NATIONAL QUALITY FORUM

Moderator: Adeela Khan
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10:30 am CT

Operator: Good day everyone and welcome to today's conference. Please note, today's call is being recorded. Please stand by.

Adeela Khan: Hello everyone. Welcome to the Cancer Palliative Workgroup. And I think we're all here. I just want to go quickly through the roster here. Dr. Bruera? Are you on?

Eduardo Bruera: Hello.

Adeela Khan: Oh hello. Welcome. Dr. Lutz?

Stephen Lutz: Hey guys.

Adeela Khan: Dr. Naierman, or Naomi Naierman?

Naomi Naierman: Yes, here.

Adeela Khan: Ms. Tapay?

Nicole Tapay: Yes.

Adeela Khan: Okay. And that's all I have on my list. So welcome and the process for today's call - first let me start out to say, apologies. There's been a problem with the Survey Monkey, so I understand not everyone was able to enter their comments and voting in Survey Monkey. And at the end of this call, we'll be sending you an email to go ahead and readdress the Survey Monkey.

Also please let us know the specific issues you were having, and we'll see if we can get those fixed for you following the call. So apologies for that, and still today is important because we're going to be discussing the measures with the group as a group and getting your input as to your initial recommendations on the measures. And then the Survey Monkey will serve to record your votes. Any questions about that or comments?

Naomi Naierman: I have two questions, this is Naomi.

Adeela Khan: Yes.

Naomi Naierman: Is it usual, usually the process that we actually see the results of the Survey Monkey survey, I mean, results or not. In other words...

Adeela Khan: Prior to our in-person meeting or...

Naomi Naierman: Yes.

Adeela Khan: ...prior to the workgroup - prior to the in-person, yes...

Naomi Naierman: ...prior to this call.

Jennifer Malin: Well, usually we do try and send them out but...

Naomi Naierman: Okay - because of the problems you had.

Adeela Khan: Yes, we've been having some...

Naomi Naierman: I understand.

Adeela Khan: ...technical problems this morning, so...

Naomi Naierman: Okay.

Adeela Khan: ...we weren't able to send them out, but as soon as everyone has them all entered in, we'll definitely turn those around to you. And we'll also give you a copy right before the in-person meeting so that it's fresh in your mind how you voted.

Naomi Naierman: Terrific.

Eduardo Bruera: Hi, it's Eduardo. But are you going to tell us how to fix it? Because we've been trying to do it in many different ways, and it was just impossible to put them into Survey Monkey.

Jennifer Malin: Yes, we are working with the people at Survey Monkey to try and find out what's going on. And so what we'll do is, after this call we'll send out an email to everyone when we fix the problem, and we'll - hopefully that'll work out.

Naomi Naierman: I have another question.

Adeela Khan: Sure.

Naomi Naierman: I don't recall - having served on the End of Life Steering Committee, the NQF steering committee, I know we reviewed the Family Evaluation of Hospice Care. Did I see on the list of measures that we were to consider in this committee the FAHC? Or is that history, even though it's in the past been endorsed by the Cancer Committee?

Jennifer Malin: We don't have that measure before us for this cycle. It could...

Naomi Naierman: Okay.

Jennifer Malin: Okay. It could be that...

Naomi Naierman: I was wondering because I know that in a previous Cancer Steering Committee meeting several years ago it was considered and endorsed and I wasn't sure whether we would be presented with a maintenance endorsement. So you've answered my question.

Adeela Khan: Okay, all right. Anything else.

Craig Earl: Yes, one other thing, just - Craig Earl, here, developer of several of the measures and, just, I didn't hear my name called on the role, so just to let people know that I'm here.

Jennifer Malin: Thank you. Actually, typically the developers are in the, kind of the public segment of the call. So but welcome.

Craig Earl: Oh, I'm happy to do that if you'd like.

Adeela Khan: No, you're fine.

Craig Earl: When would I call back?

Jennifer Malin: No, no, no, don't call back. What usually happens is the workgroup really has to go through its deliberations, and then we might ask you for questions. At this point, we don't have to ask you to come off mute, that's the biggest thing, so - or the operator to open your line. So we might have questions as we go through, and feel free to respond at that time. But otherwise it'll just be a workgroup discussion.

Craig Earl: Okay, I'll mute myself, then.

