NATIONAL QUALITY FORUM

Moderator: Measure Developer Maintenance
August 2, 2017
1:00 p.m. ET

OPERATOR: This is Conference #: 12381465.

Operator: Welcome everyone. The webcast is about to begin. Please not today's call is being recorded. Please standby.

Male: Yes, let me call you …

Suzanne Theberge: Good afternoon, everyone. Welcome to the Person & Family Center Care Off-Cycle Webinar. Appreciate you joining us today. This is Suzanne Theberge. I'm the Senior Project Manager on the team. And before we begin to start usual housekeeping items if you could just put your phone on mute and turn your computer speakers off during the call we'd appreciate it. Speaking happens through the conference line and the webinar streaming both video and audio.

So, next slide.

David Celle: Excuse me.

Suzanne Theberge: Yes?

David Cella: This is David Cella. Am I the only one who's not able to get in to the webinar?

Suzanne Theberge: I don't know. I have not seen any other concerns. We can …

David Cella: OK, so maybe …

Suzanne Theberge: … try to troubleshoot for you.

David Cella: Maybe it's the link in my invitation. But the link in the invitation in the calendar is not – it gets me to a point where I try to get in and then it fails.

Suzanne Theberge: OK. Hang on, I will send you the link directly from the agenda maybe that one will work better.

David Cella: Or try a new browse. Do you have trouble with Google Chrome? Maybe I'll try a different browser. Sorry for the delay.

Christopher Stille: This is Chris. I'm in Google Chrome, it's working OK for me.

David Cella: Go on ahead, I'll work on it.

Brian Lindberg: This is Brian Lindberg. My problem is it won't open up. I guess I'm – I may have something in my own computer blocking it.

Suzanne Theberge: OK. I …

Female: Hello?

Female: Hello?

David Cella: I just got in with Firefox, so I'm OK. This is David Cella.

Female: I also think they sent around slides on the 26 at around 2:40 Eastern Time. If people can't get in to the webinar maybe they can follow on the slides. And I don't know what happened to the NQF staff audio.

Andrew Anderson: Hi everyone. This is NQF staff. Suzanne, I think her line dropped. She's calling back in right now. So, please bear with us for a minute or two.

Male: Hey, everyone having a good summer?

Male: Yes, so far.

Female: It's very hot. It's very, very, hot summer this year, hottest. Second hottest on record in Salt Lake City.

Male: Wow. And that's a hot summer usually in Utah.

Suzanne Theberge: Hi, everyone this is Suzanne. Sorry about that. I lost the call. I apologize. All right. Is anybody else having any technical issues or should we dive in to the content here?

All right, great. So just to briefly go over the agenda. I'm just going to do a quick roll call so we know who's on the phone. And then we have a couple NQF staffers on the line to present to us on some recent works that NQF has done that we thought the PFCC committee might find interesting.

We got – Drew Anderson will be presenting on the National Standards for Patients Decisions Aids. And Kavitha Nallathambi will be presenting on the National Quality Partners in Project on Shared Decision Making. And then we'll have some time for question and discussions from the committee. And then I have an updates for you all on changes to the CDP.

So with that, I will dive into the roll call. And just let us know if you're on line when I call your name. Lee Partridge?

Lee Partridge: I'm here.

Suzanne Theberge: And Chris Stille?

Chris Stille: Here.

Suzanne Theberge: Beth Averbeck?

Beth Averbeck: Here.

Suzanne Theberge: Sam Biener? Adrienne Boissy? Becky Bradley? Jennifer Bright? David Cella?

David Cella: Here.

Suzanne Theberge: Sharon Cross? Dawn Dowding? Nicole Friedman?

Dawn Dowding: Sorry, here, here. I'm here. Sorry, my mute is on.

Suzanne Theberge: Thank you. Nicole Friedman? Stephen Hoy?

Stephen Hoy: Yes, here. Hello everybody.

Suzanne Theberge: Great. Sherrie Kaplan? Brian Lindberg?

Brian Lindberg: Here.

Suzanne Theberge: Linda Melillo? Ann Monroe? Lisa Morrise?

Lisa Morrise: I'm here, thanks.

Suzanne Theberge: Thank you. Elizabeth Mort? Lenard Parisi?

Lenard Parisi: I'm here.

Suzanne Theberge: Deb Saliba?

Debra Saliba: Here.

Suzanne Theberge: Lisa Gale Suter?

Lisa Gale Suter: Here.

Suzanne Theberge: Great. And Peter Thomas? All right. Thanks, everybody. I think we have a couple folks on the webinar as well.

All right. I already introduced the staff but the next slide just let you know which staff members will be presenting today. And next slide just quickly goes over off-cycle activities. I think you all are familiar with our off-cycle work since we had call earlier this summer. But basically when we're not reviewing measure as you know, we bring the Committee together to get your input on something or tell you about some recent works, some things that are happening that we think you might find interesting.

So with that, I will turn it over to Drew to begin the first presentation. Drew?

Andrew Anderson: Hi, everyone. Thank you for listening in today. I'm really glad to be share to the work of the Decision Aids expert panel with this committee in particular.

So, I'm going to start off by just giving you a little info on the panel, go through some of the objectives of the project, some background information on what led us to do this work. And then talk a little bit about the outcome and some of the possible ideas moving forward.

Next slide.

So we already had an all star team as expert panel members to this project. They were comprised with leaders in the field of shared decision making. We have patient, advocates, researchers, clinicians, legal professionals, and many others. You might recognize some of the names on from this committee, for example, Jack Fowler and Karen Sepucha submitted shared decision making measures to you all last year for review.

This panel was led by our two coaches, Christopher Saigal at UCLA and Maureen Corry at the National Partnership for Women and Families.

Next slide.

