible for almost any of the other measures. Does that make sense?

Melissa Marinelarena: Yes.

Gregary Bocsi: But you can't either be eligible for post breast conservation surgery until you have breast cancer and that’s, you know, we're way at the beginning of the game, hoping to make the diagnosis. Does that make sense?

Melissa Marinelarena: Yes.

Gregary Bocsi: So, I mean, on -- I mean, the high -- I mean, but because that, like, the -- our measures are exceedingly high impact because you can't really get anywhere because they're so integral, like, the information is still key to any subsequent decision or treatment or anything that happens begins in some -- in some sense with that piece of information. So, you know, arguably, you could not have something that could be quite so high in impact as making the diagnosis, you know, malignant or nonmalignant.

Melissa Marinelarena: Does anybody else have any thoughts?

Karen Fields: What I think he's pointing out that there has to be high quality fundamental information to launch any of the subsequent measures. So, we have to come up with a category for some of -- some of the kinds of documentation that he's talking about in a -- and they maybe can't even be linked to this high impact measure at this time. Like, on the hematology measures, adequate documentation of iron stores. You know, you're trying to make sure that the patient is -- does truly have a malignancy, you know, and not another medical problem.

And so there -- pathology is fundamental to many, many, many of the different high impact categories, not just the patient experience category. And that’s fundamental.

When I look on this page, truly, the -- like the examples of things that are truly more directly related to getting to the high impact measure, care coordination would be 0381, treatment summary communication because, obviously, that's critical for care coordination to make sure that continuity of care and appropriateness of treatment is documented.

And so, I think, maybe some of the pathology measures can't necessarily fit in to this grid right now very easily. They're essential fundamental elements.

Greg, am I describing that fairly?

Gregary Bocsi: Yes. I think the -I mean, because they are so fundamental, they almost need their own high impact category. Because how -- how would you split them? I mean, that -- it seems hard to split into any other category.

They either lend themselves to being seem to be like the -- an internal QI measure, right, at one end or a high impact -- like the highest impact measure on the other end. But it's hard to find a place, you know, in between because our contributions, you know, like I said, get the ball rolling and provide the information.

So, like the example you gave with iron stores, you know, much of that assessment is going to be based on the work of the pathologist and our laboratories. And I mean, we're integral to that in the sense that, you know, how will that be measured and determined. But for the things that measure us directly, they really seem like they rated other -- depending upon how you look at it, they're either high impact measures in and of themselves or internal QI measures. I think it's hard for us to find a place kind of in between.

Karen Fields: Yes. So, we're making the dilemma greater for you, Melissa, but I think that Greg's making some excellent points. Because, like, you know, the pathologist has to appropriately do HER2/neu. We threw out some of those measures so we got rid of some of the -- or they never represented some of the very -- the last generation of HER2/neu measures like where the three plus -- the two plus is getting (dish) appropriately.

But that was a very fundamental measure to have the appropriate information from which to make intervention, a quality intervention, which is -- should they get Herceptin or not. So, I think, again, I guess we need to have some thoughts about a category for fundament -- appropriate and fundamental performance of pathology activities.

Melissa Marinelarena: OK. We'll -- we'll play around with the grid and come up with some language. And again, I think I could see these -- and maybe a part of a composite and definitely see if they may be fitting under total cost high-value care, preventable pharma complications. I see sort of a how to access the need of care maybe but in equity of care.

And maybe we can come up with, again, a composite or some, you know, a general idea. But we'll play around with some ideas and some wording and send it out to you and see what you think.

Yes. So, we can move on. So, here is our total cost high-value care. These are the two measures that were tagged as cost measures of some sort. So, it's one of the breast cancer measures, the HER2 measures and then the other one was prostate cancer measures, (have a number of coupons with these) measure I believe were reviewed by this committee last time we met.

So, it's the same type of conversations. I didn’t find any company measures that it felt were under internal QI measures. But, again, I think there's probably big gaps here.

Karen Fields: Well, I'll launch the conversation and say I think these two are appropriately categorized. It's the best ones on the whole list because they meet the criteria for high cost care that's appropriately given. So, but I think there's many,

many examples of total cost and I'm sure that if we open up to the committee, we'll get some great ideas.