Adeela Khan: Okay, thanks. Thanks for being on. All right, we can go ahead and start, because we know we have a lot of measures to get through. Dr. Bruera, I have you listed for our first two measures. The first measure is 0210, Proportion Receiving Chemotherapy in the Last 14 Days of Life.

And the process is, if you would tell us what your thoughts and highlights are about the measure, your thoughts on the recommendation. And then we'll open it up to the rest of the workgroup members to discuss their concerns and recommendations for the measure. So with that, Dr. Bruera?

Eduardo Bruera: Thank you very much. This measure is a measure that some of us are completely familiar with because it was presented before the Palliative Care Committee, and it pertains to the administration of chemotherapy within the last two weeks of life. They had initially (incentive) data about 30 versus 14 days, and that was reasonably well settled, and the evidence was reasonably well presented.

There was also some discussion regarding the presence of a rather, a little bit of an older database and some need for further clarification about what was implied in the treatment. And some of those requests went back to the sponsor, in this case, the American Society of Clinical Oncology.

The way the measure is outlined, to me is very, very clear, is very practical, and basically I was left with no further concerns about that patients who died of cancer and received chemotherapy in the last 14 days of life, is evidence based, is highly reproducible from existing records. And therefore I personally gave it the highest level of endorsement.

Stephen Lutz: Yes, this is Steve. I'd like to agree. Since we had the time, since we went over these in the Palliative meeting last summer I've been thinking about these. And I agree, I think this, you know, Craig had mentioned when we asked him in that meeting which one he thought was highest level quality or most important.

And I agree, of all those submitted by ASCO, I like this one and I actually like it the most.

Jennifer Malin: Okay.

Naomi Naierman: This is Naomi. I, too agree. The only question I had in my mind is whether the quality, certainly the quantity of the studies and everything else I thought should get the highest rating, but there was some mention, even in the developer's notes that the quality was not as high as it could be.

And I wondered if that referred to the fact that it wasn't a perfect randomized trial kind of study or evidence. And anyone, I mean, otherwise I think the data are pretty self-evident. I just wondered if anybody had any questions about the "quality" of the data in the studies.

Eduardo Bruera: Hi, it's Eduardo. I think the point is well taken. These are outcomes research, and you cannot really do randomized controlled trials to measure many of these variables. I have to say that a lot of the so called high evidence that was based on the, for example, in our previous

committee, in the End of Life Committee, was based on the fact that they applied instrument development techniques or methodologies, and then you can have higher level of evidence.

But it's also quite trivial. This is huge; this is major as an outcome. But regrettably, for ethical reasons as well as funding reasons, generating Level 1 evidence in many of these cases is just not going to happen. I was left very comfortable that the level of evidence is strong enough as compared to all the other outcome measures that were not related to instrument development, for example, that then you could really do a very thorough process of psychometric testing and so on.

So the point is well taken. We will not have an incredibly high level of evidence, but as compared to all the other ones that have already been approved, I think this one is not necessarily behind at all.

Naomi Naierman: Okay. The other question I have is, when you refer to this as outcome measure, I, to me it seemed like a process measure. In other words, yes, if this happens, if fewer days are spent, we think and we know - we think that quality of care is actually improved. Do we know that for sure?

Eduardo Bruera: Well, I think we have quite good evidence that there is considerable suffering, both symptom wise, psychosocial wise and financial, in addition to potential life shortening from using therapeutic interventions that might not be useful. So one could argue it in many ways, if you consider that an outcome, or if you consider it a process measure.

I personally think that it's, in my view, think that you might do that, might not be necessarily very good and have side effects, would be a reasonable outcome to decide quality. But, you know, if - I don't know how to say that, you know, this is one of the gray areas where processes result in outcomes, should then we say that the outcome would be the suffering or the money, and so on?

Well, that's where I think things get very complex, because there are multidimensional reasons why somebody might be suffering more side effects or have more financial distress and so on. I think that making this a very firm event that is measurable and that is associated with quality, it to me would be very appropriate.

And, you know, I would personally see these as a true outcome of the process of care that has been delivered to that patient. But I understand your point very well, that some people might say this is a process. I'm not sure if it does make a big difference.

Naomi Naierman: Probably not. It just technically seemed like a process measure.