So the project was funded by the Gordon and Betty Moore Foundation and we started a little bit in the beginning of 2016. And the main objective of the project was to see how we as a nation can improve or ensure patients and surrogate decision makers have access to high quality decision aids.

So the main objective or to propose to this panel to propose a set of national standards criteria and a process for national certification decision aids, examine approaches to measure the quality of decision making including the appropriateness and effectiveness and outcomes, and then also looking at opportunities to spur the development of measures that can assess the impact of shared decision making including those through the use of patient decision

aids, but really we look broader overall quality of decision – shared decision making and the process. I'll talk about a little bit about that shortly.

So, why do we need national standards for decision aids? So, the – there are many cases where decisions are preference sensitive which legitimate treatment options exist. Options that involved significant tradeoffs among different possible outcomes of each treatment, some people prepared accept small risk to improve their function and others won't. There are also instances where clinical evidence supports multiple options.

Another reason patient decision aids empower individuals to take more active role in their healthcare. As we all know, we're moving toward the system, this Committee in particular, knows that we're moving into a system where patients and families have a greater role in decision making and taking control of their care.

Another reason why we need national standard this year is that there's a great deal of variation in the quality of patient decision aids. There are decision aids that are not up-to-date in terms of evidence. They don't walk through patients – while walk patients through an exercise that allow them to fully assess their preferences and values. And then there are those don't – that don't present all the options that patients have available to them.

And so there's the evidence of the effectiveness of decision aids improving outcomes and supporting the shared decision making process, there's also a need to incentivize the use of decision, patient decision aids. And that's where the component came in where we started to look at performance measures for shared decision making.

And so, lastly, there are also no standards. So, mainly, this project came about because there are no standards on the best resources for patients and their families to use to make decisions, because ultimately we want patient and families to have these resources to make informed decision.

So, some of the benefits of national standards, there are over 500 patients decision aids available or being developed by many different individuals and groups around the world. However, people are having difficult in knowing or

whether or not a decision aid source of reliable health information that can be helpful in decision making.

And national standards in particular promotes the use of decision aids that receive some sort of seal of approval based on evidence and sound development protocols. So, patients and families can use or surrogate decision makers can use this seal of approval to know when they can trust the information that they are receiving. And it's basically that it's OK for a certain vetting process.

It's also important to clearly define the basic features, standard, and attributes of these tools and delineate what is a good decision aid versus one that is not so good. Patient decision aid should include information that we know based on evidence lead to better decision making.

Another benefit is providing a baseline set of criteria that allows decision aid develops to create and implement tools in a more consistent way. So, it reduces the amount of variation and the types of decision aids that are out there available for patient.

So, quickly moving into the project outcome. This project has four major outcomes. We begin by reaching out to the Dartmouth Institute for Health Policy and Clinical Practice. You conduct or to put together a white paper to synthesis all the evidence related to share – patient decision aids and shared decision making and this is led by (Glen Allen) and a team of researchers there. And this really provided the conceptual basis for why we're doing this work, what's the history of the debate. And I'll go into a little bit more about what that white paper consisted of.

We also did an environmental scan measures that assess shared decision making and decision quality. So, this was a separate goals to see what measures can be available for potentially including them in accountability program to increase the use of shared decision making.

And then another major goal was to provide the expert panel provide a recommendation for the national certification criteria and a process for

certification. So, when the Gordon and Betty Moore Foundation approached us to do this work, they wanted to see different business models if NQF became the certifying entity for this, what would that look like, what are the potential funding vehicles and what are the different options in terms of being a reviewers – a few reviewers or multiple reviewers and I'll talk about that a little bit more.

Next slide.

So, going to a little bit background on this decision aids white paper as it was really foundational to this work. You all maybe familiar with the International Patient Decision Aid Standard collaboration or IPDAS, which is or the group of researchers, practitioners and stakeholders that came together to put together a vetted set of criteria. And much of the work in this project goes on IPDAS's initial work. The lead of there, as I mentioned, the Dartmouth on the white paper was also one of the leaders of the IPDAS's work.

So, more specifically, the white paper describes the history, debates, and evidence related to the assessment of Patient Decision Aid quality. It also summarizes the literature that is consistently shown that Patient Decision Aids have a positive effect on patient – on a patient outcome specifically the quality of their decision.

It also establishes the conceptual rationale for having certification of Patient Decision Aid and present the IPDAS certification development work, as well as the work from Washington, the Washington State Healthcare Authority to develop state level, a state level certification process.

Just a little bit of background on that. In 2007, the Washington State was one of the first to pass legislation around shared decision making through a shared decision making pilot. The legislation provided that for – if a provider uses a certified decision aid as a part of the informed consent process that there's a presumption that informed consent has been given and obtained.

So, to support this effort, the Washington State Healthcare Authority began certifying decision aids in 2016. So, we – as I shared you earlier, the panel but we did have – one of the panel members was the – one of the panel members was from Washington State but we also had their team who is working on the certifying process to the right input on this process. So, we tried to really look at their – the lessons that they learned from doing it at the state level to see what we could take to apply to a national certifying process.

So, as I mentioned, one of the goals of this project was also to better understand how measurement can be used to incentivize the – of shared decision making. So to support this goal, NQF conduct an environmental scan to assess the current measurement landscape for our shared decision making. So, we searched the number of places, you know, measure repositories, we conducted key informant interviews, we looked in the literature. And we organized the measures that we found in three categories.

The first was decision (antecedents). So these are really concepts that are, well, aspects that the patients or surrogate decision maker or family member bring to the table, so their preferences, their health literacy, attitudes, numerous skills. We also categorize them by decision making process, so the level of patient engagement, aspects of shared decision making and the tools that were used – so this way we found the measures related to whether or not a patient decision aid was used. So, this is how well was shared decision making facilitates.

