NATIONAL QUALITY FORUM

Moderator: Measure Developer Maintenance
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OPERATOR: This is Conference #: 81097953.

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

Shaconna Gorham: Good afternoon. We would like to welcome you to the Eye Care, Ear, Nose, and Throat Standing Committee Off-Cycle Review Webinar. Thank you for joining today.

I'm going to turn it over to our chair, Kathy and Dan.

Kathleen Yaremchuk: Thank you, Shaconna. This is Kathleen Yaremchuk, co-chair of the committee. I'm the Chair of Otolaryngology in Henry Ford Hospital in Detroit. And welcome you to this off-cycle meeting which is going to be done obviously on the webinar and on the phone. Dan?

Daniel Merenstein: Yes, this is Dan Merenstein. I'm a family physician from Georgetown University, also representing the American Academy of Family Physicians. And as Kathleen said last time, we did this with in-person so it's little easier when people wanted to talk, but hopefully people can just speak out somehow. We'll get this going. Thank you.

Shaconna Gorham: All right, and my name is Shaconna Gorham and I am the Senior Project Manager. And I will be helping to staff this webinar today. And I will also be working with Karen Johnson. Karen, would you like to introduce yourself?

Karen Johnson: Hi, good afternoon everybody. I'm Karen Johnson. I'm one of the senior directors at NQF. I'm also helping out on this webinar. So, thank you for joining us.

Shaconna Gorham: And we also have Jason Goldwater. Jason?

Jason Goldwater: Hi, I'm Jason Goldwater. I'm also a Senior Director at NQF. And I oversee most of the work revolving around electronic measures.

Shaconna Gorham: OK, great.

Kathleen Yaremchuk: Thank you.

Shaconna Gorham: OK, Kathy?

Kathleen Yaremchuk: All right, so hopefully you've all got the agenda in front of you. Basically, we're going to go through two measures today, have some discussion of harmonization, will allow members and public comment, and then follow-up with committee timeline and next steps.

Now, I would like to introduce Ann Hammersmith, General Counsel of NQF, to discuss the Introduction and Disclosure of Interest.

Ann Hammersmith: Thanks, Kathleen. Hi, everyone. I will – as Kathleen said I'll lead you through the Disclosures of Interest. If you recall, you received a form from us where we asked you very detailed questions about your professional activity. What we do today is we will have you go around the virtual table. I will call your name and have you disclose anything that you believe is relevant to the work that the committee will do.

So, just a few reminders, just because you disclosed does not mean that you have a conflict. One of the reasons we do this is for openness and transparency. So you may have something that is somewhat related to the subject matter of this committee but isn't a conflict, but we would still appreciate your disclosure of that.

The other thing to remember is that you sit on the committee as an individual because you're an expert. You don't represent your employer. You don't represent anyone who may have nominated you to serve on the committee.

Our conflict of interest process is a bit different from a lot of other places. Many places only focus on financial disclosures and financial conflicts of interest. Because of the nature of the work we do, there are often groups that consist of volunteers that may work on measures around the lead up to a measure. So, for example, if you served on your specialty society committee and it's relevant to the work that this committee does and you did it as a volunteer, we would still look for you to disclose that.

So with that, I will call names. Tell us who you are, who you're with, and if had -- you have anything you would like to disclose, but only if it's relevant to the work the committee will do.

So, I will start with the co-chairs. Kathleen?

Kathleen Yaremchuk: Hi, Kathleen Yaremchuk. I'm representing the Henry Ford Health System, Otolaryngologist and the Chair of that institution and I don't have any disclosure of interest.

Ann Hammersmith: Just a reminder, actually you're not representing the Henry Ford Health System because you're sitting as an individual expert.

Kathleen Yaremchuk: OK, thank you.

Ann Hammersmith: I just wanted to be clear. Daniel Merenstein?

Daniel Merenstein: Yes. Hi, Dan Merenstein. I don't have any conflicts that I need to disclose.

Ann Hammersmith: OK. Do you want to tell us who you're with?

Daniel Merenstein: Oh, Georgetown University.

Ann Hammersmith: OK, thanks. Tamala Bradham? Is Tamala Bradham on the phone?

Matthew Carnahan? Is Matthew Carnahan on the phone?

Scott Friedman?

Scott Friedman: Hi, Scott Friedman. I represent the American Academy of Ophthalmology. I have no relevant financial disclosures.

Ann Hammersmith: OK. Just a general reminder, you're not representing a specialty society, so none of you sitting on the committee represents anybody. You're here as an expert. You sit as an individual. So, you're not representing the interest of anybody because it's an expert panel.

David Keller?

David Keller: Hi, David Keller. I work at the University of Colorado School of Medicine, Department of Pediatrics. I'm a member of the Standing Committee on Pediatric Measures. I was invited to join this committee, I guess, because of that for this time only as part of that expertise.

Ann Hammersmith: OK.

David Keller: And I have no – and I have no disclosures.

Ann Hammersmith: OK, thank you.

John McClay? Is John McClay on the line?

Vaishali Patel? Is Vaishali Patel on the line?

Todd Rambasek? Is Todd Rambasek on the line?

Andrew Schachat? Is Andrew Schachat or Schachat on the line?

Shaconna Gorham: Excuse me, Ann, if I may. Just a reminder for our committee members, we need you to dial in today to be part of the discussion and that number is 855-696-3824. Repeating, 855-696-3824. Thank you, Ann.

Ann Hammersmith: OK, thank you.

Joshua Stein? Is Joshua Stein on the phone?

Michael Stewart? Michael Stewart on the line?

Steven Strode?

Steven Strode: I have worked not as an employee but as a panel member with the American Academy of Orthopaedic Surgery on guidelines and with the ENT Head and Neck Surgery Specialty Organization on guidelines.

Ann Hammersmith: OK. Do you want to tell us who you're with?

Steven Strode: Oh, just in government service right now for the State of Arkansas.

Ann Hammersmith: OK, thank you.

Jacquelyn Youde?

Jacquelyn Youde: Hello, Jacky Youde. I'm an audiologist.

Steven Strode: Hello.

Jacquelyn Youde: And I am not currently with anyone and I have nothing to disclose. Thank you.

Ann Hammersmith: OK, thank you. Did I miss any committee members on the phone?

John McClay: This is John McClay. I actually just came on the phone.

Ann Hammersmith: OK. We're doing disclosures.

John McClay: Correct. I was listening on the computer.

Ann Hammersmith: Oh OK. You know the drill.

John McClay: So, I have nothing to disclose and I am not representing anybody. But I became a committee member by being on the executive committee for our Specialty of Pediatric Otolaryngology for the American Academy of Pediatrics.

Ann Hammersmith: OK, thank you. Did I miss anyone else? Any other committee members?

Todd Rambasek: Yes, this is Todd Rambasek. I was also online only. Can you hear me?

Ann Hammersmith: Yes, I can.

Todd Rambasek: Yes. I'm an allergist with ENT & Allergy Health Services and I have no relevant disclosures.

Ann Hammersmith: OK, thank you. Anybody else?

Joshua Stein: Hi, this is Josh …

(Crosstalk)

Ann Hammersmith: Sorry?

Joshua Stein: Hello?

Ann Hammersmith: Yes?

Joshua Stein: This is Josh Stein. I'm at the University of Michigan. I'm an ophthalmologist. I have no disclosures.

Ann Hammersmith: OK. Anyone else?

Shaconna Gorham: And Ann, it does appear that you have Tamala Bradham in chat, have marked that she has no disclosures.

Ann Hammersmith: OK, thank you. The only other thing I'm going to remind you of is that during the meeting, if you think you have a conflict of interest, if you think that someone else from the committee have a conflict of interest, or if you think that someone is being unduly bias, we ask that you speak up in real time. We don't want to get several months down the road and then a have committee members say, "You know, I really think I have a conflict on that measure." So, you can bring this up during the meeting if you would like. You can send your co-chairs an e-mail. You can send NQF staff an e-mail and we'll work to resolve any issue.

Are there other questions? OK, thank you.

Vaishali Patel: Hi, excuse me please.

Ann Hammersmith: Yes?

Vaishali Patel: This is Vaishali Patel.

Ann Hammersmith: Yes.

Vaishali Patel: I just joined. I was having trouble with audio earlier. I could hear you but you couldn't hear me. So, I'm on.

Ann Hammersmith: Would you like to disclose?

Vaishali Patel: I have no disclosures.

Ann Hammersmith: OK, thank you. Anyone else?

Tamala Bradham: This is Tamala Bradham.

Ann Hammersmith: OK.

Tamala Bradham: I'm at Vanderbilt University Medical Center and I have no disclosures.

Ann Hammersmith: OK, thank you. Anybody else?

OK, thank you.

Shaconna Gorham: Thank you, Ann. We will continue. I just want to briefly go over just to remind everyone because it has been a while since we've met for our original EENT meeting of the EENT portfolio.

So next slide, we will – so the next couple of slides, actually, you will see the actual portfolio. So, next slide. We have the eye care measures as well as the ear, nose and throat measures. These are measures that we reviewed during our clinical team review. The measure is highlighted in orange are measures that were reviewed in other programs.

So, for example, measure 0069 on your screen, now, that was reviewed in the pulmonary project but that measure also was not submitted. And then, we also have measures that we would use. So just for your reminder, measure 0002, we discussed in that measure was not – the endorsement was removed for that measure. And measure 0656, although it is not marked on the slide, is inactive endorsement with reserve status. I just want to again remind you of the portfolio. The next slide, we have the EENT measures that will retire by this developer.

And next slide. The purpose of the meeting today, again, is to consider candidate measures for endorsement. And just as a reminder, we discussed the endorsement criteria during the orientation call a few weeks ago. Next slide. And as a reminder, I included that slide again just so that we can go through real quickly before we actually get into the measures.

The criteria include the importance to measure and report. So, of course, that is including evidence. And so, your job is to decide whether the measure focus is evidence-based. And opportunities for improvement is basically does the measure demonstrate a quality problem. So, this is a must-pass criterion.

The next criterion, scientific susceptibility of measure properties, this is really the crux of a good measure. The measure must produce reliable and valid test results. This is also a must-pass criterion.

So as we discuss and vote, if the measure will both – because we have two measures, so if either of the measures fails to pass the importance to measure and report or scientific acceptability, then we will stop this session for that measure.

If they pass the two must-pass criterion, then we move on to feasibility, the extent to which required data are readily available and retrievable without undo burden. And then we have usability and use, the extent to which potential audiences are using or could use performance results. Later in the call, we will have a discussion of related measures.

So next slide, the Process For Measure Discussions, which we will get into in a little while. The measure developer will have two to three minutes to introduce his measure. Our chairs will help to facilitate and move us along. But we also have lead discussants on for each measure. And so, the lead discussants will begin the committee discussion. Provide a summary of the pre-meeting evaluation comments. Those are the comments that you submitted via survey. And then also, emphasize areas of concern or difference of opinion. The developers will be available to respond to questions at the discretion of the committee. So committee members can definitely call on the developer. And then the committee will vote on the criteria and the sub-criteria.

So this is a call. We do not have the benefit of seeing your smiling faces. So, just a reminder that before you speak, if you could announce your name so that we know who we're speaking with and we can keep track of the conversation in that lens.

Next slide. So it is very important for us to achieve consensus. We have consensus now. If at any time you have to leave the call, please let us know. Quorum is 66 percent – quorum is 66 percent, so we do have quorum now. And so, we – in achieving consensus, we want to have a greater than 60 percent of the committee vote yes, either it's a high or moderate. And 40 percent to 60 percent is Consensus Not Reached. Less than 40 percent, the measure will not be recommended with that criteria, criterion will not be recommended. (CNR) measures move forward to comment and the committee will revote. So we do have a comment call scheduled later on.

So, with that said and those reminders given, we want to move on to this first measure to be discussed. And I'll hand it back over to our chair, Kathy, so that she can begin that discussion and introduce our lead discussants as well as our developer who is on the line.