Nicole Tapay: Well, I mean, this is Nicole Tapay from NCCS, and again, I'm not a clinician, I'm a lawyer and I'm here as a patient representative. But I did think it was a process measure, as least as it was explained and so I, it was like, at least perhaps from the NQF staff, that some...

Naomi Naierman: I can't hear you very well, I'm sorry.

Nicole Tapay: What we, are we - if we're to endorse it, are we endorsing it in a measure type as a process or an outcome measure, is my question. But then on the substance, I guess, I noticed in some of the discussion of the literature there was some discussion of the differential between some kinds of cancer such as breast and ovarian.

I personally lost my mom to ovarian and had, and was with hospice and her in the last months of her life, so I have some experience on a direct level with this. And so I would just like to ask the clinicians on the line if you feel like, you know - and again, that's why I was a little more comfortable with it as a process measure than I was as an outcome measure.

Because I think there was actually some question in her case whether it extended life for a couple of months. So obviously that's not a randomized trial, that's one person.

Jennifer Malin: Well Nicole, Anthony, do we have the developer on the line from ASCO or anyone from ASCO on the line?

Craig Earl: Yes, I'm the developer, I'm on the line. Regarding process versus outcome, to be perfectly honest, as I think back to which thing got checked off for that, these measures have been part of the NQF thing for several years and the, part of the prior submissions were sort of ported over into the new electronic submission form.

And I think that was, I believe it's the case that that was, they were put in as outcome and I thought, well if that's what, that that's fine. You can definitely argue it either way. It is a process as care. I'm not sure what the implications from your point of view end up being if it's classified as process versus outcome, but I believe it was more a passive decision to categorize it that way on my part.

Stephen Lutz: So this is Steve, I - go ahead. Oh, so that's the key question. We've had a lot of, you know, from the Palliative Care meeting on to now, the first one here, we've had a lot of lengthy discussion about what is process or what is outcome. And I guess I walked away from the Palliative Care meeting still not certain, as Craig just said, what the implication is either way.

I, to me it sounds more semantic. Maybe there are more nuances that we don't understand, but it doesn't make a difference to me. It's important.

Naomi Naierman: Yes, I think it makes a difference. It's just one of the questions that were asked, and I just wanted to be sure that I understood it one way or the other. But I don't think it really matters in this discussion.

Nicole Tapay: Well, I mean, the reason I asked was there was a note that said that this is not intended to identify a never event. And again, I'm not an expert on quality outcomes measurement, I'm a health policy expert but, you know, I didn't know if by using as an outcome versus process that was going to make it more, look like something that you would never want to have happen, and therefore give no discretion as the process is being measured to, or less discretion to providers on that.

Craig Earl: Correct. And that applies to - this discussion applies to all of the measures that we've submitted, so the next several of them. And from my point of view, it's perfectly fine and appropriate to consider them as process measures, if that works from an NQF definitional point of view.

Eduardo Bruera: I would say that - it's Eduardo, I think that would not be the case, really, because outcomes are also not a never event at all. I mean, the outcomes are something that you will look in a cohort level. And we got bogged down in an incredible way in the Palliative Care one regarding the ICU Admission ones and two or three or more, about the fact, exactly that point.

And I think, I don't understand that there is any reason to think that outcomes, per se, would be never events or always events. It's like C-sections or anything else. You do C-sections in 20% of your deliveries you are fine. You do C-sections in 80% of your deliveries, and then you have a problem.

But if you're going to say that because a C-section was decided it should be a never event, that would be making outcomes almost impossible. So I'm not sure that the fact that you do something in process or in outcome would result in never event, because they are processes that would also, we probably never event.

Operating on the wrong side might be an outcome that you want to never see. And from the process part, there's a lot of processes that you don't want to have done ever. And so I'm sure that we can probably categorize things as outcomes, and those outcomes don't necessarily have to be never events.

And then the frequency of those outcomes in a comparative manner might help us understand if those outcomes are biased in one way or another. Otherwise it would be absolutely impossible to come up with conclusions today.

Nicole Tapay: Okay, that's very helpful.

Jennifer Malin: That's correct. Are there any more questions around that? Okay. Any more discussion about this particular measure and the recommendation for this measure? Okay. So Dr. Bruera, I believe we heard from you that you are recommending this measure be endorsed.