And then finally, we categorized them by decision outcomes. There's some in the outcomes in the literature related to improve knowledge, concordance between goals and the treatment, open at treatment, and quality. And so this was – what's the overall outcome of the decision and the shared decision making process leads to better decision outcomes.

Through this environmental scan, we identified 64 instruments and 13 performance measures. Two of which were endorsed by this standing committee. But some of the follow on work is looking at how can we, you know, improve the existing instruments and use those as sources of data to generate performance measure. But ultimately, the major finding of this

environmental scan was that, there needs to be more development of performance measures. They're just aren't enough out there. But there are a lot of – there's a lot of research and there's a lot of tools that has been developed.

So, finally, one of the major products of this project was the certification criteria. And so the expert panel really built on the white paper. I didn't mention that the white paper is posted to our Decision Aid Project page. So, if you – you can just Google NQF Decision Aids and take a look at that, if you got the time because that really has a – it was very foundational to this work.

So they worked on the paper, the environmental scan to propose these three different categories of criteria. The first criteria is the screening criteria. So, the screening criteria is just criteria to determine whether or not a decision aid would be even eligible for certification. So a lot of criteria around – if it's actually a decision aid based on an accepted definition of a patient decision aid.

And the second criteria was the certifying criteria. So these are – oh I forgot to mention, the screening criteria more so yes or no. That criteria about the certifying criteria are more judgment based and can be rated – you can rate a decision aid base on low, medium or high. But these are the criteria – certifying criteria really the ones that the reviewer or committee or expert panel that would end up certifying the decision aid would use to determine whether or not they need certain quality standard.

So just (two) main set of criteria. These are the main (inaudible). But the – they – the decision aid expert panel recognize that this would not all – apply to all decision aids because there's a lot of variation and content and purposes, and the target users of the decision aid. So, developers who (sent) decision aids to (poor) certification would have the option of providing rationale for why their decision may or may not have included certain elements that are required for certification.

The third set of criteria that the panel proposed was screening and diagnostic test specific criteria. So the panel recognized that towards the screening and

diagnostic test, it would be – it requires a certain another set of questions that need to be addressed in the decision aid. So, basically, how can questions that allow the patients or surrogate decision makers to decide how to interpret the results of a screening or diagnostic test.

So, some of the – finally, some of the opportunities and challenges for performance measurement. So this was really synthesizing all of what we know. We're going through this process, what are some of the barriers to increasing the use of patient decision aids to even creating a certification process.

As I mentioned earlier because of the environmental scan, one of the expert panel's recommendation was to identify and develop performance measures to improve the quality of shared decision making. Because there's a recognized growing interest in the use of shared decision making and quality improvement and accountable – accountability program. For instance, shared decision making is a requirement for ACOs participating in the Medicare Shared Saving Program. So, getting set of measures – better measures that can be used in similar programs was one of their recommendations.

There is also an opportunity to build conceptual model that illustrates the relationship between measure SDM and/or measuring share decision making and improving patient outcomes. There are several conceptual models in the literature but none that clearly articulates this relationship, especially for users of – or providers, users of patient decision aids.

So some of the challenges we found. So, one, which is the huge barrier that shared decision making has not been widely adopted for clinical use. The literature shows that providers are having difficulty integrating shared decision making into their routine workflows for a various reasons.

Another barrier is data availability. And so this is a big barrier when it comes to developing measures, the expert panel did sight this one specific issue is that often only decision outcomes for patient who choose treatment can be assess. So patients who do not choose an intervention are typically not documented. So that introduces bias into measurement.

So these are some of the opportunities and challenges that rose to the top. But we're happy that, you know, we are continuing to work in this area and discussing these issues. But as you may have heard like CMS now has the shared decision making model that they'll be recruiting accountable care organizations to participate and more participate in this program to advance shared decision making. So at least we – we're seeing more and more of an interest at least from the government and adopting these practices.

So with that, I will open it up for questions. And it's OK if you don't have any questions right now. We can go to the next – we have Kavitha here. She's going to share our work that followed this project.

David Cella: This is David. This is David. So I actually I have a question.

Andrew Anderson: OK.

David Cella: Can I ask? Yes. So I mean – I think share decision making is so important and I understand that are hundreds of these shared decision making boards. But a concern I have is that they become dated very quickly, you know. When a new treatment comes along or new option comes along or maybe want to sound to be inferior overtime and, you know, with new evidence and the boards don't always get to modify. But what really seems important and maybe I'm thinking more along the lines of process measures than outcome measures. But what really seems important this to make sure that the provider did review options and make it clear to patients that they have options and explain those options whether or not they use a board

I mean what – how does a group and there is – there are more than 500 decisions that, you know, people make in health care. So, there's also issue of limited availability of actual decision boards. I mean I'm little skeptical of that the way to change health cares to find validated decision boards and then make sure people use them. But instead to make sure the providers are really explaining options to patient whether there's a board or not.

Andrew Anderson: Yes. So I think a lot of people see the use of – or development and use of patient decision aids as a way to ensure that providers are presenting all the

options and that are – it's evidence based. So, one of the reasons for a certification process is to – so one – their expert panel talks about these decision aids being certified every three years so the developer would have the responsibility of keeping this decision aids up to date.

And so, one thing that I didn't mention is that there are pre-encounter and encounter decision aids. The pre-encounter decision aid is something that a patient could probably go online and sign and it would walk them through a series of exercises and provide them with the information their need. And then there also – encounter decision aids that providers would use to facilitate that conversation.

So it really as suppose to just be a way to help them have that conversation. And …

(Crosstalk)

Female: Go ahead.