Kathleen Yaremchuk: OK. So we're going to be looking at measure 2640, Otitis Media with Effusion, Antibiotics Avoidance.

And do you want the developer representative to discuss it and then we go to our discussants, Tamala and Dan?

Shaconna Gorham: Yes, that would be good, Kathy.

Kathleen Yaremchuk: OK. Charles Bailey, are you on the line? And can you introduce the measure?

Charles Bailey: Yes, ma'am. Thank you very much for the opportunity to talk. My name is mentioned as Charles Bailey. And I am one of the faculty at the Children's Hospital of Pennsylvania. And I also work with the PEDSnet Multi-Site Research Network. So we'll be including both of them in the discussion today.

I'm not on the committee. But in fairness, other than working on the …

(Off-Mic)

Charles Bailey: … I have no conflict to disclose.

The motivation for this measure I think is fairly familiar to the committee by way of very brief summary. Antibiotics overuse is a well-recognized problem causing both side effects, change in resistance pattern.

In pediatrics, it's estimated that otitis media of some form drives about 50 percent of all antibiotic usage. And it is clearly the principal diagnosis associated with avoidable antibiotic usage. So we've took on these measures with the perspective of trying to get more insight into patterns of antibiotic usage and drive appropriate antibiotic usage in care of children.

I'll start with the OME measure 2640. This, as you know, is based on an existing measure that is – or was developed by AAO-HNS. But based on chart review, it was re-specified as an electronic measure as part of the initial (Chipper) core set. That one was the so-called called measure 16. Then, measure proved infeasible. The principal reason was the use of HCPCS two codes for alternative diagnosis, which was not a terminology in which diagnoses tends to be captured in electronic health records.

And so, we are attempting to re-specify this measure using the kinds of terminologies and the kinds of criteria that are in use …

(Off-Mic)

Charles Bailey: … in building this to both existing billing practices and to the specification from the Office of the National Coordinator driving the CMS Meaningful Use initiative. And it's effectively setting the practice standards for electronic health record deployment and operation.

And we have tried to place a particular focus in our testing plan on addressing the eMeasure as an eMeasure, and asking how can we broaden the testing? And so far as the eMeasure is intended to scale in a different way than a chart review measure about how we can make the testing plan reflect those differences in scale.

So I will stop there in order to keep the summary very brief. But I would be more than happy to answer any questions. And if I've omitted anything, please don't hesitate to let me know.

Kathleen Yaremchuk: This is Kathy Yaremchuk and I have a question. In light of the changes in immunization patterns, I'm wondering what the changes has been in the incident of otitis media usage or diagnosis and usage of antibiotics in the last 10 years? I have looked at some material. I think the original incidents and statistics that were used were from 2011. Is there anything that's more recent?

Charles Bailey: There is not that I'm aware of. That is – that's the large – that's large national surveys, you know, consistent with the expansion of particularly the pneumococcal vaccine. There has been some decrease in otitis media, although not the kinds of changes that we've seen and more in basic pneumococcal disease.

The clinical guideline on which this is based, not the AAO-HNS measure but the clinical practice guideline that AAP and the AAONHS jointly endorsed was revised in 2016. And there were no changes made with respect to antibiotic recommendations for otitis media.

Kathleen Yaremchuk: I guess my question was in terms of relevance, because some of the information I've looked at showed something between a 20 percent and a 40 percent decrease in the incidence of the conditions. And so, I guess my question is not so much about a change in the appropriateness of the antibiotic recommended, but the incidence of the disease that whether this is widespread enough that it is still significant.

Charles Bailey: Fair enough. I …

(Crosstalk)

Dan Merenstein: So the data we were given – this is Dan Merenstein. And I know – I'll have few things to say is that it was occur in 6.5 percent of children. So if it's really (quoted) that off and that's pretty consistent.

(Crosstalk)

Kathleen Yaremchuk: And is that six – do you know what year that 6.5 percent comes from?

Daniel Merenstein: Good question. Does developer know?

Charles Bailey: That's our review with local data. So, the update are across this population.

Kathleen Yaremchuk: What year?

Charles Bailey: Ranges from 2009 to 2015.

Tamala Bradham: This is Tammy Bradham. I may have to leave. I'm having a red alert fire alarm in my building. But I did look at some of the literature and they have said that over the last 10 years in the decade, this was research published out of U.K., that there has been a steady decline in identification of otitis media.

Kathleen Yaremchuk: And so, that's why I'm wondering if you're looking at a six-year or a seven-year spread, it could have been 20 percent in 2009, and now, down to 5 percent. And so, I guess I'm trying to see if we're on a downward slope, how relevant this continues to be.

Charles Bailey: Got it. Well, I would be happy if the committee wants during the commentary to go back and provide you with annual time places for these diagnoses. They remain year over year in our data set, the primary driver of antibiotic prescription.

Shaconna Gorham: And so, let me just interrupt. Both Tamala and Dan have spoken but not really been introduced as the lead discussant. So, I just want to acknowledge the fact they are lead discussants.

Kathleen Yaremchuk: OK. Do you want to introduce the next measure, Charlie?

Charles Bailey: Sure. Sure. I'm happy to talk about both. So, we followed up 2640 with 2811 because apropos of our discussion of incidents, otitis media with effusion, while it's clearly not – and in fact, this diagnosis also has an incidence that's a about a (log) under that of acute otitis media.

Again, the currency of the data are important but, you know, there are – there is evidence from the last five years that suggest that over half of children will have at least one episode of acute otitis media, and about a third will have more than three episodes. There, again, have been evidence-based clinical guidelines published for about the last decade that reflect our understanding of the past physiology of the disease.

Approximately 90 percent in the vaccine era is not thought to be due to bacterial etiology. Over 90 percent will resolve within seven days. Excuse me. And in the absence of fever and significant findings in ear exams are significant pain, the likelihood that an infection is bacterial is small.

All of those are aspects of the guideline that I quote just for general relevance. In particular, in the measure, we did not attempt to assess the appropriateness of an antibiotic prescribing decision. And we didn't do that because published guidelines in the clinical practice involve a number of subjective factors. Essentially, the recommendation is for antibiotic …

(Off-Mic)

Charles Bailey: … acute otitis is severe enough, and that's not something that we didn't feel we could rely have in an electronic measure.

However, the guidelines do specify that when a decision is made to prescribe antibiotics, the appropriate first-line antibiotics is amoxicillin and not other broader spectrum antibiotics. There is a provision made in some patients to use amoxicillin clavulanate. That's a minority recommendation. And the data that it produces a different outcome are limited. So we chose to focus on amoxicillin.

We also picked amoxicillin because we were constructing this measure in parallel with existing clinical guidelines for pediatric sinusitis and pediatric community-acquired pneumonia, which are behind otitis media and pharyngitis, but still major drivers of antibiotic usage, and which specify amoxicillin specifically.

So again, this measure is designed to assess appropriateness of antibiotic prescription in the case that the clinician has judged the disease to be serious enough to require an antibiotic in the first place.

Kathleen Yaremchuk: OK, thank you. Yes, I was going to introduce Tamala and Dan to do their discussion of the measure.

Daniel Merenstein: Tammy, are you still there or you did leave?

Tamala Bradham: Yes, I'm here.

Daniel Merenstein: I think the background was given, do we need to add anything? I think we're good with that. Sorry, go ahead.

Tamala Bradham: Yes, yes. Yes, we've already talked about the introduction of the measure. This is a new measure. It's considered a process measure. And there are practice guidelines for this measure and it's recommended by the American Academy of Otolaryngology, Head and Neck Surgery Foundation, and American Academy of Pediatrics, and the American Academy of Family Physicians. They have just recently submitted that we had just mentioned

earlier, a revised guideline practice for accuracy of diagnosis and treatment, and that was published in 2016.

They did do a systematic review of 20 systematic reviews, 49 random controlled trials. And they – they have continued to recommend that antibiotics not be prescribed for OME. Based on the committee responses, there's high evidence rating for questions that centered around the measurements that were used, mean versus median. There were concerns about performance gaps and gaps in care. And also, as mentioned earlier, is this measure still needed and warranted.

Daniel Merenstein: Yes. The only thing I'd add is are we – we're voting on the evidence one first, right? Is that how we need to do it?

Tamala Bradham: Yes.

Daniel Merenstein: So, as Tammy said, this Grade A evidence, it's (our) view that you shouldn't be using antibiotics for OME. And according to the NQF algorithm, the evidence grading, I think it would be a high. And I don't believe I have much to add on update. Any committee members have questions about the evidence behind this?

Kathleen Yaremchuk: So anyone that's on the line has any comments to make? OK.

David Keller: So, this is David Keller speaking as a pediatrician. I think I have to echo the measure developer's comment that I do believe that otitis – acute otitis media is still the most common infection diagnosed in pediatric offices, certainly in our office. The overall prevalence has been reduced overtime. And the question of antibiotic administration in those cases is interesting. We now have policies where we often will give families antibiotic prescriptions but told them not to fill them to prevent second visits. It'll be interesting. So this kind of measure is interesting to us.

Daniel Merenstein: There's, I think, a little confusion. The slides still have 2811 up but we're talking about OME right now though.

Kathleen Yaremchuk: So we should have the slide 2640.

David Keller: Oh, you're talking – I thought we had gone to AOM. I'm sorry.

Daniel Merenstein: All right, no, that's confusing you, yes. That was our fault. But yes, but we're already talking about – we're going to – we've got the back on the boat. But now, we're going to go through each specific one and vote I think on. So now, we're doing …

David Keller: OK. So again, now, so that the problem I have is actually going to be in the reliability measure because – part of the measure. Because I think the big problem with these two measures from my standpoint is I am not convinced that pediatricians accurately differentiate between these two conditions. And that I don't believe that the diagnosis codes actually – I think there's a problem with the denominator, but we'll go that eventually.

Daniel Merenstein: I think Tammy and I agree with you, but that's a point. But I think the way it works, Tamala, we need to vote first in the evidence, right?

Tamala Bradham: Yes, yes, we do need to vote on the evidence at this point, and …

Kathleen Yaremchuk: OK.

(Crosstalk)

David Keller: The evidence is that there's a lot of (effusions) up there.

Tamala Bradham: … based on what Dan and I said …

David Keller: Yes.

Tamala Bradham: And just to summarize what Dan and I said, that based on the NQF algorithm that we have, we rated the evidence to be high.

Kathleen Yaremchuk: OK. So, Shaconna, how are we going to vote on this? Is there going to be something – OK, here it is. All right, good.

Daniel Merenstein: So, do we vote on the link?

Shaconna Gorham: So you should have – this is Shaconna. You should have received a link for all committee members. You should have received a link that will give you access to voting.

But (Sheila), if you can provide a little bit of direction, that would be helpful, please.

(Sheila): Would you like me to do that for you, Shaconna?

Shaconna Gorham: Yes.

(Sheila): Excellent. So what you see on the screen right now is a voting slide. You should see a box to the side of the letter A and B choices. You simply click in the box next to the answer of your choice and it registers your vote. Voting is open for committee members only. Do we still have Tamala with us or did she …

Tamala Bradham: Yes.

(Sheila): … have to leave for the alarm? OK, great.

Tamala Bradham: I am …

(Sheila): So we should have 10.

Karen Johnson: And this is Karen. I just want to make sure, (Sheila), that is not the correct slide up for evidence. This is a process measure. So we need to have – yes, there you go.

Tamala Bradham: So start over. This is Tammy. Thank you.

Shaconna Gorham: So looks like we're still missing a few votes. If the boxes do not appear for you, you can also refresh your session by pressing F5 on your keyboard for a P.C. or command R for a Mac.

Daniel Merenstein: Looks like we got all the votes.

Steven Strode: This is Steven Strode. I vote for but I'm having problems with my connection on the web meeting.

Shaconna Gorham: Looks like we've got your vote.

Steven Strode: OK.