Eduardo Bruera: Yes.

Jennifer Malin: Okay. All right and if there's no other discussion from the workgroup on this, we'll move on to measure 0211, Proportion with More than One Emergency Room Visit in the Last Days of Life.

Eduardo Bruera: Yes, we, many of us who were participating on this before, we are also aware of this measure, and basically we are also aware of the fact that there had been some discussions about the specifics of the database that I think have been addressed, to my understanding, very well. There had been a very good response package for this.

Now we go into the same situation of everything we discussed before, and I am glad that the colleagues have raised the fact that more than one emergency room visit in the last 30 days of

life would never be an outcome that one would say one would never like to see. A lot of patients will go through the whole complete perfect process but then will choose to decertify from hospice and come back to an emergency room.

And I think this one as the ICU one had a strong level of debate. I think that with our understanding now, this looks to me as a very solid measure. There has been debate about the 30 days here too, and basically, I guess ultimately the shorter the period the stronger the evidence for this not being a good idea, but to me it's very well put together.

So I was, I felt that the data from (Dana Farb) and basically the assessments that they provide were very good. And I feel that this is also something that can be easily retrieved from existing information, and therefore I was strongly supportive.

Jennifer Malin: Okay. Thank you.

Naomi Naierman: Ditto Naomi. This is Naomi.

Jennifer Malin: Okay, thanks.

Stephen Lutz: And this is Steve, I agree. I think the only thing I would add, this one and I don't want to jump ahead, but the one after that talks about hospitalization, I think that, in my mind if one gets passed, probably both should. And the reason I say that is, I practice at two hospitals and one set of medical oncologists will tell patients if there's a question that they might get admitted, go through the ER.

At the other hospital, that is never done. They direct admit and then go assess them themselves. So if we are going to use a measure of ER visits, I can already tell you, my hospitals are markedly

different, but if you also take into account number of hospitalizations in the last 30 days it would catch up to that, if that makes sense.

In other words, there are ways to say, oh, you're almost going to be assessed in an ER but I'll do it on the floor, versus, I don't ever want to go and take care of patients in the hospital, I'll send you through the ER. So I just, I see them as being more paired than maybe I did before I thought it through.

Male: Good.

Jennifer Malin: Are you saying paired with the next one, 0212?

Stephen Lutz: Well, I'm saying that if, yes, I'm saying if this one passes and the next one doesn't, I can see a way where there'd be a discrepancy perceived, but not necessarily a discrepancy in terms of the amount of, you know, very active care in the final weeks of life. So I'd, you know, I'm just making the point that it'd be nice if both of them get passed, then that'll be nice. If only one does, then I'm going to have a little concern.

Jennifer Malin: Got you, got you. Other comments? Okay, well I'm hearing a recommendation for that one.

Male: Yes.

Jennifer Malin: That's a yes, okay. Any more discussion about 0211? So our next measure is 0212, Proportion with More than One Hospitalization in the Last 30 Days of Life. And we didn't - I believe we may have asked Dr. Lutz to walk us through this measure. I don't think we have a discussion lead for this measure or the next one, unfortunately. So Dr. Lutz, are you able to speak to this one? Or did you want to sort of...

Stephen Lutz: No I can. I can, yes, I didn't realize we were, but now I'm happy to, because I looked through them all.

Jennifer Malin: Okay.

Stephen Lutz: I think this is similar to the last one, that it's a very good overuse measure. My only question, and I'm asking this out of complete ignorance, since I don't admit to the hospital. And I think I asked this when were on site in July and I'm not sure I can remember the answer.

But the only question I have about this one is, in my staff meetings it seems like there are now so many different levels of hospitalization. There's, you know, admissions, there's 23-hour stays, there's - I mean, is it going to be harder to pull the data out for hospitalization than it would have been, you know, in 1980 when you were either in the hospital or you were not in the hospital?

And so that's the only - looking through this, I think it pairs well with the one before. I think it's an extremely well done and useful measure. Is there anything that might be missed just by virtue of the fact that there's apparently so many levels of hospitalization these days? Or is that a non-issue?

Jennifer Malin: Is that a question for our clinical experts on the call?