Adrienne Boissy: Sorry, it's Adrienne Boissy, Cleveland Clinic. Dave, I sort of similarly resonate with your comments. I mean my – just from the – so I am curious sort of we seem to start separating out all these elements of effective communication that should be occurring naturally and we seem to think that if we keep adding questions or outcomes measures that somehow will force people to communicate effectively, which I'm a big fan of. I think part of the challenge though I guess for me, so I'm curious I was excited that things like time bubbled up to barriers to implementation because there is no extra time for people to do this.

And so, how are you reconciling sort of the reality of clinical practice which is people might have 10, 15, 20 minutes to not just connect, review meds, check the 18 things in the inbox, you know, check all the boxes and documentation appropriate for billing and use decision aids. And then even get dinged if they don't being them necessary to the conversation.

So where does – where are you reconciling sort of operational flow of actual visits with use of decision aids in term of time and efficiency? And how are

honoring the idea that a clinician could decide a decision aid would be hurtful rather than harmful in the conversation. And that still OK as long as you're having the conversation. I don't feel like that's answered. So I'm curious as to how you have thought about it.

Andrew Anderson: So those are all very good questions. The expert panel did talk about that to some extent. They mentioned that – you know, so the use of a decision aid is not always going to be appropriate in every situation.

One of the main ways that rose to the top is just when a provider – seeing as that Washington State is taken this position that it may be better informed or a way to conduct to inform consent in a more thorough way. That's one way that we could enter – we could use that as a tool. But I don't think that the recommendation is that it should be used in every single patient interaction and in some cases the provider might give the patient just to pre-encounter decision aid that will allow them to make that independently just to the supplement to their conversation. So it really just depends.

I don't think that there is like a hard fast way to apply it across the board. But these are all considerations that a committee or that review the decision aid would have to consider. And so within the application for certification, the developer would have to indicate the potential – the target user and also include a detailed description of its intended uses and the circumstances that it would be appropriate to be employed.

Lee Partridge: Andrew, this is Lee Partridge. Did you talk at all about – in the committee about the cost of actually producing some of the decision aids? I work with Maureen Corry on these issues, five or six years ago. And some of them actually turnout to be small video, which if done correctly can involve a substantial amount of cash. And others I know are done by medical profession itself but even there you're talking about not small dollars for their time and review and so on. Did that come in to the discussions at all?

Andrew Anderson: Yes. Yes, they did talk about the cost of producing them. I think the – it was less of an emphasis because there are so many that have already been developed and it was more about if there's a way we could walk or review the

ones that are – already exist and provide developers a way to update ones that are already exist base on this criteria that it wouldn't be a significant lift.

But we – I think there was recognition that this is not going to be a cheap thing to do especially if they involved testing the decision aids with the patients which was one of the recommendations of the panel that a certified decision aid should at least to be reviewed by the intended user. And there should some information about how that information was, you know, how it was received.

So yes, they did speak about that but the conversation mostly centered around the criteria and like what made is a good quality decision aid versus what isn't.

Lisa Morrise: This is Lisa Morrise. I'm wondering going back to the earlier question around the patients taking for using the decision made and the time that is allocated for an appointment. I'm wondering if a decision aid can be utilized by a patient in consultation with somebody other than their provider, specifically maybe an aid or social worker or nurse practitioner or a nurse in the practice that works specifically in the context of helping with these issues that arise that require informed decision making.

Andrew Anderson: No. Yes, thank you for bringing that point out. Yes, so these are – the patient decision aids are not just for the physician who use what the patient. They are certainly therefore allied health professionals and, you know, direct clinical staff like nurses and others even health educators can be – it depends on the content but it's – they certainly can be used by professionals outside of the traditional physician.

So again, it would depend on – that would also be described in the application for the certification process on who the developer sees as the – if it is an encountered the decision aid who the developer sees as the facilitator for that conversation or what sets of people.

Lisa Morrise: This is Lisa Morrise again. I'm also wondering what kind of timing we're looking at in terms of utilization of the decision aid relative to when the impact of the decision making process itself. So, in other words, if I received

an informed consent form shoved in my face right before I go back for surgery, the chances that I'm really making an informed consent are less. Then if it's a few days prior to surgery when I actually have an opportunity to read the form and understand what the procedure entails. So, is that something that would be captured also in the decision aid?

Andrew Anderson: Yes. So that would – the panel talks about that at length. And that is something that would also be included in whatever guide that came along with the decision aid if it wasn't encounter decision aid used for informed consent. That's some of the guidance that we would ask if we were the certifying entity or whoever is the certifying entity would ask to be included.

The other point that the expert panel raised was the issue of – so, if we actually have measures of whether or not these tools are impacting patient outcomes, the timing of – between when the patient decision aid is being – is given to the patient and they're actually walked through a process and then when the decision is made versus the actual outcome.

So, for example, one of the outcomes – outcome measures is related to concordance between the patient's goals and preferences and the ultimate treatment outcome or – and they have – there's a scale called the decision regret scale. And so that scale has a certain time period that after the decision is made that the patient would need to be asked again whether or not they regretted it or the decision they made or they are – or if it's still in line with what – if what happened is still in line with the decision that they made.

So these issues of timing did come up in the expert panel discussion. But it's something that we would require for the developers to indicate in their form and the guidance that comes along with it. And again, this is specific to the types of decision aids that we're talking about, so it might vary.

Any other questions? OK. So, I'm going to go ahead and turn it over to my colleague, Kavitha. She's going to speak to you about our work on the patient decision aid, well, the shared decision making action team through our quality innovations group.

Kavitha Nallathambi: Thanks, Drew. I think this discussion of them already raised a lot of important barriers and potential solutions that the National Quality Partners Shared Decision Making action team is discussing as well. So, I'm going to talk a little bit about the work of National Quality Partners as well as the shared decision making project today. And I don't know how familiar everyone might be with NQP and what we do, so I just wanted to provide a little bit of background.