Karen Johnson: I'm sorry. Can you repeat what he has voted? I mean I – did you say you voted for? I don't want to …

Kathleen Yaremchuk: Well, it's A, B, C or D.

Karen Johnson: Yes. Did somebody vote anything other than A? OK, just checking.

Daniel Merenstein: So can we go to reliability?

Tamala Bradham: OK. This is Tammy. Are you ready? OK. So for reliability, our numerator is the eligible encounters that which this systematic antibiotic was not prescribed. Our denominator …

Shaconna Gorham: Tammy? Tammy, one minute before you go to reliability.

Tamala Bradham: OK.

Shaconna Gorham: We need to vote on the gap – I mean gap importance to measure and vote on gaps. So (Sheila), if you can go next a slide, please.

Karen Johnson: And (Sheila), can – I don't know if you were planning on leading up the votes, (Sheila) or Shaconna. Let's remember to do that so that we can account for our transcript.

Shaconna Gorham: OK, so if we can go back to the evidence and just announce the vote for evidence.

Karen Johnson: So this is Karen. What I saw on the screen with 10 votes for A high, zero votes moderate, zero votes below, and zero votes insufficient.

Shaconna Gorham: OK, that’s feasible. OK.

Karen Johnson: Right.

Shaconna Gorham: OK. So if we can move on to gaps.

Karen Johnson: And sorry, this is Karen, just one thing. Usually we are trying to show part of the submission on the screen for the committee members to look at. We're having difficulties making that work today. You can – if you don't already have it pulled up, you can pull up the submission materials for the various measures from the links section of your screen there. So, apologies that we can't just pull up the data and (why don't) you look at it on the webinar.

So now, for our lead discussant will just talk a little bit about gap and what they developed or submitted.

Tamala Bradham: So there were comments – this Tammy Bradham again. There were comments from the pre-evaluation that it was difficult to understand the gap analysis that was completed and that there were small disparities that were not really large enough to affect the measure. But they also commented that there were differences in measurements that were used, mean versus median, gaps of care were not addressed adequately.

Dan, do you have anything to add?

Daniel Merenstein: Yes, I know, I was one of the people that were confused by the gaps. So yes, it didn't seem like it was – it's discussed much. So there wasn't much of an issue but then it did seem to be there's some difference. So I don't know if the developer has something to add?

Jacquelyn Youde: This is Jacque. I have a question on that as well. So I'm looking at the form and it's saying that the mean failure rate was 15 percent for provider specific evaluations. Is that noting that in15 percent of the population, the antibiotic was given to OME? So they failed it? Or is it – how should I interpret the mean failure rate of that?

Charles Bailey: So I want to make sure I'm answering the right question. Are you – you're asking about the mean failure rate that we're reporting for the candidate measure, yes?

Jacquelyn Youde: That's correct, yes, the OME performance gap. And so, just to quote that form, four characteristics for provider specific evaluation and of 531 with 285 representing providers with five or more visits where it's followed mean failure rate of 15.05 percent and so on. Is that 15 percent saying that in 15 percent of the population that we're looking at, the provider prescribed antibiotics for OME which is inappropriate? And then my second question on that, is that 15 percent of 531 or is that 15 percent of 285 and those had the five qualifying visits?

Charles Bailey: So what we're saying there is that an individual provider is scored for the proportion of visits in which they state that the patient has OME, they do not state that the patient has any other indication for antibiotics and they prescribed an antibiotic. And the mean score across providers there was 85 percent. So, that the mean provider prescribed an antibiotic 15 percent of the time stating that the patient had OME not AOM and stating that the patient had no other reason of antibiotics.

Jacquelyn Youde: OK, thank you very much. And then are we looking at the 531 – 15 percent of the 531, are we looking at 15 percent of the 285 because they had five or more qualifying visits?

Charles Bailey: And if you give me just a moment to get to the right place in the testing test. I want to make sure I 'm giving you the right answer.

Jacquelyn Youde: Oh, I appreciate it. Thank you so much.

Charles Bailey: Sure. Can you tell me which section you're reading from just so I'm …

Jacquelyn Youde: Yes, absolutely. So I'm on 1b on page 3 at the very top of the final measure worksheet that was e-mailed out at least to the committee today. I'm not sure when it went to you. But it's the very sub-bullet point and it's saying core characters for provider specific evaluations, so on and so forth, 531, 285. So that first sub-bullet, not the first original bullet.

Charles Bailey: So this is in the testing attachment?

Jacquelyn Youde: I'm looking at the final measure worksheet.

Charles Bailey: Oh OK, I'm sorry. That's why I'm – if I sound confused, I apologize. It's just …

Jacquelyn Youde: No worries.

Charles Bailey: I was looking at the testing attachment and thinking …

Jacquelyn Youde: Yes, there's a lot to read.

Charles Bailey: OK. Let me go to the measure worksheet and make sure we're talking about the same thing.

OK. So I'm looking at a document entitled addendum. I'm wondering if I got a different set of documents than you did.

Jacquelyn Youde: I'm wondering the same thing actually.

Charles Bailey: Yes. So Karen, can you …

(Off-Mic)

Karen Johnson: You should have the same.

Charles Bailey: It's probably just me goofing up. What's the title of the …

Karen Johnson: Charlie? This is Karen, Charlie. Let me just e-mail you both of those.

Charles Bailey: OK.

Karen Johnson: That way you'll have them.

Charles Bailey: Yes. I'm so sorry for the confusion.

Jacquelyn Youde: It's OK.

(Off-Mic)

Jacquelyn Youde: I have a third question on this failure rate as well. So I'll let you get that because I don't want to cause confusion.

Charles Bailey: OK. And I'm happy to try to answer it if it's not tied to a particular page or paragraph.

Jacquelyn Youde: No, it's not. So on the mean failure rate, on that 15 percent of providers who prescribed the antibiotic inappropriately for OME, do we know why? Could we do any analysis within the failure rate?

Charles Bailey: So there are two lines of analysis we follow. For One Health System, we actually went back through and performed chart review to try to identify any patterns …

(Off-Mic)

Charles Bailey: In that circumstance, we had a couple of charts – excuse me. We had a couple of charts that were discordant in the diagnosis. I think if I'm trying – I'm trying to remember precisely there may have been one case where a provider reported a cellulitis but didn't record the diagnosis. But by and large, there was very high concordance in the data element. So we weren't getting a lot of information back from notes. And we over sampled providers who have low scores to try to see if we could find patterns.

The other thing that we did was we looked at the other diagnosis recorded at the visit. And again, we find that a low number of visits where we have things recorded like a urinary tract infection or a cellulitis, but some of them accounted more than about 1 percent of the disease.

So I have to speculate that prescribers …

(Off-Mic)

Charles Bailey: … are using an empirical trial of antibiotic just to see whether a patient's condition improves. But I want to be careful about that because it is a speculation on my part.

(Off-Mic)

Charles Bailey: And I'm biased here. That's exactly is the behavior that the guideline is published to try to change. So, you know, and so far as I'm promoting a measure intended to support that, take what I say with a grain of salt.

Tamala Bradham: This is Tammy Bradham.

Daniel Merenstein: I'm Merenstein. Can I ask? I'm sorry. I don't want to lead people but I guess I misunderstood. So this 15 percent, what's the goal to get that to?

Charles Bailey: So I – since the third quartile is at a 100 percent, it's clear that a substantial number of providers performed at 100 percent, and so the goal here would be 100 percent.

(Crosstalk)

Daniel Merenstein: I think the way to defined it the way I heard is 15 percent of them are prescribing antibiotics for OME. But that's not what you're saying, right?

Charles Bailey: Dan, I'm saying that the average provider prescribes antibiotics for OME 15 percent of the time.

Kathleen Yaremchuk: So, you want to get the failure rate to zero percent?

Charles Bailey: Yes.

Kathleen Yaremchuk: OK. So, it's not a 100 percent, just to clarify.

Charles Bailey: I'm sorry. The failure rate should be zero percent. The measure – just like – that the measure score would be a 100. Again, the failure rate would be zero percent and that appears to be achievable with this measure.

Daniel Merenstein: Why is it achievable?

Charles Bailey: What we're seeing is that over a sufficiently large population of providers, about a quarter of them achieve it.

Daniel Merenstein: So we're trying to go deal the 75 percent of providers?

Charles Bailey: Yes.

Daniel Merenstein: All right.

Charles Bailey: OK. I mean, I guess that's a much better rate than sinusitis or bronchitis, I mean, it's because it's unbelievably low. I'm not sure we can really improve on that.

Tamala Bradham: This is Tammy Bradham and I have a question.

Charles Bailey: So – and it will matter. You may – you know, you may be right. I mean to the extent that in the face of published clinical guidelines and in the face of local quality initiatives and in the face of a burgeoning literature on inappropriate use of antibiotics, several studies have shown that it's very difficult to deflect prescriber behavior. I certainly understand that concern.

We've shown at some other context that we can deflect for a prescriber behavior at least locally with point of care decision support. That's a different question than deflecting in the population. I think we're – my perspective is we're sort of in a bind here because on the one hand, the baseline behavior is reasonably good. On the other hand, these diagnoses remain the major driver of inappropriate antibiotic usage. And we're certainly seeing shift in resistance patterns in the community. And you know, in adults, the drivers are things like bronchitis and sinusitis. In childhood, particularly early childhood, otitis media swamps those other conditions.

John McClay: This is John McClay. Can you hear me?

Kathleen Yaremchuk: Yes.

Tamala Bradham: Yes.

John McClay: You know, you can't ever set a goal of a 100 percent, I mean, in any quality metric. It's just – I mean, it's unreasonable. I mean I think in your mind, you can. But if you're going to officially create some percentage, there's just no way that that's achievable. I just I can't see it. I mean, like you said, I don't

know what's your point of contact, you know, health that you guys are using to improve your metrics. But when you – and is it mainly in academic center that you all were looking at this or was it some community physicians?

Charles Bailey: So these are principally academic sides.

John McClay: And so, like your point of contact for help would be like a hard stop in the medical records, like Epic or something?

Charles Bailey: So interestingly, what we found in the past looking at quality improvement initiatives, that the intervention that seems to be most effective is providing individual level feedback on performance relative to guidelines. So more effective than putting the recommendation at the point of prescribing is – and sending back to the providers every couple of months a report that says, you know, you prescribed the antibiotics without documenting a reason 10 percent of the time, 30 percent of the time, 50 percent of the time.

John McClay: Yes.

Charles Bailey: And we see improvements in guideline adherence behavior. I can't prove to you that that's not in effect an improvement in coding behavior.

John McClay: Right.

Charles Bailey: But, you know what, what we see is, you know, improvement in the outcome.

John McClay: You're right. Well, I mean you said …

Tamala Bradham: Are we saying – I'm sorry.

John McClay: Did you say 3/4 or 1/4 had a 100 percent compliance?

Charles Bailey: One fourth.

John McClay: One fourth.

Charles Bailey: Yes.

John McClay: OK, thank you.

Kathleen Yaremchuk: Is there anything else regarding gap analysis at this point? Any other comments?

(Off-Mic)

Tamala Bradham: This is Tammy Bradham.

Kathleen Yaremchuk: Yes?

Tamala Bradham: I have a question. In the gap analysis, was there anything that looked at population groups like by ethnicity, race, gender, social economic status? Was there anything along those lines?

Charles Bailey: So we did not include that in what we reported. We can certainly do that. In an earlier version of our test, that we did do that. We saw in that version not much of a gender-related gap. It's small gaps based on ethnicity. And I don't believe we had clear enough data about socioeconomic status. You know, what we have are proportion of patients whose insurance is public payer versus private payer. Ad I'm not sure that carefully enough captures socioeconomic status.

Kathleen Yaremchuk: Are we ready to vote on this?

Scott Friedman: One more quick question. This is Scott Friedman. I'm an eye doctor as you all know. So the mean failure rate is 34 – 35 percent. The question is out of the 65 percent that – out of the failure rate, did they not prescribe any antibiotic when they should've or did they prescribe a different antibiotic? And then if they did prescribe different antibiotic which may have been somewhat appropriate, should this – and this gets to the crux of the whole measure, should this be an overuse measure?