Female: And you already have the other measure, I think, the 1860 patients with metastatic colorectal and KRAS mutation spare treatment with epidermal growth factor receptor monoclonal antibody? That's another (one to add).

Melissa Marinelarena: I don’t have that one. Is it in NQF endorsed measure?

Female: I'm sorry. It's slide 26 where you have the high-impact outcome for colon cancer and as 1860 after primary driver measure. Because that could be added, I suppose?

Karen Fields: Absolutely. Eighteen-sixty. It belongs down there. You're absolutely right.

David Cella: Can I -- this is Dave. Can I introduce something that I'm aware as I introduce it might be rejected or at least avoided in this category of total cost high value care?

Melissa Marinelarena: yes.

David Cella: I mean, as a -- as an observer of oncology for decades now and watching oncologists work and having friends and family involved in this as well, so, getting a kind of -- it's fairly proximal personal perspective.

The management of decision making and treatment of people who, you know, are on their third or fourth or fifth line of therapy where there's a -- there's a tension between, you know, the patient-centered gives them a hope and the societally-centered this is futile perspective. I don’t -- you know, I don’t know if there's a way to develop a quality measure that identifies providers that are good having patients engaged but also good at disengaging them from futility?

Melissa Marinelarena: Jean, did palliative care talk about that?

Jean-Luc Tilly: Yes, let’s take a look.

Melissa Marinelarena: Because that might have been covered in the palliative care end of life.

Jean-Luc Tilly: Yes. So, in palliative care, the measures that they talk about around, you know, dialysis at the end of life, you know, medication cessation at the end of life, you know, even in taking things like…

(Off-Mic)

Jean-Luc Tilly: …discontinue those drugs. And then also admission rate. So, admission to the ICU in the last 30 days of like or (sort of grieving, discharge).

David Cella: OK. All right. Well, maybe that's best then because there's certainly plenty to -- as I introduced, this is maybe something that we work around. It's nice to know that there's another group working, you know, dealing with it. Thanks.

Melissa Marinelarena: Yes. And we can share that work -- that group work's through this exercise. We can definitely share that because there is -- there is an overlap, I think, in the work.

David Cella: Yes, and…

Karen Fields: Yes. A couple of years ago, our committee also tackled, not in the last cycle, but previously utilization, hospice referrals, et cetera, at the end of life, the six end of life measures. So, I think those fit in to this category. And, you know…

David Cella: Maybe that was…

Karen Fields: Yes. They're in the palliative care portfolio.

David Cella: Right. Yes. So, maybe it was moved over. OK. Great.

Melissa Marinelarena: Yes. When I first started this exercise, I started plugging a lot of the measures from the palliative care portfolio into this. But then I thought -- then I took them out. I did this multiple times, but then I took them out thinking maybe we should just focus on (measures that we have)

David Cella: Yes, no, there's a whole other -- there's a whole other committee working on it. So, that's good.

Melissa Marinelarena: Yes. And then -- and then we can bring the two together. So, this is good. Thank you, Dave.

David Cella: Yes. Sure.

Melissa Marinelarena: OK.

Karen Fields: Well, I think somebody -- somebody brought up earlier at ASCO the quality measures focused on patient symptoms and patient reported symptoms and decreasing total cost of care and improving survivorship. So, I think, certainly, there's many groups working on that and something that we should be asking for measures and…

Melissa Marinelarena: OK.

Female: And then there's going to be, over the next several years, a lot more targeted therapy directed agents with targets and just like we've measured HER2/neu or KRAS, I'm sure we'll see a proliferation of other appropriate utilizations of drugs that are very, very expensive and have limited benefit outside of the target and are appropriately utilized.

It's hard to answer that one right now because many of the targets are low volume in any given cancer but I think we'll see a proliferation of those kinds of measures and I defer to the group that they agree or disagree with that.

Len Lichtenfeld: I mean, this is -- this is Len. I mean, if we don’t have measures on ALK and EGFR and (month cancer one), then we'll probably -- I mean, if we -- if we don’t have these measures, we – (probably we need them).

There's a lot of discussion about the fact and particularly in community settings that appropriate testing with lung cancers and some types of particulars is (lacking).