Stephen Lutz: Yes, I'm checking, I don't know if, Eduardo, if you or anyone else has a thought on that. I just, you know, literally every time I go to a staff meeting all they talk about is, you know, well this, it's a 23-hour, this is an observation versus a 23-hour admission versus an actual admission, is - does anyone know, is that going to make it harder to figure out what hospitalized even means? I don't know. I mean...

Eduardo Bruera: I would agree with the comment that was very appropriately made about the fact that if we define hospitalization as more than 23 hours and we define that, then people would accept that emergency room is probably not a good idea. Probably the hospitalization would fit the same definition.

Now, and I think that, again, to calm down some anxieties that were generated in the last meeting, I think if we agree that this is not something that anybody should feel that there was, there is going to be a major issue with quality or reimbursement or whatever it is that happens once in a while.

But it's those institutions that I think Steve was making a point, that might do this 50% of the time are the ones that might be outliers as compared to the rest, then I would feel that this is well written.

Stephen Lutz: I agree. I think it's very well worth passing. And I don't know how well it, how easy it is to pass on caveats, but I think those are the, sort of the caveats to sort of pay attention to.

Nicole Tapay: Yes, I mean, this is Nicole. I would just second that caveat, because I think that given the policy landscape we are in and the reimbursement landscape we are in, obviously these kinds of things are going to be looking at...

(Crosstalk)

Nicole Tapay: ...considering reimbursing. But that being said, I would concur with the recommendation.

Jennifer Malin: Did we want to hear from the developer on that question?

Craig Earl: Sure, the - so far the, when we've looked at this it has not been a problem differentiating these two. But it is true that it's a changing landscape and that that may change in the future.

The main thing was to differentiate emergency rooms stays, which can last up to 23 hours and are usually billed that way versus an actual inpatient admission from non-acute, meaning palliative types of designations.

And so far, in Medicare claims we've been able to do that. So as long as the definition is the same across the board it should not be a problem.

Stephen Lutz: Okay, that helps, yes. Like I said, I came from a complete, you know, point of ignorance, so that helps. I think it's a very good measure to pass, absolutely.

Jennifer Malin: Okay. All right, very good. Any additional questions about 0212? All right, hearing none we'll move on to 0213, and again, Dr. Lutz, do you mind reviewing, or would you like to...

Stephen Lutz: No, no, I'm happy to. I'm happy to and, you know, this was the one, if we recall from the Palliative Care meeting I think was the most discussed and, I don't want to say contentious, but there was more ideas brought up over this.

So this is Proportion Admitted to the ICU in the Last 30 Days of Life. And is true with the previous three, I think there's been some good additions since we first discussed this last summer.

I think the only, if I play devil's advocate, the only things I can think of are two things, and they might be minor, but I'll just mention them as a discussion point. One is, I do think that there are some smaller hospitals that are concerned about their level of - as we have less and less cancer floors I think there are some hospitals that worry about the level of average or nursing care on a

standard floor and will admit cancer patients to ICUs just thinking they might be more sick and might require more nursing care.

I don't know if that's true at all in bigger hospitals but I've noticed that in smaller hospitals. And then - I'm trying to think of the other point I was going to make. I guess the - that was my main one. I mean, I think, like we said, this one's been discussed a lot. For me it's still passable, but it's sort of less relevant than all the three prior to it and even a couple after it.

I think it's a good measure but it doesn't quite, I can't sink my teeth into it as much to report to the public, oh, ICU days, yes, that gets so, that's more, sort of for policy people in medicine, a little bit less easily understood by some folks outside of those venues, I think.

Eduardo Bruera: Hi, it's Eduardo. I'd like to express that I think this a very major problem in cancer care, and I think it is acquiring the size of being quite epidemic. So and the level of distress and suffering brought by mechanical ventilation, hemodialysis, multiple central lines, can be enormous, as well as the financial burden is almost impossible to estimate appropriately.

And basically there is really limited justification because it is a very expensive and very unfortunate event. I think the way it is worded it will, hopefully, be very reassuring to those who might have had concerns before about the fact that this might somehow preclude people who had an event that, in hindsight would result in the death from being admitted. It doesn't look like that at all.

And again, it is looking at trends rather than looking at events that would make this a problem. Meaning by that, institutions in which 60% or 70% of the deaths are ICU and regrettably there are institutions where 60% or 70% of the cancer deaths occur in the ICU setting, then, versus institutions where these might happen in a much, much lower percentage, might be a fair quality outcome.