Kathleen Yaremchuk: Scott …

Scott Friedman: And that's what I addressed at the beginning.

Kathleen Yaremchuk: Scott, this is – the mean failure rate we're looking at is 15 percent and we're on …

Scott Friedman: OK. I'm looking under performance gaps says the mean failure rate is 34.8 percent.

Kathleen Yaremchuk: We're looking at …

Scott Friedman: Mean is 25.2.

Kathleen Yaremchuk: Are you looking at 2640?

Scott Friedman: No, I'm looking at 2811, problem number one.

Kathleen Yaremchuk: Yes.

Scott Friedman: OK, so we're on 2640?

Kathleen Yaremchuk: Yes, sorry sad but true.

Scott Friedman: Got it. My mistake.

Kathleen Yaremchuk: OK. So your question of 15 percent, do you still have the question or do you withdraw it?

Scott Friedman: I'll withdraw it for now.

Kathleen Yaremchuk: OK, thank you. Are we now ready to vote? Can you bring it up on the screen?

Shaconna Gorham: OK. Voting is open for performance gap for measure 2640.

It looks like we have 10 votes. Committee members voted for moderate is 60 percent and four voted low for 40 percent. So that is 60 percent for moderate and that takes us to Consensus Not Reached for performance gap.

So we can continue the conversation and move on to reliability.

Tamala Bradham: OK. This is Tammy Bradham again. Reliability, we looked at the numerator was the eligible encounters at which a systematic antibiotic was not prescribed. And the denominator is outpatient encounters at which otitis media with effusion is diagnosed, but at which common conditions for which antibiotics are indicated are not diagnosed. And the denominator exclusion is diagnosis at the visit of common childhood infection for which antibiotics are frequently indicated. The data source is the electronic health record.

From the comment, there were concerns around defining an adequate denominator as they conclude other reasons why the child would be prescribed an antibiotic. There were concerns about face validity, which I know will be discussed later. There were also concerns raised if the child is appropriately diagnosed with otitis media actually citing some research from (Pichichero), I'm sorry if I said their name wrong, in 2001 which basically said that pediatrician correctly identify OME 50 percent of the time, and otolaryngologist 73 percent of the time. So that was a concern. And another one was missing medication standard code.

So, in summary, this measure is at the aggregate data level. There were some concerns about reliability analysis in which an addendum was provided with additional information regarding reliability. And the preliminary rating for reliability was considered to be high with the addendum.

Daniel Merenstein: Yes. The only thing, I guess I would just reiterate that. That it seems like the National Quality Forum analysis said more information was needed. And it was difficult also to distinguish – that it was possible to distinguish those as very low measures. But it wasn't clear if you could distinguish ones that didn't have – who weren't at the low measure. And I'm not sure those questions were answered before we reviewed everything.

Tamala Bradham: And the issue still remains even in literature published in 2016 about appropriately diagnosing OME. So do we even have the right numerator and denominator because we're still having some difficulties with the appropriate diagnosis?

Kathleen Yaremchuk: Any discussion from members or from the panel? Or do you wanted, from the measurement developer, a response?

Jacquelyn Youde: This is Jacque Youde. I have a comment on this measure as well as the next one. And it relates to accurate diagnosis. Just going through the comments on this measure, there just seemed to be some concern with accurate diagnosis. And one of the concerns that I have, especially given the conversation around performance gap, it is we're seeing improvement on the quality measure but are we seeing an improvement in coding? So we're coding appropriately but we're not necessarily diagnosing accurately.

And so, what we're seeing is, OK, what I'm giving – or what we're possibly seeing is, OK, I'm prescribing antibiotic so I need to code AOM. I'm not prescribing an antibiotic, so I need to code OME. So I just want to make sure we're not creating a system that can be gained and that providers don't end up gaining the system. And we're starting to see improvement in quality but we're not necessarily seeing true improvement.

David Keller: Yes.

Daniel Merenstein: Yes, this is Dan Merenstein. I would second that. I actually consider that a fatal flaw to this one. I don't – it seems like that 15 percent of people haven't caught on yet what they're supposed to do and I don't see how this changes that. I mean, it actually just makes it worse. It just get to the point where eventually they just call everything AOM and then – then you have a …

David Keller: So …

Daniel Merenstein: … a thing that does nothing.

David Keller: Yes. This is David Keller and I'd echo that. And I certainly watched that happen with – and with sinusitis in my clinical practice. Where we knew we weren't supposed to be prescribing antibiotics for colds, so we just started calling everything sinusitis. Not me personally, by the way.

Kathleen Yaremchuk: OK.

David Keller: The other piece so is particularly around the diagnosis of otitis media with effusion. To diagnose an OME, requires the use of an insufflation bulb. You really can't do it any other way. And I just don't see that being used in practice often enough. So I think pediatricians have real trouble making this diagnosis.

Daniel Merenstein: So what are the goals standard for differentiating the two? How do you determine if someone is underdiagnosing or misdiagnosing OME, for example, and they're calling it AOM? How do you know that?

David Keller: Well, I tell you, the way – so my fellowship was with Jack Paradise out in Pittsburgh. And the way when we were doing research on this, they made us to go through a process where we had to validate ourselves as otoscopists. And every otoscope in the clinic had an insufflation bulb hooked up to it at all times. And then we had to take a test where were examine the ears and kids were about to go for surgery, and then have the surgeon tell us five minutes later whether or not there was fluid behind that ear.

The first time I took the test, I failed. That was after being in practice for three years, when I thought I knew what I was doing. So I just – you know, I don't think there is a practical way to validate that diagnosis in practice. Sorry, I just don't think there is.

(Crosstalk)

Tamala Bradham: This is Tammy Bradham.

Daniel Merenstein: Yes. Go ahead, sorry.

Tamala Bradham: This is Tammy Bradham. According to the guidelines that have been published, one of the steps is to include tympanometry if pneumatic otoscopy is inconclusive.

David Keller: Yes.

Tamala Bradham: And to follow it up with tympanometry. And I think most pediatric practices do not have that.

David Keller: That is correct.

John McClay: So this is …

David Keller: There was a time when we thought about it, but we don't anymore.

John McClay: This is John McClay from – I'm a pediatric otolaryngologist. And the – Tammy, the tympanometry or the pneumatic otoscopy is going to be the same whether you have an infection or you have a fluid. It's just whether or not you have a clear ear or you have …

David Keller: Yes, exactly.

John McClay: … you know, something there. So if differentiating AOM from OME, it's not going to differentiate that with tympanometry or pneumatic otoscopy. It's really, you know, the visual aspect. You know, is it bulging? Is it yellow and you have purulent like erythematous? Of course if it's now, if it's clear and gray and flat, you may diagnose OME when there's no infection. So pneumatic otoscopy helps with that.

(Crosstalk)

Jacquelyn Youde: This is Jacque Youde. I second that comment.

John McClay: So there's no way to validate any of this as far as knowing if the person who've seen that ear is making a correct diagnosis. So I agree with everyone that what's going to happen is that people would just code based on what they're going to do. And so then you have to look at if that is helping – it will in fact, in the back of people mind, think well you know, they'll be more conscientious about what they do, so it may help decrease your prescriptions. But your success rate in that measure is not going to really determine what's actually happen in the environment. But it could still could have a positive effect potentially that makes people think about it a little bit.

Jacquelyn Youde: Yes, and I agree and add to that. That I fear we'd be putting the antibiotics first, the decision to prescribe in front of the decision or the accuracy of

diagnosis. And that's my fear with both of these measures, and we're going to start driving antibiotics as far as coding rather than quality improvement.

Daniel Merenstein: Yes. This is Dan Merenstein. So OME though, you should have no pay, right? You should be relatively asymptomatic with – from pain (device)?

John McClay: It's variable. I mean …

Kathleen Yaremchuk: It depends if it's chronic or not. I mean, don't you agree that sometimes if it's chronic, I mean they can have purulent material but it's – they're just not as much with pain but I've seen it both ways.

John McClay: Yes.

Daniel Merenstein: Because to me, the measure is saying if you're symptomatic free or pain free, you shouldn't give antibiotics more than if you have AOM versus OME. I mean, I think that's the goal.

John McClay: Well, that's interesting because, I mean, I can – I've seen kids with bulging eardrums and they are asymptomatic. And whether or not that kid is going to get better, I mean, you know, the old study show. And even just indicates, you get one day of improvement, if you watch it for several days, it may just get better on its own even if it's acute otitis media. So, you know, that's a good point. And I think in these discussions about if it's painful or not, they just don't allow you to not use antibiotics because the kid does not have any symptoms.

Daniel Merenstein: Maybe the developers then needs to – I mean that's how I read it, that their goal was, look, if people coming asymptomatic, I mean let's try not to give antibiotics. Otherwise, if it's just a diagnosis, then I agree, then I'm not sure what we're debating.

John McClay: But that's the rare kid though that comes in that doesn't have pain with an acute otitis media.

Daniel Merenstein: No, no, I'm saying with OME.

John McClay: Oh.

(Crosstalk)

Charles Bailey: So I think from my perspective as a developer, I think you're hitting a nail on the head, right? In a sense that, you know, this is – in some respect, this is a discussion that sounds like, you know, it's reasonably any discussion of any eMeasure. Now, and that at some point, what we have, you know, what we to evaluate is the documentation that people leave behind them. And so, there is certainly a risk and that there is certainly a misclassification problem in practice. And we were aware of that enough that we didn't try to specify the measure to second guess the clinician.

John McClay: Right.

Charles Bailey: If anything, OME is probably underdiagnosed from available evidence out there. So we specified the measure to say, as the very first, if the clinician has told us this child has OME, then we'll think about the measure.

I think you make very appropriate point that if a measure like this goes into practice, then you know, part of what it may do is write differential coding. It would actually be interesting to know whether that the existing chart review based OME measure has done that. I'm not aware of any public results from looking at the outcomes from that measure.

I will say, and this is certainly at a lower grade, I would be OK with that in the sense that part of what we may be doing here is driving more accurate recording of diagnoses. And frankly, if the net effect of 2640 was to drive utilization in a 2811 where we can actually ask what the – you know, what the appropriateness of the antibiotic you're picking, then that's a positive outcome for me. I mean one of the things that that – quite a few insight here is just in the testing population here, you know. So only in these six centers, eligible business were responsible for 33,000 antibiotic prescriptions. And these are in situations where somebody said this is not a child with acute otitis media. So, I am trying to move the needle a little. But I also am trying to be aware of the fact that it's a very big needle that I'm trying to move.

Kathleen Yaremchuk: All right, any other questions? I'm going to try to keep this moving along so that we make progress.

Joshua Stein: This is Joshua Stein. I'm an ophthalmologist. I'm trying to follow the whole conversation. It sounds like both these conditions are easy – it's difficult for clinicians to distinguish the two based on signs and symptoms. And one of them is appropriately treated with antibiotics and the other is not. Is that correct?

David Keller: Yes.

Female: Yes.

Daniel Merenstein: Well, one's by over treated too, but yes, close.

Scott Friedman: So, and again, Scott Friedman, ophthalmologist. So basically, if you have a bias and you want to treat him with antibiotic, you just code it as AOM instead of OME. And we can't we deal with that with the measure, that's the problem, and that we can have – we can gain the system. But at least if they diagnosed with OME, they shouldn't use antibiotics. If they want to use antibiotics, at least they could do is code it differently.

Daniel Merenstein: Exactly.

Todd Rambasek: This is Todd Rambasek, allergist. Just a question about the, I guess, the big picture. Do we think, I don't know if this is the correct phrase, so lowly about the doctors who would do this, that they would look at an ear, see clear fluid, think it's OME but say, I don't want to give antibiotics even though I know it's not going to help and lie about the code to do that? It seems like a pretty pejorative.

