

NATIONAL QUALITY FORUM

**Moderator: Reva Winkler
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3:00 pm CT**

Operator: Good day everyone and welcome to today's conference. Please note today's call is being recorded. You may begin.

Reva Winkler: Good afternoon everybody, this is Reva Winkler with the National Quality Forum. Thank you very much joining us today on this conference call, the Cardiovascular Endorsement Maintenance Steering Committee.

Today, we have two major agenda items; one is to look at the updated specifications and submissions on the AMI and heart failure mortality measures and the heart failure readmission measures as well as to continue our conversation from last - from September 2 on the comments received during the recent NQF member and public comment period.

With that, I will turn it over to our Co-Chairs, Ray Gibbons and Mary George.

Ray Gibbons: Hi everybody thanks for taking the time to join this call. Reva has indicated that the agenda has two headings on it. I would like for us to think of this as a three-part agenda. The new measures on MI and heart failure and then the review of the letter from the ACCF, AHA, and PCPI regarding the measures we didn't recommend and then the competing measures.

And the reason I'd like to do that - think that way is I think we were going to roughly allocate 30 to 35 minutes for each one of those three items. So I will be trying to move us along in an effort to keep to that.

For those who were on the September 2 call, we tried to point out what items we were deferring. For those of you who weren't on that call the - we never got to the Yale measures, the new measures on that call. We didn't think we would and we didn't.

We also deferred discussion of comments on Measure 330, which was the hospital readmission rate following heart failure. We briefly got to the ACCF, AHA, PCPI letter but felt that we needed more time to adequately review that. And we had a discussion on competing measures and I think we would have benefited from all being reminded of the grid that we had reviewed prepared by staff at the time we had first bolded on those. And they have regenerated that and revised it a bit so that it is included in the agenda materials.

For this call you need the email that was sent around on Wednesday, September 7 at 19:06 and that has attachments, the agenda. And then two separate attachments entitled MM Revised CMS Measures, MM SC Comments. Those are the three items you need for this call. So if you don't have those in front of you on your computer see if you can find them quickly because I think that will facilitate your involvement. And we'd like to have everybody involved if possible.

So with that preview we're going to start with the revised AMI and heart failure mortality and heart failure readmission measures from CMS and the group at Yale. I believe we have several people from Yale on the call so I would ask them at this time whether they want to make any brief comments or they just want to wait and answer any questions that arise during the discussions.

Elizabeth Drye: I would - this is Elizabeth Drye at Yale. I would - for all ((inaudible)) staff, I don't know if you're going to present our findings or, you know, we're fine, you know, just waiting and making comment later but if it's helpful I could give a quick overview.

Ray Gibbons: If you want to take three minutes to do so, that would be fine or you could just wait and field questions, either way is fine with me, whatever you prefer.

Elizabeth Drye: Okay, well, let me just give a very, very short introduction to what we tried to here, which was to evaluate the three measures that are up for endorsement maintenance in all payer data using data from California, which was a great data set because it's so large with so many hospitals and 10% of the US population.

And so we really structured the question and focused on two - we focused on two questions, one was can we - can the - does the measure work when we only use admissions - data from admissions for risk adjustment versus data from both admissions and outpatient visits and hospital outpatient information for risk adjustment? Because we know most all payer data sets are really going to be just including admissions data for patients.

And the second question, which was - we looked at much more in depth was do the variables we selected, model we created work well when you move from a 65 and older population to an 18 and over population? And as you know the way our model is specified, we always reset the model and the data that - in the data set.

So our model is - been in all the hospitals that are being evaluated and we estimate the coefficients for risk adjustment - a new - every time. They're looking at a population of hospitals and it wasn't enough just to look at, you know, does the model looks like it performs well, have a good T statistic.

We really want to understand when we bring in ((inaudible)) and over patients - sort of the questions we were asking was should we have selected different variables? Are these variables that we selected using a 65 and older population going to be good enough in an 18 and over population?

And as you can see from our report and our recommendation that the measures ((inaudible)) specified for 18 and older without changing the variables except the age variables when moved from 65 and older to a continuous 18 and over age variable. The results were really reassuring and it looks like the variables worked really well in the full 18 and over population.

It looks like the risk adjustment worked well without the Part B non-admission data for risk adjustment. So we were pleased with the results. We think the measure would work well. And we didn't want to - we don't think we need to go back and reselect all the variables to have this measure be usable in a fuller all payer population. So I'll stop there.