So I would see it from that perspective rather than really being an occasional unstable patient that an institution might want to admit for stronger levels of observation. I'm not sure that this, the way it's written would preclude a smaller institution from admitting those very unstable patients. It's more bringing those dying patients that might be an issue.

Stephen Lutz: Well you've educated me, because I don't have access or exposure to a lot of places, so the fact that there might be places, as you describe that are having that many people in ICUs, then yes, it makes me much more interested in passing this one. I didn't realize that, that there are places with that level of involvement of ICU care for these patients.

Jennifer Malin: That goes to the importance of this measure, okay. Okay.

Stephen Lutz: So I would say, given that reality, I think it's very reasonable to pass, absolutely.

Jennifer Malin: All right, thank you. So any other discussion about this measure, proportion admitted to the ICU in the last 30 days of life?

Okay, hearing none I, we'll move on to measure 0214, Proportion Dying from Cancer in an Acute Care Setting, and Dr...

Stephen Lutz: All right, there's, this - I'll say, I think you get to hear my voice some more, sorry.

Jennifer Malin: That's okay, thanks.

Stephen Lutz: So this is, I think in some ways related to the previous few and, you know, so the, not just the percent that have involvement in ICUs or hospitals in the last month, but that are actually dying in the acute care setting. And I think the reason that this is an important measure, from my

perspective, it's not just the practice pattern of the physician who has a patient that dies in the hospital setting, I think this actually also speaks to a bigger picturability or set of capabilities of a region.

Is there an established hospice program that can handle these patients? Or is this a measure that proves that hospice should be more robust? I mean, there's an entire list of things that would have to "go wrong" for someone to have an extremely high rate of patients dying from cancer in the acute care setting compared to their peers.

So I think it's a measure of a lot of things, and for that reason I like it, even in addition to all the previous measure that somehow seem loosely related.

Jennifer Malin: All right. So throwing it open to the rest of the workgroup, are there other comments? Naomi or Nicole?

Naomi Naierman: I totally agree. There's a whole lot of similarity among these measures even though they're quite different from each other. Certainly they're of the same source and the same rationale.

Eduardo Bruera: One of the - it's Eduardo, one of the concerns that might be approached is that in recent years the development of palliative care units and palliative care programs does change the equation of acute care hospital death. I am - and also the clear limitations and lack of interest by hospice in cancer is another component that puts some problems in the equation.

I don't, I'm not sure we understand it that well. I would support what Steve very well proposed, but I think that's something we all need to be aware of, that hospice has progressively moved from delivering more than 85% to 90% of their care to cancer patients to less than 30%, in the recent statistics, 35% or so, and in some of them, 28%.

So that is partially because of the complexity of the cancer patient, but also, acute care facilities have compensated by creating palliative care units. So it's a more complex scenario. I still think that what Steve proposed is appropriate at this point. It might need to be reviewed.

Stephen Lutz: I think that's one of these - it's a very good point. One of the questions that I wonder about, I know for some of the other quality measures in things like heart failure, if someone has received a palliative care consult or admission, they're actually not counted against cardiologists for having, you know, patients die within a certain number of months of diagnosis or whatever quality measures.

I don't know if those are NQF or not but I guess, you know, the question is, is there a way to work in here a caveat like that, where if someone, you know, is in, you know, an acute care hospital because they're in hospice? Are they getting specific oncology related palliative care that that takes them out of the, you know, out of the number to be assessed?

I don't know. It's just - I know, because our hospital got in trouble for not sending heart failure patients for palliative care consults, and as soon as they did they said that our heart failure care was fantastic. We went from last in the - third from last in the country to top 10%, and all we did was do more palliative care consults. So I don't know if that's...

Jennifer Malin: Well, Dr. Earl, are you on? Do you want to speak to that at all?

Craig Earl: Yes, unfortunately the issue is that these are intended to be evaluated with administrative claims, and that currently, in that way who we're not able to identify, in the U.S. we're not able to identify the palliative care consult. When these have been applied in Canada we can, and so that's less of an issue. So when the data catches up then that would be a good modification for us to make.

Jennifer Malin: Other comments from the workgroup? So the - am I hearing this is a recommended measure for endorsement?