John McClay: Let me answer your question. What happens in clinical practice is you have a nine months old you see or maybe a four months old who has a lot of wax in their ear and you have a busy clinic. So you look in the ear and you think you may see fluid or you may see an infection. It's hard to tell. The kid is crying. He's got a fever. He's got a lot of signs that you would think that the kid has

infection but you're not exactly sure. And to – you clean up the ear and try to do pneumatic otoscopy on that infant. It's going to be hard.

So you would say, in this clinical scenario, I bet he's got acute otitis media, so I'm going to treat him. And I don't think people – if you – unless – so you look at the ear and say, that's clearly otitis media with effusion but maybe it's been there three months and the parents want to do something and then you might do it or – I don't think doctors, you know, are doing the wrong thing just to do the wrong thing. I think there are circumstances where it's easier to treat than not treat.

David Keller: Yes.

Todd Rambasek: You're saying they're getting (in with) the parents?

David Keller: Hello. This is – and this is David Keller. The fact that we used the word treat to be the equivalent of prescribe antibiotics, I constantly reminding my students, we are always treating the patient.

John McClay: Right.

David Keller: Sometimes we watch them with watchful waiting. But the common parlance is, do I treat or not treat. And that drives us to overuse antibiotics. So I think it's actually quite – I think what very often happens is the findings are marginal. And like you just said, people can't decide and so they say, "Well, what's the harm? I might as well call it and then just give the antibiotics." That happens.

Kathleen Yaremchuk: And so I guess the question is though are they also going to be coding it as otitis media as opposed to OME? So that's what we're talking about in terms of reliability. Dan or Tamala, do you have – Tamala, do you have anything to add?

Tamala Bradham: Not at this time.

Kathleen Yaremchuk: OK.

Daniel Merenstein: No.

Kathleen Yaremchuk: Do you think we can now vote? And I'm looking at the screen and there's a 2a1 and then a 2a2. So we're only voting once but it's for both parts of that.

Shaconna Gorham: Yes.

Karen Johnson: And this is Karen from NQF. I just want to make sure everybody is clear about the testing. When the testing originally came in, we did mark as preliminary rating insufficient because we weren't clear. And we actually did work with the developer. And you have the addendum. So the developer did provide additional testing information. So we actually offered an updated preliminary rating for reliability based on that new information in that addendum.

Tamala Bradham: And the addendum – this is Tammy Bradham. And the addendum rating was, as I said earlier, was high.

Kathleen Yaremchuk: And so, is everyone ready to vote?

Shaconna Gorham: All right, voting is open for measure 2640 for reliability.

And it looks we have 10 votes, two for moderate which is 20 percent, and eight for low which is 80 percent, so this criterion is now passed.

Kathleen Yaremchuk: So our next is on validity.

Shaconna Gorham: So actually – and Karen correct me if I'm wrong, because this did not pass the reliability and reliability is a must-pass, we stop discussion on this measure?

Karen Johnson: That's correct. So, as it stands right now, the recommendation of the committee would be not to recommend this measure for endorsement. So we can go on the next measure. I think that would be the appropriate thing to do next.

Daniel Merenstein: Hi. Kathy, I should take over?

Kathleen Yaremchuk: Yes.

Daniel Merenstein: All right, this is Dan Merenstein. I think we already got the background. I don't know if who's leading it. Jacque and Steve, is that right?

Jacquelyn Youde: Yes, that's right.

Daniel Merenstein: Do you guys have any other background you want to add before you go to the evidence?

Jacquelyn Youde: No. Just a reminder that it was based originally on a manual chart review and that we're reviewing an eMeasure for this one is the only thing I would add or flash remind people of.

All right, let's move on to evidence.

Daniel Merenstein: OK, yes, why don't you guys start with evidence? Thank you.

Jacquelyn Youde: OK, cool. So the level of analysis of care is provider department group and institution. Measure 2811 is a process measure based on clinical practice guidelines from the AAP. The systematic review for the clinical practice guideline assess the (QQC) of 48 randomly – or random controlled trials, that aggregate evidence quality was graded as a B.

The committee had about four notes regarding the evidence. One, that is overall high-level of evidence and the process measure relates to the desired outcome. Two, given that the developers state that some practitioners prescribe more expensive antibiotics is an overuse measure more appropriate, for example, looking at patients that are unnecessarily treated with more expensive antibiotics. Number three, are there any updated guidelines, for example, recommending amoxicillin except for children that are in the day care and each will resistant an organism. And one of the weaknesses in the evidence is that the antibiotic treatment is associated with revolution effective one day sooner when compared with patients who do not receive treatment. Alter an evidence section here over for discussion and voting.

Daniel Merenstein: Any questions from the committee? I have a question. This is Dan Merenstein. Did we figure out if it's just amoxicillin that counts? And what if it's penicillin?

Jacquelyn Youde: That's a great question for the developer. I have that down in the measurement section, but we can start and discuss it now.

Daniel Merenstein: All right, and maybe I'm jumping ahead.

Charles Bailey: Sorry, I heard about half of the question. I know it has to do with amoxicillin and penicillin, but I'm not sure what the question was.

Daniel Merenstein: Is amox the only medicine that counts as accepted? Or what if you had penicillin?

Charles Bailey: We allowed penicillin. That's not highly used, but we permitted it.

Daniel Merenstein: So those are the two drugs?

Charles Bailey: Yes.

Daniel Merenstein: OK. Any other questions about the evidence behind it?

Steven Strode: This is Steven Strode, a family physician. I've got a follow-up to that. There was mention in the previous measure about amoxicillin (inaudible). Was that expressly excluded?

Charles Bailey: It's excluded here, yes.

Steven Strode: OK.

Tamala Bradham: And this is Tammy Bradham. Is there in the – this maybe underneath reliability. Do we have allergens, like if they're allergic to it, is that part of the exclusion?

Charles Bailey: So it's not. And it's not because – in a nutshell, it's not possible to rely at the assessed allergies in an eMeasure. In particular, the exclusion criterion is a type one hypersensitivity reaction to penicillin. And that the degree through

which discrete electronic health record data captures both the allergen with specificity and the reaction with a non-specificity to determine that is a type 1 hypersensitivity reaction. It's two variables between EHR products. And frankly, to refer back to some of the discussions in the prior measure, it's also two variable between clinicians.

There is a reasonably solid literature out there that pegs the true allergy (rig) to penicillin and amoxicillin at about 5 percent of the population. That's if you look in specific systems where we can tailor our analysis to what people record, that's consistent with what we see. But it's not the kind of thing we can specify an eMeasure because it, essentially, it requires you using a part, you know, whether rash is different from rash with some lip swelling, is different from wheezing.

So we – our judgment was that this was more – that was more appropriate consideration for setting the performance target for the measure up than it was for exclusion in the measure.

Tamala Bradham: Thank you.

Daniel Merenstein: But unlike last time, when you said the goal was 100 percent, I assume the goal is lower then.

Charles Bailey: It is, right. The goal has to be lower here because, first of all, we expect about 5 percent allergy in the population. And second of all, again, apropos of our prior discussion, our expectation is that the bias for gray zone cases is going to be towards acute otitis media. Again, we find lower performance and a slightly lower performance but reasonable.

We are also specifically trying to avoid the prescribing physician in this measure because, again, that's hard to do as an eMeasure. It's not something – I would actually argue, you couldn't do this as a chart review measure either. It's very hard to construct the measure that is sitting on the shoulder of the clinician as she looks into that ear and, you know, and trying to decide should you really prescribe antibiotics for this child? Is their pain serious enough? Was that enough for the fever?

And so, essentially, what we're saying here is, again, without second guessing the clinician, if you decide to prescribe antibiotics, the clear evidence-based guideline is that amoxicillin is the correct antibiotic to prescribe unless the patient is allergic.

Daniel Merenstein: All right, is there any other question? I think we can vote on the evidence before we go on to gaps.

(Off-Mic)

Shaconna Gorham: All right, voting is open for measure 2811 on evidence.

I think we're still missing a few votes.

So we're still missing two votes.

One more vote. We're missing one vote.

(Sheila): If you're having difficulty voting, you can either refresh your screen. Or if you'd like, you can send your vote in via the chat.

Daniel Merenstein: Can you guys reset? And maybe everything thinks they voted, and we're going to vote one more time?

Jacquelyn Youde: Just make sure that box is checked.

Daniel Merenstein: All right.

(Sheila): Yes, you can, and you can. If you voted once before, you can check the box again, it won't alter the total. The numbers will settle.

Daniel Merenstein: Maybe we lost somebody.

Male: Can you e-mail the person who's not responded?

Daniel Merenstein: Shaconna, can you tell who doesn't respond?

Shaconna Gorham: I can't tell, but we're working behind the scene.

(Sheila): Steve, is the box checked on your connection?

Steven Strode: Yes, ma'am.

(Sheila): OK.

Daniel Merenstein: There you go.

Shaconna Gorham: I think we have it.

Kathleen Yaremchuk: There we are.

Shaconna Gorham: We have …

Daniel Merenstein: Jacque, if we can go on to the gaps?

Jacquelyn Youde: Yes.

Shaconna Gorham: So before we do that, let me just for transcript purposes. So we have seven committee members who voted high, so that is 70 percent, 30 percent which is three standing committee members who voted moderate. So on evidence, this measure passes.

Jacquelyn Youde: Great. So let's move on to opportunity for improvement. The rational for this measures is that AOM, the highly (probable) condition is major driver of outpatient healthcare and antibiotic utilization.

For this population, the test population, that they looked at acute otitis media occurred in 17 percent of the test population. This is not of America, just of the test population. Otitis media is the most common condition for which antibiotics are prescribed to children. And the cost to treat otitis media in the U.S. is approximately $2 billion.

For the performance gaps, the developer reports the measure was initially tested on in just over 106,000 encounter records from EHR from 2009 to 2014. For the providers, specifically (evaluating the N1623), so only 418

providers have decide qualifying visits that were included in the analysis from what I can tell.

The mean failure rate for providers here was approximately 1/3, exactly 34.8 percent, indicating that in approximately 1/3 of the example, that providers did not prescribed the appropriate antibiotic. In my interpretation of that, I'd some clarification from the developer. Does that mean that they did not prescribe the appropriate antibiotics or that they did not prescribe an antibiotic at all?

Charles Bailey: It means that they prescribed an antibiotic and it was not the appropriate one.

Jacquelyn Youde: OK, thank you. The trends continued with specialties with specific evaluation where the mean failure rate was, again, 1/3.

For the disparities, the type (grade) testing identifies statistically significant small differences in provider level performance, stratified by race and ethnicity, and an individual's performance based on insurance information, however the specifics were not presented.

The comments from the committee show that that preliminary rating for the improvement is high. Another comment surrounded the priority that immunizations have decreased the incidence of otitis media, so is this still a high priority? And another question around the mean failure rate, what happened in those failures? Were they – and how does the failure rate impact the target of 90 percent?

So, I think maybe if we continue on the developer – with the developer on how does the failure rate impact the target on this measure and what happened in those failures? Was there any failure rate analysis when they go back to the priority discussion?

Charles Bailey: Sure. So we looked at failure rates in a sample of charts, you know, to provide some, you know, improvement to discriminate. And what we found was consistent with national estimates. There's about 5 percent rate of allergy that were not speaking. There was, I believe, one case of an alternate infection that was not documented. And otherwise, it appears that we're

seeing broad spectrum antibiotics prescribed for otitis – acute otitis media. And that's not a surprising observation to us. There's a sort of broad literature out there that documents just using both claims data and records review.

Jacquelyn Youde: Great, thank you.

Charles Bailey: Sure.

Jacquelyn Youde: And then so our second comment was around immunizations have decreased the incidence of otitis media. So is this still a high priority? I'd love to get the committee's thoughts on that or any other discussion around this.

Daniel Merenstein: Can you repeat that question? Sorry, Jacque.

Jacquelyn Youde: Sure. The immunizations have decreased the incidence of otitis media, so is this still a high priority?