Karen Fields: That’s true. Another good example of just a disease that's longer, more well, established is the appropriate -- or in ER positive breast cancer patients testing for recurrent scores and avoidance of chemotherapy in those patients. So, there's some great examples like that coming up, I think. But I don’t know that there's quality measures being developed in any of those areas yet. So, I think…

Len Lichtenfeld: You know, one of the things that come to mind when we had a discussion this past week about the new (ACC) recommendations particularly in breast cancer and I just wanted to what degree anyone seeks, you know, this something (we knew was) coming in so -- you know, look at them and organization talking about incorporating that into their accrediting process.

What is done to actually harmonize what we do here versus what those organizations are doing and they have some excellent data that show -- that making all these determinations and the appropriate (staging of patients) is valuable.

But it would almost seem that the decision would have to be made whether or not to be proactive to make sure that the quality guidelines that we have here are in line with accepted quality metrics that were put together by other organizations such as (HACC).

That's a pretty intense undertaking because (physicians) make a lot of changes that's becoming clear biology and breast cancer, for example (is – is)very important (for) outcome and treatment that goes along with the discussion we're having now. But that would require proactive -- and collaboration with another organization to see where -- where -- what the evidence is and then what we can encourage in terms of measure development to make sure that we are -- that we are, in turn encouraging capture of appropriate information.

Melissa Marinelarena: Well, it's a good thing that you said that because we're going to talk about that before we log off today, Len.

Len Lichtenfeld: OK. All right. Next.

Melissa Marinelarena: So, I think, maybe we're on the right track. We might be on to something here.

Karen or Dave, do you want to add anything else to total cost here? Is there anything else that we should capture, that anybody else want to think about or should we move on?

Karen Fields: Well, another good example of a total cost of care was on planned readmissions and hospitalizations or preventable readmissions. So, we know that there's a -- there was one presented to us. There's another one that's in another, I guess, the cancer-related readmissions is in a different portfolio. But those are good examples of resource utilization, appropriate resource utilization. So…

Melissa Marinelarena: Yes.

Karen Fields: …toxicity management.

Melissa Marinelarena: The readmission measure, I just got an update on it. So, in membership voting right now, it's number 3188 and it is 30-day un-planned readmissions for cancer patients and that one's being reviewed by the readmissions committee.

Karen Fields: Yes. So that will be a perfect example of total cost of care and appropriate. Because it focuses on -- on toxicity management as well. So, I think that's a great example.

Melissa Marinelarena: I can add that in to the introduce grid.

David Cella: I don’t remember. Do we have a measure or sort of over -- overuse of post-treatment imaging?

Melissa Marinelarena: We have -- I put it under -- let me see. We have one on…

Karen Fields: There used to be a melanoma one.

Melissa Marinelarena: Yes. The melanoma one's all got…

Karen Fields: Yes.

Melissa Marinelarena: The developer did not resubmit them but there's a…

Melissa Marinelarena: Yes. There's a prostate cancer one, avoidance of overuse of bone scan for…

David Cella: That's on here. Right?

Melissa Marinelarena: Yes

David Cella: Yes.

Melissa Marinelarena: And I'm…

David Cella: Well, it might be -- there might be a gap there. I mean, it seems like we could -- this kind of a high-impact measure aspiration could pull for more, you know, detecting of overuse of follow-up radiology.

Karen Fields: Yes. I think, also, the external beam -- decreasing fractions is 1822. That is a total cost high value. There's a radiologist here. Any comment on that one?

David Sher: Yes. I was just going to actually say that exact point. This is equal efficacy, less cost. Perfect for – yes.

David Cella: Aren't we down to one dose now?

David Sher: In many respect, yes. In many cases

David Cella: Yes. Yes. That might be a good envelope to push.

Karen Fields: Yes. Because I think there's also -- there's going to be some hypofractionation strategies coming up as well, not just in palliative radiation. So, any comments about other types of measures like that?

David Sher: I would say, generally, from a radiation perspective, hypofractionation is going to be moved to that curative paradigms as well. So, some guidelines that affect some points…

(Dan): Yes. This is (Dan). I mean, we certainly have -- sorry, we have hypofractionated regimens now in breast cancer and prostate cancer that are pretty well evolved at this point.