Stephen Lutz: Yes.

Jennifer Malin: Okay. All right. Unless there's more comments on 0214, we'll move to Naomi Naierman and 0215, Proportion Not Admitted to Hospice.

Naomi Naierman: So this is almost the converse of all the others we've just talked about, is do we, is there evidence that shows that when you do get referred to hospice, you're going to get increased, when it's appropriate, increased quality of care, especially knowing that most people do want to die at home and that hospice provides palliative care rather than aggressive care, or not the care that you'd get in acute care settings or certainly ICUs.

All the related, you know, the technical questions, I thought were addressed very well, and in a way, actually, very similarly to the other measures, so I have no qualms about recommending this measure to the committee.

Jennifer Malin: Okay. More discussions from the workgroup?

Nicole Tapay: There was just a clarification but I think Naomi answered it. I mean, by admission to hospice, whether it's at home hospice or a facility hospice, if they were going to be a correct...

Naomi Naierman: Yes, because in reality, a very large portion of patients get treated at home or where they reside, and which is, can include nursing homes and other kinds of retirement facilities. So they're, only get referred to inpatient hospice when it's too complicated or too unsafe to treat them

in their home so - or to care for them in their home. So yes, I think it's equivalent, it's, there's no reason to distinguish between the two.

Jennifer Malin: Okay.

Stephen Lutz: Yes, I think it's a good measure.

Jennifer Malin: All right. So that, this one also, recommends it for endorsement?

Naomi Naierman: Yes.

Jennifer Malin: Okay. We'll move on, unless there's more discussion, no. We'll move on to 0216, and Nicole Tapay, Proportion Admitted to Hospice for Less Than Three Days.

Nicole Tapay: Hi, yes, similarly to Naomi, I think this is a strong measure. I think it looks a relevant question about whether people are having, you know, the offering of palliative care and, you know, end of life conversations with their providers and others and their family early enough to help them get the support at the end of life.

I mean, it does dovetail with, I think, some of the more difficult policy questions about whether people have to give up any, so for curative care and the whole question of when people give up hope. But given the three day time frame for that, rather than what might have been a month or two, and again, I haven't been a part of some of these earlier discussions, but I did work on the Hill on these issues in my past as well as have the personal experience.

And so I think, you know, that the evidence presented is strong, to look at it as a good tool measure for comparing across settings and populations. So I would support it.

Jennifer Malin: Okay, thank you. Discussion by the workgroup? Very similar...

Stephen Lutz: Another good one.

Naomi Naierman: Yes.

Jennifer Malin: Good one, okay.

Naomi Naierman: Yes, definitely endorse it.

Jennifer Malin: Okay, very good. All right, that brings us to measure number 1822, and I'll pause here, I think that Dr. Lutz, did you also agree to review this measure?

Stephen Lutz: Right, right as long as I can add a disclaimer. And the disclaimer is that the guidelines that this was the impetus for this one is mostly based on, I wrote. And so from the time there were guidelines to when ASTRO worked through the submission for the measure I had nothing to do with it, but I did sort of do that background stuff, so, if I sound...

Jennifer Malin: Okay.

Stephen Lutz: ...yes, so just so everyone knows, if I sound a little bit more passionate or have a deeper knowledge of it, that's why. So...

Jennifer Malin: Before you get - oh, sorry. Before you get started, I would like to ask if, the operator if someone from the American Society for Radiation Oncology is on the line.

Anushree Vichare: Hi, this is Anushree and I'm from ASTRO. I'm on the line and...

Jennifer Malin: Okay.

Anushree: And Potters, who was our radiation oncology expert, will be also joining in shortly, but I don't think he's going to have the open line, so...

Jennifer Malin: Okay, we'll watch for that. Okay, I'm sorry to interrupt, Dr. Lutz. Go ahead.

Stephen Lutz: Okay. And I'd say, since we haven't been through this one before, if you don't mind I'll give sort of a view from 30,000 feet for a couple of sentences so you can picture. So treatment with, for bone metastasis with external beam radiation is extremely common.

The recent survey worldwide of, we call it fractionation schemes, how many treatments you use and what total dose and what dose per day, there was 101 different schemes being used worldwide for a situation as simple as treating for pain and bone metastases. And so the request was made that we go and look at the available data to determine what would be most reasonable.