John McClay: This is John McClay.

Daniel Merenstein: Oh sorry, go ahead.

John McClay: I would say, anytime you can reduce the amount of antibiotics given as the high priority, I mean in acute otitis media, I think it's still the most common diagnostic goes for a young child with a fever for antibiotics. So even though I know that there was question about the incidence and we haven't clearly stated that – I mean, and clearly, it's a little – it decreased over the last decade but that doesn't mean it's still not significant.

Daniel Merenstein: Yes, that's what I was going to say. I have a question about gaps. Do you have a difference between family docs and pediatricians for this?

Charles Bailey: This (inaudible) in pediatric centers, I actually don't know how many family docs are there. We don't have information on the specialty certification of the providers.

Daniel Merenstein: Oh, but these are generally pediatricians?

Charles Bailey: It'd be more common. We can identify the otolaryngologist generally because the hospital captures the clinic I.D., but I couldn't tell you who in the general pediatrics clinic is a pediatrician and who is a family doc.

Daniel Merenstein: All right. But if it's from general ped clinic, it's probably general peds, all right. So actually the data might be from (inaudible). OK.

John McClay: Did Children's Hospital of Philadelphia by practices, so these are community physicians that are associated with the hospital?

Charles Bailey: So in the child case, yes. Across the six sites that we tested, there's a mix of community practices that were – networks. Academic practices, that exists for resident training and specialty practices.

Oh, I'm sorry, and I also missed this category of community practices that are remote from the site but part of a network.

Scott Friedman: Yes. OK. So this is Scott Friedman again, ophthalmology. So the mean failure rate, and this one is 35 percent, I have it right. So it's not that the docs weren't prescribing an antibiotic. It's that they were prescribing a more expensive antibiotic. So now, my point which I said before was, should this be an overuse measure of prescribing a more expensive antibiotic, getting to the fact that that's more costly and we're trying to reduce cost? Presumably, the ones who prescribed the more expensive antibiotic still got better.

Kathleen Yaremchuk: Right. And I guess the other question is we don't know that it's more expensive. I guess we're assuming that amoxicillin is the least expensive. All it means is they prescribed a different antibiotic.

Daniel Merenstein: Yes. Well …

Scott Friedman: Yes, but if it's not more expensive, what's the – for the non-pediatricians or family practice, what's the downside for that?

Charles Bailey: Well, the …

(Crosstalk)

Male: … resistance to …

(Off-Mic)

Scott Friedman: Resistant organism, obviously. So you're trying to reduce the problems of resistant organisms.

Charles Bailey: Yes.

Scott Friedman: And possibly decrease the cost. So, either way, should this be – should the measure be awarded differently, saying inappropriate use of an antibiotic, of a non appropriate antibiotic, something like that.

David Keller: This is David Keller. I was going to say exactly that, that it's both and it may be a cost reducing measure although there are generic forms of most of the alternative antibiotics that are not a lot more expensive than amoxicillin. But the more – to me, the more important issue is that the one of antibiotic resistance, which I think – so I don't think you could say that this is an – it's an overuse measure in that sense, but it's really trying to drive the reduction of resistant organisms.

Charles Bailey: The final thing I'll offer from the developer's perspective is that most of the alternative antibiotics are also associated with higher rates of antibiotics associated diarrhea. And that's another complication we're trying to reduce.

Daniel Merenstein: Amox has a pretty high rate of antibiotic (inaudible).

David Keller: Especially at the high dose.

Daniel Merenstein: Yes.

David Keller: Where we need to dose it lower …

Daniel Merenstein: One of the higher ones.

David Keller: Yes.

Daniel Merenstein: Much more than like a Z-Pak.

Charles Bailey: Yes, certainly. Certainly, the few groups I was thinking of were …

(Off-Mic)

Charles Bailey: But yes, not so much (azithromycin).

Daniel Merenstein: Any other questions about the gaps or can we vote on gaps?

David Keller: Along that line of what's just been mentioned, a question for the developer under the developer rationale, towards the bottom of that paragraph, it says antibiotic "side effects". I'm wondering what's being communicated there by the addition of the quotation marks, so possible side effects, maybe side effects?

Charles Bailey: What do you mean, by the use of the quotation marks rather than simply stating it?

David Keller: Yes, sir. Yes, sir.

Charles Bailey: Got it. There wasn't an agenda behind that. We were just trying to capture the term that people were using. And essentially, if I'm doing anything, avoiding the debate about whether things like diarrhea or alterations in calorie absorption or things like that are side effects or anticipated effects of antibiotics.

David Keller: OK, thank you.

Charles Bailey: Sure, no more agenda from that.

John McClay: And in the denominator, you are including that you haven't had a prescription in the past 30 days.

Charles Bailey: Correct. So you're not evaluated if there's been a prescription in the past 30 days because that constitutes an indication for a broader spectrum antibiotics.

John McClay: OK.

Joshua Stein: This is Joshua Stein, ophthalmology. Did you – did someone say that over $2 billion are being spent necessarily on antibiotics for this condition? Is that correct?

Charles Bailey: So the total cost of antibiotics is about $2 billion. I think I would be a little unfair if I said all of them were unnecessary. That, you know, it's just that there's debate as to what is or is not necessary. But that's clearly the cost.

Joshua Stein: So then there are must be a – well that includes both the appropriate and the inappropriate antibiotics?

Charles Bailey: I believe so.

Joshua Stein: OK.

David Keller: I thought the $2 billion in healthcare included the cost of the visit and all that too. Is it just the antibiotic itself? I thought it was the total cost of just the diagnosis?

Charles Bailey: Yes, it's just the cost burden of the condition, OK. So it's the cost, the valuation, their antibiotics with (that) or otherwise, follow-up visits …

(Off-Mic)

Charles Bailey: That sort of thing.

David Keller: Right, so it's not just the antibiotic itself. You're still going to have the visits, potentially follow-up, and all those other things.

Daniel Merenstein: And just to be clear, sorry, maybe that you said this I think. But if they decide not to give antibiotics, they don't get punished with this measure?

Charles Bailey: Correct. Again, that fell into the class of things that we felt an eMeasure couldn't capture. That there's too much clinical judgment involved in deciding whether a particular patient needs antibiotic therapy. So there's no penalty if you don't prescribe an antibiotic.

Daniel Merenstein: That's good. I did get that. OK, perfect. Can we now vote on the gaps? Are there any questions?

(Crosstalk)

Shaconna Gorham: OK, voting is open for measure 2811 for gap.

Again, we need one more vote. OK.

So we had seven votes which is 70 percent for high and three votes for moderate. So the measure passes on gap.

Jacquelyn Youde: Great. All right, let's move on to reliability. This measure specifies for providers, department groups, and institutions. The numerator of this measure is eligible encountered at which patients were prescribed amoxicillin in conformance with the AAP/AAFP recommendation that this drug be the first-line antibiotic choice for AOM. This is something we covered that the developers only listed amoxicillin, but it sounds like there's – we need to include penicillin and possibly Ampicillin in that statement.

So then, will the numerator need to be updated with all of the included meds as they only say it's amoxicillin at this point in time?

Charles Bailey: So I am – from developer's perspective, I'm happy to approach it either way, we then discuss the medications we permit or we can adjust the definition of the measure. We allowed penicillin essentially because it was hard for us to justify its harm in the face of penicillin prescription, whether that's appropriate. Or otitis media is another question, most people would probably say no. But you might prescribe it at a – to a patient who has a clear pharyngitis and a questionable otitis.

Jacquelyn Youde: So, is everybody OK with the numerator statement as it stands or would you prefer to have it updated with the – with penicillin and ampicillin?

Daniel Merenstein: I thought it – so it doesn't say it but it's implied? I mean I think it has have (process), penicillin has to be allowed.

Charles Bailey: Great. We're happy to update the statement.

Daniel Merenstein: Yes, I think it has too, right? I mean that's …

Jacquelyn Youde: Yes, but clarity.

David Keller: Yes, for clarity, you do. Although I have to say that number of people would prescribe either penicillin or ampicillin in these days is – are probably very few.

Charles Bailey: Yes. I would be – if I had my choice here and I'm not, you know, hardly – on variation what committee has to say, I would happily add penicillin because it's the recommended antibiotics for frequently co-occurring condition. As you point out, ampicillin is vanishingly rare, particularly oral ampicillin, right? I.V. ampicillin is not that uncommon but that's not what this measure is targeting.

Daniel Merenstein: Yes, I don't have strong feelings about amp, but I have never seen that prescribed. But penicillin I feel like used a lot in strep. So I would imagine it's used by some people for, you know, an other cases and otitis media.

David Keller: Well, the more – it would more be – actually more be the case that you have a concomitant strep throat, you gave them penicillin, you saw that otitis media but decided you didn't need to add them amoxicillin for some reason or change it to amoxicillin because you were engaging in watchful-waiting as far as the ear goes. But yes, it could happen.

Jacquelyn Youde: So this is a question for NQF and our committee leaders. Can we continue with the measure as it's stated and make a note like the numerator needs to be updated? Or, how do we proceed?

Karen Johnson: So, this is Karen. Yes, and really what happened is in one place in the submission, all three were mentioned, in the other place, only the one was mentioned. So it's really just a matter of having Dr. Bailey go back in and make everything consistent.

Jacquelyn Youde: OK, great. Well, let's move on to the denominator. The denominator is all patient ages two months to 12 years with a diagnosis of AOM, an antibiotic prescribed at the current visit, and no antibiotic prescription within the last 30 days. Denominator exclusions are diagnosis of alternate, co-occurring infection for which antibiotics are typically indicated.

Of note, in the opportunity for improvement analysis, there was a minimum of five encounters necessary to be included in the analysis. I don't see those five encounters presented here. And I need a little clarifications of are the five encounters necessary to be included or how does that factor in since that was part of the analysis?

Charles Bailey: From the perspective of the analysis, we did not examine anyone with fewer than five measures in our overtime analyses mostly because the hysteresis and score become – dominates there. So your signal to noise ratio or your discriminate ability really drops.

We had a conversation with NQF staff about this during the testing. I think we would be happy to say that a four of five visits is appropriate for application of the measure. One's ability to detect differences over time at a lower threshold becomes, you know, much more difficult.

Jacquelyn Youde: OK.

John McClay: So is – so you're saying the provider – this is John McClay. You're saying that provider had to have five visits in which they saw a child with acute otitis media?

Charles Bailey: Right. But actually it doesn't include – exclude many providers because of the high prevalence of the disease. And our concern is that if you have fewer than five visits, then your score gets very quantized. You know, at four visits, it can only be a 0, 25, 50, 75 or a 100.

John McClay: Right. Yes, that – and you're not going to find that very often unless you make your time period half of, you know, a morning clinic.

Charles Bailey: Right.

John McClay: So.

Charles Bailey: Right. We had kept the measure definition open to – hoping for inputs. But I think it makes all the sense in the world here there's, perhaps, a little more debate about what the right threshold would be for OME because it's a less common disease. But you're really not changing the population you evaluate here in a significant way.

David Keller: Yes. This is David Keller. Thanks for clarifying that because I was thinking you were talking about five visits for the patient not for the provider. That makes sense for us then.

(Crosstalk)

Jacquelyn Youde: So that also begs the question of timeframe. And this might be the difference between collecting information and recording on information. So, the timeframe is not currently specified for the developer to allow analysis over any interval and that any timeframe plus that these remain consistent in the numerator and the denominator.

Are we looking at reporting intervals or collection intervals? Because one concern I do have about not specifying that interval is we could start saying, "OK. Well, let me look back over time and report it once," and that's reported twice. And we don't necessary see the changes in behavior, that we don't necessarily see patterns. We're just looking at such a large number that it's just the rates.

Does anyone have any comments around timeframe either?

John McClay: You know, I'm not sure if, John McClay again, if the measure should stay at timeframe. Certainly, when people apply the measure, then they can try to decide on a yearly or a monthly basis, you know, what change there is, people just utilizing the measure, institutions, or whoever is going to use it.