Karen Fields: Yes. So, I think we should be asking for those because that's definitely a hot topic, number one, because there's a lot of new data. But certainly, improved quality of life and outcomes for patients without changing outcomes. So, that's an excellent example, I think.

Melissa Marinelarena: OK. I will -- we'll add something in there around that. Is there anything else on total process and high value?

Karen Fields: Well, you know, Beverly, at the very beginning talked about preop evaluations, what's the -- what's the better way to say that, Beverly? But there's a lot of -- the (EBREF) work, a lot of improved outcome and -- yes.

Beverly Reigle: Yes. Rehabilitation and survivorship work that I was talking about lymphedema. I think you had mentioned that too. Yes.

Karen Fields: And I think that's cost effective and certainly needs to be more widely adopted with a lot of evidence to support that. So, it should be approaching those developers.

Melissa Marinelarena: Right. OK. Anything else? OK. If not, then we have preventable harm in complication. Again, some of these measures we already discuss in other categories.

I do want to mention the one outcome throughout the measure that we have left in our portfolio you see here, 1790 is the risk adjusted morbidity and mortality for lung resection, for lung cancer. So, I placed it here under preventable harm and complication.

We could also include, I think, the readmissions, the new readmission measure that Karen just mentioned. Probably fit under here as well. And, again, the measures on the right, our documentation measures, 2930, the febrile neutropenia risk assessment measure, was a new measure that you reviewed last year.

I put it here because if you recall, it was -- what the measure is actually capturing is documentation that the assessment was done. So it was -- it ends up being a yes/no. Remember, the developer did provide a template for an assessment but it felt like it wasn't being done enough so this was the first step. So that was why I placed it there. Does anybody have any questions?

Karen Fields: Well, I think -- again, I agree with adding those others back and I think these are our quantified OK, although we're -- we have the fifth -- 1855, the HER2/neu evaluation. It sort of goes back to our previous discussion about what are we going to do about appropriately done pathology testing that is the lynchpin for lots of decisions rather than just preventable harm decisions.

And but I would say that there's more -- again, toxicity management outcomes we need to seek more toxicity management outcomes. And we'll -- and we'll start to see more of that as we -- as some of the new and more complex drugs come out that have a new array of toxicities that oncologists have been less trained to manager, older oncologists, I'll speak for myself.

So, we -- I'm sure we can find some categories or some areas in that area.

Melissa Marinelarena: OK. Thank you, Karen. Anybody else?

And I'll also make some -- do some homework. I'll do some homework on this.

Karen Fields: Yes. And I think Beverly's -- Beverly's category fits in here as well to the preevaluation.

Melissa Marinelarena: OK.

David Sher: Can I ask a quick question on this? Just kind of from a left to right perspective?

Melissa Marinelarena: Yes.

David Sher: This is Dave, from radiation oncology again. So, (O3E2) I think is a yes/no, right, whether it's evaluation. Would a priority measure then be for that particular limit was exceeded? You know, in term to understand where this would fall on the spectrum?

So, if you have, like a lung measure, lung radiation called the V20. The V20 is over 35, objectively as a -- as a number. Would that become a priority measure because it's more proximal to the proximal to the endpoints in pneumonitis or would it have to be more impactful than that to reach the priority measure phase.

Melissa Marinelarena: With I would touch back to you but I'll tell you what this measure is. So, this measure is patients that had documentation and medical record that radiation dose limits to normal tissues were established prior to the initiation 3D conformal radiation for a minimum of two tissues.

David Sher: Yes. So, I think it's more or less and – (and I'll roll kind of a yes/no) as opposed to (inaudible)

Melissa Marinelarena: Yes. So the way I -- you know, for internal QI, you can go internally and check charts to see if that -- there were documentation done. So, what is the step has that thinking of priority measure.

David Cella: Melissa?

Melissa Marinelarena: Yes?

David Cella: Hi. This is Dave. I'm just noticing the time and, unfortunately, I have a -- I have to stop right at 2 o'clock central to see a patient.

Shall we to the public? There's one more slide I know but I don't want to miss out on the public comments because there are public comments.

Melissa Marinelarena: Sure. The next slide are pretty blank.