So, the National Quality Partners evolved from the work of the National Priorities Partnership and they had done work around reducing early elective deliveries, re-admissions and some work around patient and family engagement as well. So NQP is sort of the next iteration of this multistakeholder-type of work.

And so NQP aims to engage NQF members who are convened to drive quality measurement and improvement and building on NQF's established role as the trusted neutral convener. And then also, NQP works to support NQF's strategic plan to drive measures that matter. And our mission statement is to collectively work to impact health and health care quality through collaboration and partnership to catalyze action and accelerate improvement.

So, we've been working on this through what we call action teams. And NQP action teams consist of about 15 to 20 NQF members who are brought together to drive action on a specific health care priority. And action teams use a model of collective action which involved developing shared agenda and goals per action, a common measurement strategy, which includes promoting NQF endorsed measures whenever they're available, having continuous communication, working on reinforcing activities. And NQF serves as the sort of backbone support organization for all of these activities.

Action teams also work on to use levers and policy and alignment to impact health and health care quality. And we qualify members of the action team to drive action and alignment within their own spheres of influence and really look to members own networks in promoting the outcomes of the group.

And each action team has worked on pursuing a specific goal or deliverable and depending on the amount of resources that we do have. This can take the form of an action brief which is a shorter document of work around preferred practices which would be a longer issue brief. And then we've also worked on a couple of playbooks which are focused on implementation and providing solutions to barriers as well as tools and resources.

So, NQP in its current iteration, we have completed two action teams, one around antibiotic stewardship in acute care settings and the other one in advanced illness care. And right now, we are – we launched the shared decision making action team earlier this year. And there is a call for submission out as well for an opioid stewardship action team which some of you may have seen.

And some of the best practices that we take into consideration for what might constitute a successful action team include the topic area being a public priority that's in need of timely action and response, being able to have a clear vision and shared goals that's important to members and funders, having examples of innovation that we can then spread, relevant policy drivers in the environment.

Having an endorsed measure that's not broadly implemented is also an opportunity for an action team with the case with the maternity action team in terms of reducing early elective deliveries and then also having stakeholders who are committed to this work and to collaborating together.

And this next slide here just sort of emphasizes the multistakeholder collaboration approach and policy and measurement, practice change, and patient and family engagement and reiterates NQF's role as the backbone organization that connects different stakeholders together.

So, some of the results from the work of NQP include the work of the maternity action team around reducing early elective deliveries. There was a playbook and the work of that action team contributes to a 73 percent national reduction in EED by promoting accountability through accreditation and other

policies and messaging. There was also the work of the patient family engagement action team and of the readmissions action team as well.

Some of the specific deliverables that have resulted from the work NQP includes the maternity action playbook, the playbook around antibiotic stewardship and acute care which you may have seen. And then also there is initial brief that the events from this care action team developed around person-centered preferences in advanced illness care.

So, I wanted to talk now a little about the shared decision making, action team and project specifically and some of the objectives that we are working on. So the shared decision making action team is working on it's – on developing a shared agenda and issuing a call to action to make sure decision making of standard of care and clinical practice, and also looking to identify barriers as well as solutions to advance shared decision making on a national scale.

And on this slide here, we have the members that are part of the shared decision making action team. So these are the organizational members. We have about 20 and Maureen Corry with the National Partnership for Women and Families and Norman Kahn with the Council of Medical Specialties Societies are our co-chairs.

So there is some overlap which helped us to establish continuity with the decision aid's work as well which Drew was discussing earlier. And – so with this – with the make up of the action team, we try to have a diverse perspective and stakeholder balance. We have several patient center groups like the Connecticut Center for Patient Safety, National Coalition for Cancer Survivorship, Planetree, and then also Patient and Family Centered Care Partner. And Stephen is on the line and familiar with some of the work from NQP as well.

So, some of the considerations that the action team is working on, they're looking at concrete implementation examples, tools that are available to help providers, what kind of barriers exist (to) prevent implementation. And then also importantly, not just discussing the barriers, but trying to come up with concrete solutions that correspond to each of the barriers to identify what kind

of opportunities are available in sort of the contextual or enabling environment to drive shared decision making including quality measurement, payment, public reporting and accreditation, certification. And what measures are available as well as what measures maybe needed.

So, the deliverables of the action team is working on include an action brief which will be a short four-page document which really strives to make the case for shared decision making, and also get into some of the fundamentals that the action team has identified as being important to implementing shared decision making and highlighting some of the contextual factors.

So, this will be a short document that we anticipate on promoting wildly. And in it, we will issue – or the action team will issue call to action in order to facilitate national interest and emphasize the priority of shared decision making.

And as we work on having that action brief and issuing the call to action, we'll also be working towards developing a playbook around shared decision making. And that will aim to provide practical solutions to barriers around shared decision making and also serve as a platform for sharing best practices and identifying innovative solutions that facilitate shared decision making.

So, we will look towards providing examples of implementation for each of the key fundamentals that are identified and identifying barriers and corresponding solutions and providing tools and resources which don't all have to be peer reviewed but I think that providers can use in practice settings and providing resources that correspond to kind of each of the fundamentals.

So, this is – we don't have a draft yet of the action brief but this is an outline. We'll have a call to action described why shared decision making should be a standard of care for all patients and provide some examples of high leverage opportunities including the CMS preference-sensitive condition and in target population including those in – with advance illness and approaching the end of life, and outlining some of the special considerations implementing shared decision making. We'll get in to some of the fundamentals and then also the contextual factors including payment and policy alignment.