Jacquelyn Youde: Yes.

Charles Bailey: And also, from our perspective, we were a little reluctant specify a timeframe because we think it's context dependent. You know, if the use is across entity benchmarking, then the longer your timeframe, the higher your – and the greater your discriminate ability. On the other hand, if you're used with tracking a quality improvement initiative, you know, then you want a long enough timeframe that you actually expect to see the impacts of change. But I didn't think it would help to try to constraint it to a very long timeframe solely for the sake of reliability.

Jacquelyn Youde: We'll keep going. The measure was tested on data from six academic health systems, which use three different EHR vendors, Epic, Cerner, and a combination of Allscripts' and an institutional Emergency Department system. The data included records from January 2009 to June 2016 and included information for about 2900 clinicians and 186 practices. And patients with at least one evaluable visit were included. The demographic showed patients were mostly white male, ages 0 to 2 years old, and the full details are provided in section 2a2. And the updated reliability testing provided in the addendum shows that the measure is reliable and significant and the preliminary reading for this measure is high.

The comments from the committee and the comment is generally agree that the measure can be consistently implemented. The commenters generally agree that reliability is high. And the commenters note that the test size is adequate. Yes, there is some concern about generalizability, all testing being done in academia. There is some concern about target rate. The developer's note that the target rate will be about 90 percent due to design and the design is for large scale use. They won't account for individual patient characteristics.

Patients with drug hypersensitivity prior response of AOM to antibiotics, co-morbidities, requiring changes in the antibiotic selection, an additional consideration in patient preferences, for example, location occurrence may opt not to treat with antibiotics when they learn that the benefit is just simply 24 hours.

And there is also some concern about after diagnosis, there is known problems regarding diagnoses that we've discussed – for the other measure. And I would turn this over for committee discussion as that summarizes reliability.

Daniel Merenstein: Any questions about that guys? Any comments?

Thank you for doing that very thorough. I guess we should vote then?

Shaconna Gorham: Right, voting on reliability for measure 2811 is now open.

We need three more votes. No, I'm sorry, one more vote.

OK. So we have 50 percent for high and 50 percent for moderate, so the measure passes on reliability.

Daniel Merenstein: Shall we go on the validity? All right, feasibility, sorry.

Shaconna Gorham: Yes. They're loading, you're right.

Steven Strode: This is Steve Strode, I'm supposed to take that. I did have one question on the eMeasures. That one point and it may have been clear that by the additional information supplied by the developers. That at one point, it said that there was only one EHR used and that the NQF requires testing for more than one EHR. At another point, it said there were three different EHRs, which seems to be three for Children's Hospital of Philadelphia.

(Crosstalk)

Charles Bailey: Yes. I'm sorry. So I think we inadvertently created some confusion for which I apologize. We developed the measure against the single EHR, and so the chart review portion of (right) testing was in that EHR. The population level testing was done against six sites, six institutions or networks, three EHRs.

Steven Strode: OK, thank you.

Charles Bailey: OK. We reported some of the development specifics because it's not there.

John McClay: This is John McClay again. I have a quick question, that you mentioned that the denominator excludes concurrent other infection that would require antibiotics. And the guidelines talked about concurrent purulent conjunctivitis. Would this be one of those infections that would then take them out of the denominator?

Charles Bailey: Hypothetically, it would. In practice, it's not diagnosed. So at least in these six networks, looking at the diagnosis that we see, it doesn't show up with any appreciable frequency, which is, again, not tremendously surprising to me in the (HIP) era, you know, when the overall prevalence of purulent conjunctivitis and facial cellulitis has taken a nose dive.

John McClay: Right. I thought it was – I guess maybe it's just the age of the guideline that was created, that that's actually mentioned specifically in the guideline, purulent conjunctivitis. And I didn't – and maybe ophthalmological colleagues can – but it's not like – like you mentioned, what is the actual incidence of that. It sounds like its dropped significantly.

Daniel Merenstein: I'm sorry. What was the question again about conjunctivitis?

John McClay: What's the incidence of purulent conjunctivitis in a child who's somewhere between two months and 12 years of age?

Daniel Merenstein: Ah Josh, are you still on the phone?

Joshua Stein: Yes, I'm on the phone.

Daniel Merenstein: So we don't do pediatrics. I do retina and he does glaucoma So I think it's – I do some general stuff. I think it's pretty small but I – to be telling you honestly, I don't do that for a living.

John McClay: Got you. OK.

Joshua Stein: I mean it's certainly not as common as, you know, the "pink eye" which is viral conjunctivitis. But, I mean, it's not unheard off I would guess, you know, just from, you know, doing analyses with claims data and whatnot.

Sometimes it's difficult to distinguish bacterial, and viral, and allergic conjunctivitis from one another without, you know, formal testing.

David Keller: Right. This is – and this David Keller again. And again, general pediatrics, it's not uncommon at all. It's actually, you're correct, it's our ability to distinguish viral from bacterial conjunctivitis is tampered by the need of daycare centers for treatment notes that they say may won't let the child back into either school or daycare unless they have been treated for what the school nurse or the daycare provider perceives as bacterial conjunctivitis.

John McClay: Right.

David Keller: Try to get accurate data about how prevalent it truly is, is complicated.

(Crosstalk)

Daniel Merenstein: Right. So, just to reiterate, I agree with Josh, that probably bacterial conjunctivitis is very rare and viral conjunctivitis is over treated inappropriately with antibiotics.

(Crosstalk)

David Keller: It's driven by institutional needs. He says …

Daniel Merenstein: Correct, and a variety of other …

(Crosstalk)

Daniel Merenstein: Correct.

David Keller: Yes, he has pediatric colleagues. I mean I have so many daycare centers that won't let the kid back in unless I write the prescription.

Charles Bailey: Again, this is truly a very murky lens because we have the sort of coding biases of prescribers to account for. But I will say, we looked in the data and 1.6 million diagnoses assigned at visits where there was acute otitis media, about 2000 had a code that was likely to be a bacterial conjunctivitis. So the rate is 0.1 percent.

John McClay: Perfect. Thank you.

Daniel Merenstein: Are there …

David Keller: OK, one think I'd like to – I'm sorry, go ahead.

Daniel Merenstein: No, go ahead, go ahead. I was trying to move forward, but go.

Steven Strode: Oh, all right. In view of the discussion that we've had on a previous measure about being able for clinicians to differentiate between acute otitis media and otitis media with effusion is that we'll throw out to the committee is that also an issue for this measure. The difference here is I guess if we assume the diagnosis of acute otitis media is correct, the measure has been looking at what antibiotic is prescribed.

Charles Bailey: That's essentially the performance characteristics we were after. I mean, and in this case, essentially, what we're doing is using the diagnosis of otitis as a way to calibrate on the appropriate antibiotic.

So again, I'm – we're not in the measure making the assertion that the clinician got the diagnosis right. We're simply saying that's the reason they told us they were prescribing the antibiotic.

Steven Strode: OK. And in terms of the population of the clinicians, there are different groups but within one academic health center. I've heard that some of those providers would have – tend to be employees or affiliates of the academic health center, although they'll still not be located in what was originally the private factor. But the question that was raised in the comments is can it be extrapolated outside of academic health system?

Charles Bailey: So, I will say that the testing that we're presenting is within practices that are at least affiliated with an academic medical center. I think they are legitimate questions as to the degree to which those physicians to those practices represent the behavior of unaffiliated practices, which are responding to different community and commercial and educational pressures.

What literature is out there tends to put appropriate prescribing rates at a higher number in academic practices than it does in the community. So the expectation here would be that these results will over estimate performance in the general case.

Steven Strode: Thank you. You mentioned that the patient population was not analyzed in terms of race and gender and so forth. But in terms of generalizing from the study patient population, how much variability is there among all of those 26 signs? Is it all urban, urban and suburban, or there are even some rural (emphasis) that are included?

Charles Bailey: Yes, that the large majority are either urban or suburban. There are – yes, I should leave it at that. There are some practices that are in a more rural area, but the large majority are urban or suburban.

If you look at section 1.6 in our testing attachment, we did try to give you a network-to-network look at least ethnic differences. And so, you know, you can see that we have some variation from site to site in the contribution of different ethnic groups. We don't report Hispanic ethnicity here. There are also significant variations there. The concern is that there are some reason to think that capture of Hispanic ethnicity is even less accurate than health system capture of race. But in general, we have 15 percent patients who are identified by the health system as Hispanic, however they would identify themselves.

Steven Strode: Thank you. Any question from the committee?

Daniel Merenstein: Any question about validity?

Steven Strode: The developers, I want to thank you for responding to the request for additional information. One of those elements under validity is in using the S statistic. And I will (beg) ignorance on that and welcome any comments from the developer or members of the committee as to the applicability of that to the validity of this measure.

Daniel Merenstein: Yes. The developer – anyone from NQF want to answer that?

Karen Johnson: I'm sorry, can you repeat the question?

Steven Strode: Sure. With the additional material supplied by the developer, there was concern about the appropriateness of ANOVA testing and what the developer supplied in the additional material under validity includes the year or year (death), this included statistic. And I'm not acquainted with that. I'm just hoping somebody else was or is.

Charles Bailey: Fair enough. So, from the perspective of the developer, we would be happy to discuss alternative testing. It's essentially – I think there are variety of ways that we might have approached this statistically. The underlying goal of the analysis was to demonstrate a set of conditions in which there is expected variation and a set of conditions in which there was less of an expectation of variation, and then you use a test of variation to test that hypothesis.

We're not asserting that one way, ANOVA and an S statistic is the be all end all of, you know, of models that one might use here. Simply, that it was an approach that you could take to address this particular hypothesis.

Karen Johnson: And this is Karen from NQF. Just to amplify a little bit, the developer actually did some interesting, what we call data element testing that, you know, we did pull out in the preliminary analysis. The only problem with it in terms of NQF requirements is that it was based on just the one site with the one EHR and our requirements are that they have to use more than one.

So what that means is the data element testing that was provided can't standby itself. So, we really needed to look also at some additional score level testing. And in the original submission, the score level testing that he did, the method we thought was appropriate using the ANOVA over time. So, we just had questions about the way that the data were aggregated.

So actually when they came back with additional testing, Dr. Bailey actually did a little bit different thing where his hypothesis was that there would be less variation over time within providers than across providers and was able to show that.

So as Dr. Bailey mentioned, you know, doing score level validation, there could be a lot of different things that you could look at. This is what he chose to look at. I know he actually has done a few other things and he's thinking about a couple other things that are kind of interesting, but this is what he provided for us today.

Steven Strode: Thank you. One other concern before we move on under 2b7 missing data, there's a chart and medication standard code missing this, very useful word, new to me is 10.5 percent. And if the developer can you comment on that? All the other numbers are quite low.

Charles Bailey: Sure. So the – we looked at a number of ways to represent medication. The name of the drug, there are vendors specific codes, so statistical practice in EHR operation versus a coding system from one of three of information vendors that you use to manage your provider order entry and pharmacy inventory. And then the third level of coding that we looked at was the standard of – let's try that again, standardized medication code. So, RxNorm, which is the vocabulary that the OMC specifies as the standard for health data interchange.

What we're indicating here is that we have about 10 percent missing in that last level of code. So, for measure testing, we simply stepped up to the vendor codes in order to get data capture, but we wanted to record that miss – that degree of missing this in order to give people the most available information, excuse me, on (evaluability) if you were to be doing this based on, for instance, health information exchange data.

The impact of this particular item being missing on the measure would be to render visits ineligible. So, it's not going to produce an erroneous visit score. It's simply going to cause you the undercount eligible, otherwise, eligible visits.

Steven Strode: Thank you. Before the additional information was provided, the preliminary rating for validity was insufficient. After that material was received, the preliminary rating for validity changed to moderate. And for us, we're ready to vote.

Daniel Merenstein: All right.

Shaconna Gorham: OK.