David Cella: Yes. I'm not sure -- I wasn't sure how these roll up to Equity of care. I mean…

Melissa Marinelarena: So these were -- these tagged as disparity sensitive.

David Cella: OK.

Melissa Marinelarena: So that's why I put them here. So, you are more than welcome to disagree. And be sensitive of time if you want to -- if the committee -- if you have some really quick thoughts or if you want to e-mail me some thoughts, we can come up with something and send it back to you to react to.

David Cella: Well, there -- there may be things particularly the first two that are -- that by -- just by virtue of observation are less frequently done with people with your means, you know, underserved populations. So, I guess -- I guess that makes sense.

Karen Fields: I think, again, those -- we even thought that they may have initially our first feelings for that they had maxed out. But then when we looked, there were still…

David Cella: Right. Right.

Karen Fields: …disparities in the group.

David Cella: Right. Yes.

Karen Fields: So, I think they're appropriate.

David Cella: Yes. That's exactly right. Right. That's what happened at the last meeting.

Karen Fields: OK. So, keep them in until they -- until they max out across -- across all groups. Something like that.

I mean, it's a -- they're a sort of a marker for what should be able to be maxed out regardless of patients' means and access.

Karen Fields: Right.

David Cella: OK.

Melissa Marinelarena: And then some internal QI, some -- just some background work that I was doing with, you know, some stuff that organizations could do would be to make sure that they're capturing demographic information and that they're capturing it uniformly so that they can start measuring it. So, that would be --

what would roll up into being able to capture, you know, disparities within different category. And if you like, I can sort of fill in some gaps and have you all react to that.

So, that is all we have here. If anybody else has anything else to add? If not, we will load up the public and member comment.

While you think of anything else to add, operator, if you can open the lines?

Operator: Thank you. At this time, if you'd like to make a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment.

Melissa Marinelarena: Thank you. And those of you that are on the web, you can also enter any questions in the chat box.

Operator: And there are public phone comments at this time.

Melissa Marinelarena: Great. Thank you.

David Cella: Yes. Thanks. I just wanted to be -- I just wanted to make sure that there weren't any comments. So, thanks.

Melissa Marinelarena: Right. Thank you, Dave.

David Cella: We get eight minutes -- we get eight minutes back.

Melissa Marinelarena: If we go really quick to next step. So, I think there are the next steps. So, we will work on revising these (priority) measures and gap based on the (CVAC) that you gave us, maybe trying to give you, you know, I've -- I have some -- some resources that I found and try to fill it in, give you something to just to react to a little bit more but this is more of an exercise to show that there are more gaps than there are measures.

The next step is also, we have a webinar -- we have another one in September. So, this is to lead of of what Len was saying and Dave and Karen and I have been talking and that we wanted to get some measure developers together and there are some that are interested in talking to us in September so that you can have these conversations with measure developers and you've been wanting to do this since you first (met) and to talk to them about what are the priorities, what is important so that we're all on the same page and we're not having these conversations after the measures are fully developed and they come to us.

David Cella: That's great.

Melissa Marinelarena: Yes. And so, this committee was way ahead of all of these work that -- great work that John Luke and Helen and (John Bernaugh) have done. So that is exciting.

So I will be sending a little poll to get your availability for September. But you'll be hearing a lot from me before then as I send this back and get some feedback and try to finalize something and then we'll give you something from the palliative care committee as well.

Jean-Luc Tilly: That's right. Yes. The palliative care committee will be presenting to the CSAC in a few weeks and so during their July 11 and 12 in-person and as part of that, there'll be a kind of written report that I will be happy to (share) any of those measures.

Melissa Marinelarena: OK. Anybody else? Any questions?

Karen Fields: No. We appreciate you all. The work that you put into it and -- and also helping patiently walk us through some of these things and I absolutely think that -- I appreciate the work of the committee because I think we'll be doing a few more things like this in the future. So, again, thank you for joining us, everyone.

Melissa Marinelarena: Likewise. Thank you, everyone and thank you for your time this afternoon.

Female: Thank you.

Melissa Marinelarena: Bye-bye.

Female: Bye-bye.

Male: Thanks. Bye-bye.

Female: Bye.

Operator: Ladies and gentlemen, this does conclude today's webinar. You may now disconnect.

END