So, this is our draft call to action, still a work in progress. And as you can see, it's intended to be as comprehensive as possible in terms of calling on individuals and organizations in all of these different areas to integrate shared decision making to embrace and integrate shared decision making as a standard of person-centered care.

And this is a working definition that we have for shared decision making. And the first part of this is intended to serve as the broad vision statement which emphasizes share decision making as being a process of communication in which clinicians and patients work together to make optimal health care decisions that that aligned with what matters most to patients.

And then there are also three components that the action team has identified as – so these are more operational components to shared decision making including having clear, accurate, and unbiased medical evidence about alternative and the risks and benefits of each clinician expertise and patient values, goals and informed preference.

So talking a little bit about the fundamental of shared decision making that the action team has identified, so these are the six kind of key principles that will address in the action brief. And then also these are the fundamentals that will build out further in the playbook as well. So, these include leadership and culture, engagement and education, knowledge, action, tracking, and accountability.

And these are some of the contextual factors or the enabling factors around shared decision making including quality measurement and improvement, payment which includes CMS models that Drew was talking about earlier, accreditation and certification and then also getting a little bit into the legal and ethical standard around shared decision making and informed consent.

So, these measures will be very familiar to you. So, these are the NQF endorsed measures that we've kind of pulled out as wanting to highlight in the playbook. And then, we'll also try to provide a framework on the types of things that could be measured as well. So this is something that we did for the

antibiotics search of work as well because it turn out that there is really only one NQF endorsed measure. So the action team intended to provide a little bit more information on what could potentially be measured as well.

And as I was talking about earlier, so the action brief will be one part of the work. And as we get into the Playbook, we'll have more in-depth information on the fundamentals, on the common barriers and suggested solution. We'll use that as an opportunity to highlight some of the best practices and exemplars and tools in this area including patient decision aid.

And then, also, we will work on developing some target population case studies or vignettes around shared decision making kind of real life or hypothetical situations in terms describing scenarios in which this is done. Well done better and then perhaps in some cases it's not done quite as well.

So, our next steps for this year and into next year include releasing the action brief in October. And then on October 3rd we'll have an In-Person Playbook Development Forum which will include the action team plus the group of other individuals that we'll be inviting, and they'll work together to identify barriers and solutions, tools and resources and develop some of these case studies.

And in November, we'll be working on developing the Playbook as well as engaging stakeholders in the Call to Action that will be issued in the action brief. On December 12th, we'll have a Public Webinar on the Fundamental of Shared Decision Making as well as the NQP, overall NQP Priorities that have been identified for 2018.

Our aim is to launch the Shared Decision Making Playbook at the NQF Annual Conference in March and then have another Public Webinar at the end of that month to get more in-depth on the fundamentals and to allow an opportunity for those who were not at the annual conference to join and learn more about this work.

So, on this slide, I have a couple of discussion questions here which, I know we've already started discussing this but your thoughts on barriers and solutions to implementing shared decision making, and any best practices,

exemplars or tools that you would like to share that we should consider including in the Playbook and any additional ideas for measurement.

And then also I mentioned our Playbook Forum on October 3rd just an invitation-only meeting. But if you have any ideas for individuals that – or recommendations for individuals that you feel would be good to attend this meeting, we would definitely like to hear from you on that. We're looking to invite more people to – who have experienced implementing shared decision making in their own organization.

So with that, I'll ask if any questions or thoughts to this discussion questions or others?

Lisa Morrise: This is Lisa Morrise again. We recently had senior citizen in her 80s joins us for a partnership for patient (pacing) event and talk about shared decision making in the context of providing alternative as well as your basic yay or nay on procedure. She herself had opted to pursue a change in her nutrition regimen that kept her from having to have heart valve surgery because she was able to reverse her weight condition and relieved the stress on her heart.

What she was advocating for what especially given her advanced age and the impact surgery would have, giving others in her situation the information that they needed in order to make an informed decision around options that they had in addition the more invasive option.

So, I'm wondering if that is something that can be included in this discussion as we look at informed decision making and looking at whether the decision is more than whether to proceed with a specific procedure or not?

Kavitha Nallathambi: Yes, absolutely. And in fact I think one of the – I think the point that the action team emphasized is that the importance of looking at alternatives as well as doing nothing as being an option as well. And another – I think the action team is discussed too is how do you kind of incorporate these decisions and patient feedbacks so that others are aware of decision set up we've made.

Lisa Morrise: I like that. Thanks.

Kavitha Nallathambi: Any additional thoughts on barriers or solutions or best practices …

Christopher Stille: Yes.

Kavitha Nallathambi: … around this area?

Christopher Stille: This is Chris Stille. I thought I'd just chime in. You know, from my perspective as a primary care clinician at (ECHO), you know, a couple other people that have mentioned that, you know, time barriers and other stuff lack of incentives specifically to implement your decision making. Make it a pretty slow process even when there is a good tool to use and we certainly need some more good tools.

So, you know, I think if the more the process speaks to what can you do quickly and how can we promote policies that incentivize shared decision making, I think the more attraction will have generally. There are also some culture change involved and we can't underestimate the time that it takes to change culture. You know, I did a study a few years ago and in some of the qualitative work we did, some of the physicians define shared decision making is I make a decision and share it with the patient. So, we'll have to – we'll have to move that forward.

So, just a few things to kind of think about but I think it's great that there's a group that's actually promoting this. You know, once we have the measures to put them into practice.

Kavitha Nallathambi: Thank you.

Lee Partridge: Kavitha, this is Lee.

Kavitha Nallathambi: Hi.

Lee Partridge: Another element that I think you might want to include in your discussion is just the – what kind of information do you have about the family. For example, if they're on food stamps, they may have fairly limited options to change their diets to make accommodations to diabetic condition. And we've been doing some work at the fund on trying to build into our patient records.