And there are a tremendous number of prospective randomized trials that show remarkably similar results. And so that was the impetus for this being, I think, brought up as a measure. So it is, the measure title is, External Beam Radiotherapy for Bone Mets from ASTRO. It is to look at patients who fall within the four fractionation schemes that were considered equal after assessing all of those previous prospective randomized trials.

So the numerator is those that get that fractionation scheme and the denominator is all those that get external beam radiation therapy for bone mets. So obviously, that would mean there are other fractionation schemes that could be used. Denominator exclusions were pretty clear and just left out things like patients who were at risk for fracture or spinal cord compression.

It was thought to address a priority goal in terms of overuse of palliative care. Performance gap was seen to be about 20% to 22%. So I actually said the impact would be reasonably high, because I think this is an important measure since it's one of the few areas in radiation where we have almost a half a dozen good prospective randomized trials, all of which agree.

It would seem that's where you start to see if people are following data. I think that the opportunity for improvement is high. I think the, if you will, checking the reliability and validity has been done pretty well. And I think, in terms of public reporting, it is a little bit more nuanced than some of the other measures we've discussed like dying of cancer in a hospital.

I think it's a little bit harder to describe to the public, gee, someone didn't get a fractionation scheme that should have been accepted based upon data. It's a little bit less impactful, but I still think it's important. And I think from a devil's advocacy standpoint I think the only issue is, some of the measures for treating bone metastases are changing and there may be new data coming out in the next year or so for newer types of technologies that obviously will not be included in this.

So if this is a quality measure that's used, we just have to make sure that as more prospective randomized data comes out, even some, possibly within late 2013, early 2014, that it's included without sort of penalizing people for not following what's been true to this point. Does that make sense?

Naomi Naierman: It does to me. This is Naomi.

Jennifer Malin: Any others? So I'm hearing a recommendation for endorsement. Is there any other comment from the workgroup members? No. Is there any question that we have for the developer on this one? No.

Female: ((inaudible)).

Jennifer Malin: Okay. I'm sure it's...

Female: Are you all still there?

Stephen Lutz: I'm, so the only, the advantage we'll have, I think, is if there's one or two other radiation oncologists on the, in the bigger group. So if we come to the bigger group for discussion, they may have, you know, they may be able to push this a little bit more in the nuances. And that'd be helpful. I mean, this is something...

Jennifer Malin: Okay.

Stephen Lutz: ...again, I'm biased. It seems great to me, but I'm more than interested if some of those folks bring up other issues that we should think about.

Jennifer Malin: Okay. Yes, and we'll look forward to that in-person meeting discussion as well. As with all of these measures, this is just our first kind of preliminary recommendations, and then we'll have, again, full discussion at the in-person. At this time, if we are, if the workgroup feels like it's complete with this discussion, we'll open the line for public comment at this time.

Operator: And all...

Jennifer Malin: Anthony?

Operator: Yes, all lines are now open, so if you do have a comment or question, your line is now open.

Jennifer Malin: Hello? Anyone, any comments from the public? Okay. Well, hearing now, we'll talk about the next steps. And I will have Adeela tell you more about what's going to happen next. Again - apologies again about the Survey Monkey. I'll just say real quickly, we will be sending you a follow-up email about the Survey Monkey, and it is key that you enter your votes on each measure for each section of the measures.

And any additional comments you may have can be entered at the Survey Monkey, point it for discussion at our in-person meeting. Adeela, do you have more?

Adeela Khan: Just, our in-person meeting is in two weeks. If you haven't arranged any of your travel or anything yet, let us know and looking, we can get that information to you. We will be serving a lunch so if any of you have a restriction of some sort, just let us know again. And that's really all of it.

Again, sorry for the Survey Monkey. We'll try and get everyone's results out by the end of today. And if anything, you will have them in your materials book prior to the in-person meeting.

Jennifer Malin: Are there any questions about those items? Okay, I guess we'll be giving you back several minutes of time here. Thank you all and please feel free to email us off line if you have additional questions or concerns.

Female: Thank you.

Female: Thank you.

Female: Thank you.

Male: Thanks.

Operator: Once again, this does conclude today's conference. We thank you all for your participation.

Adeela Khan: Thanks Anthony.

Jennifer Malin: Thank you, Anthony.

END