Daniel Merenstein: The voting is up. So thanks.

Shaconna Gorham: The voting is open for measure 2811 validity.

(Off-Mic)

Daniel Merenstein: All the votes are in.

(Crosstalk)

Shaconna Gorham: So the measure passes on validity.

Daniel Merenstein: You want to read it out loud or can we go on?

Shaconna Gorham: I'm sorry, I must not – can you hear me?

Daniel Merenstein: I can hear you now. I can hear you before.

Shaconna Gorham: OK, yes, the measure passes on validity.

Daniel Merenstein: All right.

Shaconna Gorham: That's 10 vote moderate.

Daniel Merenstein: Steve or Jacque for feasibility.

Steven Strode: Yes, under feasibility, usability, and use, there certainly are potential arms with utilizing inappropriate antibiotic as we've already discussed potential harms by driving the selection that amoxicillin are smaller as I think we've also discussed. The preliminary rating is recommended as moderate, and obvious, to open it up to any questions here that the committee might have under feasibility.

Daniel Merenstein: Any questions? It seems pretty straightforward, but any questions, please.

We vote on it? Everyone's OK?

Shaconna Gorham: Yes, no more conversation, we can vote on feasibility for measure 2811.

OK, we have 10 votes. We have 20 percent for high and eight votes 80 percent for moderate. So the measure passes on feasibility.

Daniel Merenstein: All right. Usability?

Steven Strode: Again, in the interest of time because I know we're running to a bit over. I would just defer to the committee for any comments that anyone wants to make?

Daniel Merenstein: Yes. I mean, I hear one of the comments were that people could code differently to use different antibiotics but I don't think that's as much as (emphasis) for OME.

David Keller: This is David Keller. I think the difference here is because we're talking about acute otitis media, there are visual cues that drive that. And while there can still be argument over whether those were there, it's less subtle than trying to diagnose an effusion.

Daniel Merenstein: And also, I agree, we're not punishing them for prescribing antibiotics, different than OME.

Charles Bailey: And in some respect here, from the design perspective, the presence of the antibiotic is reinforcing the diagnostic code.

Daniel Merenstein: Yes. Any questions about that? Then I guess we should vote.

Shaconna Gorham: All right, voting is open for measure 2811 for usability and use.

All right, votes are in. We have four for high and six for moderate, the measure passes on usability and use.

So there is one more vote that we need to take and that is the overall suitability of the measure, if we can have that voting slide. Oh, that's OK for the endorsement.

Karen, do we need to discuss endorsement for us?

Karen Johnson: No, we will put that off.

Shaconna Gorham: OK. So voting is open for the overall suitability for endorsement for the measure 2811.

John McClay: This is John McClay. Can I have a question real quick? When we, overall, want to endorse this, are we endorsing a percentage of excess rate? Like …

Karen Johnson: This is Karen from NQF, no. There is – no, it has no bearing on what might be a benchmark.

John McClay: OK.

Tamala Bradham: And this is Tammy Bradham. Are we voting on this as it is written because it doesn't include penicillin?

Karen Johnson: Well, I believe, technically, what I think I heard and Dr. Bailey can correct me if I'm wrong. But I believe it will actually include penicillin and amoxicillin and the other one that I've forgotten. But all three of those are actually included. It was just a – it was a matter of just being inconsistent in the submission materials and he'll fix that.

Tamala Bradham: OK, thank you.

Shaconna Gorham: OK. Voting is open for overall suitability for measures 2811. One more vote. One more vote.

Can everyone vote again just to make sure we captured your vote?

(Crosstalk)

Karen Johnson: Shawnn, can you look at that, and yes, can you check to see? We're only seeing nine votes on our screen.

(Shawnn Bittorie): I'm already checking and let's see.

Steve, can you touch your selection for me one more time?

Steven Strode: Sure. It seems to be working but I'll be glad to revote.

(Shawnn Bittorie): Thank you. And Scott, can you make sure your box is checked as well, please?

Scott Friedman: Yes, mine is working. I checked it three – checked it off three times.

(Shawnn Bittorie): OK. At the moment, the reporting is not showing me anything else. I apologize.

Scott Friedman: Isn't nine qualified as pass there?

Karen Johnson: No we actually need 10 votes.

Scott Friedman: Oh, you need 10.

(Shawnn Bittorie): Yes, we need 10.

Karen Johnson: Just technically, we need 10 for quorum.

Scott Friedman: All right.

Karen Johnson: Shawnn, can you tell if 10 people had voted?

(Shawnn Bittorie): Well, I do see names on the report.

Karen Johnson: Jacque, do you have a check next to your answer?

Jacquelyn Youde: I do. I have checked it and unchecked it three times as well and it says, check yes.

(Shawnn Bittorie): OK.

Jacquelyn Youde: In case anybody wanted to know what I voted.

(Crosstalk)

Karen Johnson: All right, bear with me one ...

(Shawnn Bittorie): OK, can you just ask anyone if they say no?

Karen Johnson: Yes, I think that's probably how we need to go with this. Would anybody care to share either publicly or via chat if you said no instead of yes? Oh there we go, we got 10.

(Shawnn Bittorie): There, we got it.

Karen Johnson: All right. Thank you.

Shaconna Gorham: Right. So this measure passes and the committee is recommending endorsement for this measure 2811.

Daniel Merenstein: So I think we pass it on to Karen now?

Shaconna Gorham: We pass it on to Karen. We have about eight minutes or so. I'm not quite sure how far we'll get into the harmonization discussion, but we can start.

Karen Johnson: Sure, and let's just go to our next set of slides. So this actually will probably be a very short discussion, simply not only because it's time but just a reminder. When we have measures that come through that are similar, either in the numerator or denominator or both, we want to have a discussion about is there ways that maybe measures are differing that we may want to provide recommendations for alignment. So with that, let's get to the next slide.

We had actually teed up three measures along with the OME measure today to discuss in terms of harmonization. Now, technically, you guys have not recommended the OME measure, the 2640 measure today for endorsement. So technically, we do not really need to have this discussion. However, I will point out, let's go to the next slide.

Charles Bailey: From the developer perspective too, one of the things I would love to learn from the committee is if we can have a few minutes of time. I took away from the discussion that, essentially, we were deciding that otitis media is too difficult a clinical entity to measure. And so, if I'm getting that wrong, I would love to learn by this harmonization discussion, what characteristics you

think we should focus on or whether where we are trying to measure something from the past? Thanks.

Karen Johnson: And this Karen. And it's actually something that we wanted to make sure of as well. One of our – a little bit of difficulty that we'll have to think about is we do have a currently endorsed paper measure for otitis media, pretty much the exact same thing, only paper measure not any measure. So if a couple of you would potentially try to answer that, we can revisit this discussion on our post comment call, but we have a couple of minutes, so we could open it up.

Daniel Merenstein: This is Dan.

Male: Yes …

Daniel Merenstein: I mean I thought the paper that was presented by Tammy to begin was in the thing that it was pretty convincing. And just from my clinical anecdotal, yes, I think it is a difficult diagnosis to make. And I think partly was the diagnosis and partly that I think that physicians were just going to be – were too bright and would understand how to code and make the first one not really worthwhile. That's my thought.

David Keller: Right, this is David Keller. I think it was really – it's also a limitation of using coding as the – as accurately reflect – how accurately coding actually reflects our clinical impression. And sometimes, the coding, it gets into a level of where it does not where it does not – that we're just not good at.

Otitis media with effusion was a great example. The discussion around conjunctive was another one where I think the codes, there's no disincentive for us to not use the codes accurately. I think there were too many negatives in that sentence and I'm not sure I got my meaning across. But I think there's a – there is noise that creeps in when you rely too much on how we code a visit versus what we're actually thinking. And we need to keep that in mind when we're thinking about measures.

John McClay: I think the part of the measure is good, that when we (see) otitis media with effusion, that we should not want to prescribe or should prescribe antibiotics. And, you know, and to some degree, I understand the developer's question and

concern because shouldn't we be promoting, you know, that type of treatment or approach that healthcare, regardless of what people are going to do with the codes once they're out. I mean I think we have responsibility to set a tone for what we believe is good, but also to be realistic about what's going to happen.

So, I think that measure kind of got caught in the crosshairs of both of those. And I don't know if it's something that should be abandoned and especially in light of the fact that they're already at the measures, that exact same thing on paper.

So, I don't know if at some point, we need to do discuss this again as a committee and decide to not be judgmental about what people are going to do with it, but to just honor the spirit of the actual measure that we would, you know, like to measure.

Kathleen Yaremchuk: I guess I understand that, but at the same time, we have look at validity. And if we know people are studying for the course, we're going through a lot of effort to measure something that isn't reflective of practice.

John McClay: Right. That's true.

Charles Bailey: And I think from my perspective, and I, again, I want to be very careful about timing, but I would love to keep discussing this. It really goes to the question, what is …

(Off-Mic)

Charles Bailey: … so that the world of electronic records are new so we're still finding that out. I think our intent was – recognizing that, our intent was not to penalize someone for misdiagnosing but essentially to say, when you have used – when you have made this diagnosis, did you then respond appropriately? But that's not a simple question either. And so that the more – yes, the more I can learn, certainly, the better it will be for me. And I think the more broadly we can learn about what things are measurable, that the better – the smarter we will get about measuring them in the right way.

Shaconna Gorham: So Dr. Bailey, this is Shaconna. I recognize that you asked a question. But before anyone responds, I just want to open up for public comment because we are very, very close to time and we need to just recognize the public. So operator?

Operator: And at this time, if you would like to make a public comment, please press star, one.

And we have no public comment at this time.

Shaconna Gorham: All right. Thank you.

Karen Johnson: So, this is Karen from NQF. I think the discussion is something that we could probably spend a little bit more time on and probably we're spending some time on in our post-comment call. So Shaconna will – I think she had – yes, she has the next steps slides to tell you what we're going to be doing. But I think there is still room to think about this a little bit more a little bit later, so to be continued. Shaconna?

Shaconna Gorham: Thank you, Karen. So we have a post-meeting call setup. I don't think – I think we're agreeing that we do not need the post-meeting call but definitely the post-comment call. So with that being said, NQF will take the evaluations from the day and the discussion and write a draft report. That report would be posted for comment period between April 27th and April 30th. The post-comment call will be the week of June 12th. We are still trying to nail down a date that will accommodate everyone's schedule.

And so, we anticipate June 12th but we will send out a calendar invitation with an exact date. Then new have NQF member voting period between June 21st and July 6th. We will present the measures , we, being the NQF staff and the chairs for CSAC, July 11th and 12th. Then we will have an appeals period between July 14th and August 15th.

So again, look for an e-mail and communication from me with a date for the post-comment call and we will definitely be in touch.

I want to thank everyone for their time and just all of your inputs on the measures. I thank the developer for joining the call as well as responding to questions.

Special thanks to our chairs and our lead discussants and all of the Standing Committee members. On your screen, now you have project contact information, so you have the project e-mail address and my direct e-mail address, as well as the telephone number.

So, if there are no more questions, a last minute responses or inputs, then we are over time and I want to be respectful of your time.

Daniel Merenstein: So the post-meeting call on March 24th is cancelled, correct?

Shaconna Gorham: The post-meeting call, yes, is cancelled.

Daniel Merenstein: Thank you.

Shaconna Gorham: And I will send …

Male: Thank you.

Shaconna Gorham: … calendar cancellation.

All right, thank you. Have a good afternoon.

Charles Bailey: Thank you.

Male: Thank you.

Male: All right. Take care, everyone. Bye-bye.

Male: Thanks very much.

(Crosstalk)

Tamala Bradham: This is Tammy Bradham. I want to just thank (Chuck) again for submitting the measures and for your hard work with that.

Charles Bailey: Thank you. We really appreciate the time everyone's put into this.

(Off-Mic)

Tamala Bradham: Bye.

Shaconna Gorham: Bye-bye.

Charles Bailey: All right, bye-bye.

END