Some of that kind of information about the family setting that would in fact inform the clinician and his or her team in a system that patient to make decision.

Kavitha Nallathambi: Great, yes. That is one of the issues that the action team has raised as well. But we definitely did to keep that on our radar to make sure we include that in our playbook.

Suzanne Theberge: Any other final questions or comments? OK. Well, I am sure the team will accept them by e-mail if you have something that you think out later. I would like to thank my colleague so much for their time this afternoon on these presentations and see if there's any other final comment or questions for either presentations.

All right. Well, hearing none. I think we can move on to the next question of the webinar which is just to go over some updates that we have made contagious that are coming down the pike, to the consensus development process.

So, as you may know – next slide, please. As you may know, we did a Kaizen event in May of this past – this past May, to look at how we can improve the CDP, what the opportunities are to make it more agile, more efficient, and to address problems that we heard about overtime, how can we review measures more quickly, how can we have more efficient submission opportunities, reducing the cycle time, improving the flow of information between the CDP and that's another areas as well. So we have a great group of folks together at our office and give us a ton of ideas.

Next slide, please.

And out of that, we've come up with quite a few changes, which I'm going to go over in the next few minutes. So, this is kind of the highlights of what was proposed and what we'll be implementing this overtime and a lot of stuff still under development because this is pretty new. So, I will caveat a lot of my discussions with, you know, we're still working on some of this so you may have questions that we can't quite answer yet.

So first, the big thing and I'm going to show another slide about this in a minute. But we're going to be increasing measures submission opportunities to twice a year. So, we're now going to be running our projects twice a year and that will give folks many more opportunities to submit rather than waiting for a year or three years for some of our portfolios that will be regular submissions as (inaudible), which we're really excited about.

So, obviously, that's going to mean a lot of changes for our process just to make it a little bit more lean and to help us plan and reduce the workload on our committees.

So, one of the things that we're going to be doing is asking our developers to submit an intent to submit form. So, we'll know three months ahead of time, what measures we're going to be getting in a project. And I'll add here that we're going to make our projects a little bit smaller, maximum of 12 measures so we can do this a little bit more quickly.

The next big change which if you've been following any of our announcements lately, you might as heard about this, is that we are putting together a Scientific Methods Panel and this is going to be a panel of experts on measurement, methodologies, disparities, experts, folks who can really dig in to the reliability and validity of the measures.

So, we're pulling that piece for our complex measures and I'm going to talk about this more in a minute, for our complex measures. We're going to be having this methods panel, do a review and make a recommendation to our committees to take that burden on also our committees.

Another piece that we are very excited about is this extended and continuous commenting period with support and non-support. So, we've heard overtime that our comment periods aren't long enough so we're going to make it much longer. It’s going to be more than 12 weeks long and we're going to have the opportunity for members to indicate support or not support for measures.

The other – as soon the other changes that we'll be making, our changing the measure evaluation technical report can be more responsive to what people need, more enhancing, our stakeholder training and education and we're

improving our information exchange and access. And then a couple of other changes that might be coming down the pike which I'll talk about more in a few minutes are changing the bodies that feel with the final endorsement decision and appeals.

So, next slide.

We're – obviously we're not going to be able to do all of this right at once. It's a lot of changes. We're going to be doing a lot of them for our next round of project which starts in the fall. But some of these changes are going to take longer particularly that you about changing the endorsement decision to the standing committees and the roles of the CSAC and the Appeals Board. So, we're going to be phasing the implementation of something, just so we can have some more time to plan that out softly. But a lot of these changes are going to be ready for the next round of project.

So, next slide.

One of the big – oh here's just before I dive into another change. I did want to show you a map of what the cycles are going to look like each contract year. So you'll see that this would start in the summer and we'll be able to run – in a 12-month period, we'll be able to run to two consecutive projects.

All right, next slide.

So in order to accommodate the frequent submission and having more projects running, we did have to reduce the number outstanding committees and we looked at our portfolio, we looked at where we have a lot of volume, we looked at where our measures are, what the topics are and what topics we could make more crosscutting and what clinical areas we really needed that committee and or didn't need the committee and next slide, you will see that we have cut down to about 15 committees.

So, the big change obviously for you folks is that we have merged Person and Family Centered Care with Care Coordination into a new committee called Patient Experience and Function. And that committee will be reviewing, pretty much all of the measures in the PFCC portfolio or not quite all of them.

It will also be taking some of the care coordination measures although some of those are going into other portfolios. Some of the PFCC measures will be moving into the geriatric and palliative care portfolio and may be a couple of others, but both of them will stay here in this committee.

So, next slide.

What does this mean for you? Right now, we don't actually expected to mean much for you personally in terms of – where at the moment, we're still thinking that your terms are going to stay the same. You are also on the committee, it just has a new title. And we're going to be thinking as we find out what we're going to be reviewing. We will look at, at what measures are coming in, in a particularly round of work and then we'll pull in the committee members that we need.

So we're thinking we may have 30 to 40 committee members once we look at who's these terms are expiring and so forth and we'll see, OK, who do we need on this space of work and, you know, who can seat out the phase and then we'll bring folks on and off as needed. This is still really a little bit of a moving target. We're still working out all the details but please know that it does not mean that, you know, you guys are done. We definitely still want to keep you engaged and involved and the committee is changing a bit, but I think a lot of the work will remain the same.

So, next slide.

There's been a lot of questions about the Scientific Acceptability Review. So, I just wanted to show a brief map of what that workflow is going to look like. For complex measures which we are thinking our outcome measures, cost measures and patient reported outcome measures, things like that. Anything that's sort of more than your basic process measure. We will send to this methods panel and they will be able to take a look at the specs and the testing and make a recommendation to the committee on how it should be handled and then once the committee have that recommendation they can look at it and they can also consider some of the clinical or topical things that might be more appropriate.

For you guys, I think about things like what clinical condition should be included in the risk adjustment model or things like that. Areas where the committee would really be expected to have the expertise.

Next slide.

And I did want to also mention that nominations for that panel are still open. We're accepting those through the seventh of August. So please do submit nominations for yourself or others if you know someone who might be good.

So, the Revised Measure Evaluation Report, basically we asked our stakeholders what pieces of the report do you need, what do you use, and we took out the pieces that folks weren't using because we knew that our reports were kind of long and, you know, we wanted to make sure they are responsive to people's needs.

So, right now, it looks like the new reports are just going to have the executive summary. The brief summary is that each measure reviewed and then the details of the committees' discussions then evaluation of each measure against the criteria what we call appendix A and then the full measures specs. So, much shorter report which is hopefully more meets the needs of our stakeholders.

Next slide.

So, we are going to have this new continuous public comment, (an area) that I spoke about earlier. We're really excited about this. It's going to be at least 12 weeks long and maybe longer. And over the years we've heard, we don't have enough time for people to comment since we have these two-discrete comment period just two weeks before the committee meeting and a month afterwards.

So this comment period is going to open up pretty soon after the measure submission deadlines and we'll take comments throughout until about 30 days after (or therefore) is posted. Comments submitted before the meeting will be considered by the Committee at the meeting and then comments submitted, you know, within a certain period time before the meeting, probably a few

days to a week before the meeting and then afterward will be considered at the first comment call. So, we think this is really going to help give people more time to comment.

And the other piece that we're excited about is that NQF members and organizations will be able to indicate support or not support for measures as they comment. And we're going to do this in replacing voting. So we no longer do that two-week length period, but we'll have people able to indicate support or not support throughout that whole multi-month process.

Next slide.

So, there were a couple of recommendations that were made at the Kaizen. One was moving the final endorsement decision to the standing committees making that their role and then having the CSAC monitor the appeals and make the decisions there in addition to their role – their role and looking at the criteria and managing the process overall. And we have taken out into consideration. We're thinking about it. But there's a lot of considerations and issues that we have to hammer out first before we can really move forward on that so that's something that's still under consideration but we are really talking about it. So, that's not going to be something that's changing this fall, but it may change in the future.

So, finally, (we) – and we recognized that we can offer more education and more training for all of our stakeholders. So we're working hard on developing a series education modules and plans. We're going to have resources available both video resources and written resources available all the time online and there going to be specifically focused on our different stakeholder groups, you know, our committee members, our measure developers, people who are engaging in the process as commenters and then, of course, NQF staffs.

So, we're going to be doing a series of live webinars this summer and this fall about all these changes to the CDP for our different groups and then we'll have this recorded and placed online and (locks) more information available online.

So, next slide.

So next steps for the changes. As I mentioned the nomination for the methods panel is open through August 7th. We're working on implementing our – some of the immediate recommendations or things we can change right away. And that will all be ready in October. Longer implementation and planning for longer term recommendations will be over the next year. And then we're still discussing some of the other recommendations with stakeholders and that's kind of ongoing thing.

There's a lot more information about all of this in the final report which is posted online. And when I looked at our home page yesterday it was one of the main links on the home page so it should be pretty easy to find. And I can share that link and that link actually will go to it as well.

So, I will stop there and see if folks have any questions about all these changes. Anyone?

Lee Partridge: 3Q is we're getting rid of voting.

Suzanne Theberge: Thank you, Lee.

Adrienne Boissy: This is Adrienne – go ahead.

Suzanne Theberge: No, no, go ahead.

Adrienne Boissy: I appreciate the consolidation of these different teams. I think sort of (last) meeting is always good. So, I appreciate that effort that went into. I know last time, we spent a lot of time talking about renaming as well. So, that's doesn't go unnoticed and much appreciated.

Suzanne Theberge: Great. Well, I hope, you know, we're excited about this new part topical portfolio areas. We think it's kind of better reflects the portfolio and where the field is going. And so, you know, we're hoping that it's – and we're also kind of make things a little bit more cross-cutting so, you know, some of our smaller topical areas were merged into kind of more overarching committee. So, we're hoping that this is going to make things little better.

Other comments or questions?

Male: No, sounds good.

Suzanne Theberge: All right. Well, if you think of some, you know, definitely feel free to drop me an e-mail and know that we're going to be doing a lot more training for folks who are engaged on our process as we get into the fall and we'll be in touch with folks about how this is going to specifically affect the PFCC committee. You know, as we – as we hammer out all the details, but we are looking forward to continuing to work with everyone.

Male: (We could) say …

Suzanne Theberge: Yes.

Male: … dropping you an e-mail would be to PFCC e-mail address?

Suzanne Theberge: Yes. Yes.

Male: OK.

Suzanne Theberge: And actually we can put that up on the screen, the next slide. And it's just our kind of immediate next steps which is that we're going to be writing up a summary of today's call and I'll share that with you next week. And we'll be in touch with more info on future CDP projects. But the next slide that's have all the contact info for the project. So, if you would like to get in touch with us.

All right, well, that was our agenda for today. I don't know if anybody has any last minute thoughts or questions or anything else they wanted to discuss.

Female: No comments.

Suzanne Theberge: OK.

Female: Thank you.

Suzanne Theberge: Great. Well, hearing none. I think we can end a little bit early. And I'm sure everyone will appreciate having the next half an hour in their day. So, thank you so much for your time this afternoon and we appreciate your joining us today.

Male: Thank you.

Female: Thank you.

Male: OK. Thank you.

Male: Thank you.

Female: Bye, everyone.

Female: Bye.

END