Ray Gibbons: Okay, all right, thank you. Any questions for the committee before we move to the measures themselves? From the committee, I'm sorry. Okay, we will start then with Measure 229, which I would point out is not the first measure in the attachment so you'll need to scroll down to find 229 if you want to follow along. It's actually the second measure in the attachment.

So this is hospital, 30 day, all cause risk standardized mortality rate following hospital heart failure hospitalize for patients 18 and older. I think we earlier had a discussion about this whole issue and that discussion recognized the importance certainly of quality improvement in heart failure and the importance of looking at outcomes such as mortality rather than process measures.

I just wanted to highlight a few things in the important section of the application. The first appears on page 3 of the application where they did look at issues of disparity and basically found out that hospitals with large proportion of African American patients are not consistently performing at

either a higher or a lower level than everybody else. They have the same distribution of performance as everybody else.

Also within part - section 1 of the application, I think there's a section of the application devoted to end of life care, which came up during the public comments on our September 2 call that appears on page 5.

And the developers have added an exclusion for patients who are enrolled in hospice prior to or on the day of admission but not excluded patients who are discharged to hospice or seek palliative care during the admission to a - simply account for the fact that that may be the result of poor care.

They also have accounted for other risk factors that are measures of frailty, things like dementia, hemiplegia, etc. And I think that addresses that issue that was raised in the public comment.

So are there any questions from the committee regarding the issue of importance? We are going to vote on these by basically email online balloting subsequently but just to pursue the same format we followed during earlier discussions. Any question about importance of this measure?

Okay, hearing none we're going to move on to Measure Specifications. I think the measures in use and familiar, I think, to most people. It's very well specified. I would point as one thing that I noted on page 6 of the application, which I hadn't fully appreciated, which is that if the patient has more than one heart failure admission in the year one of those hospitalizations is randomly selected for inclusion in the measure so the measure doesn't get falsely dominated by somebody, for example, who has ten hospitalizations.

But I presume it's randomly selected simply because the group couldn't come up with a better way or rationale for choosing one hospitalization versus another.

I would also point out in terms of the specifications that on page 10 when they applied this measure to California they benefited from a unique patient identifier so that they could link State vital statistics records to assess 30-day mortality, that was one of the few questions I had about the application.

And I'd appreciate clarification from the developers because at least as I read the report data ((inaudible)) on all the testing, it made the statement that the developers thought it was unlikely that many measure specific cohort patients died outside the State within 30 days of their index hospitalization. And I just wondered whether they had any data to support that assumption.

Elizabeth Drye: No, we don't have any data. We were contracting California to state they had - you know, share more with other States but we really don't have any data to support that.

Ray Gibbons: Okay, I think that's at least one issue. I mean to some degree I, for one, think it's at least possible that people cross the Stateline and died. But are there any other questions about the scientific specification section?

Okay, and usability, obviously, this is in use on hospital compare right now. I think it's not widely appreciated but hospital compare is fee for service Medicare patients only and this potential - this application basically then widens this to all patients, age 18 and older and using the same methodology that was mentioned in the introduction that was carefully tested.

The committee received the supplemental information that Yale had prepared that numbered some 59 pages. I can tell you that I read through all 59 pages and it's very comprehensive assessment of the extension of this to the 18 and older group and not just the fee for service Medicare patients.

There are some things you notice as you would expect when you're going to adjust using just inpatient data for patient characteristics. All of the risk factors are recorded less frequently, which I don't think would surprise any of us but they still worked equally well in the models. And I think that simply reflects clinicians not always putting down every diagnosis on the sort of inpatient data for patient.

Any questions about usability? Okay, and then finally with respect to feasibility, I think this is obviously feasible for Medicare fee for services patients. And a reports and application to California that I've already mentioned prepared by Yale certainly have demonstrated that it's feasible in other cohorts.

And I think - I do think one of the issues that I see is just the one I raised about California vital statistics. As true epidemiologists, somebody like Tom Kottke may be able to tell me how ready the sources are elsewhere in the country to know whether somebody's alive or dead if they're not of Medicare age and on social security. But I'm sure there are resources available for that.

Questions or comments from the committee about the final issue of usability? I'm sorry, feasibility. Okay, does anybody have any questions whatsoever in terms of preparing them to vote online regarding this measure subsequently?

Okay, well, if that's - I think the absence of questions reflects, again, the comprehensive nature of the application from the Yale group and the previous experience in the Medicare fee for service population and the very detailed report testing it in California.

So I'm going to move on now to Measure 230, which is the hospital, 30-day all cause mortality following acute myocardial infarction. And Tom's going to lead the discussion on this. Tom?

Thomas Kottke: Yes, this is 330.

Ray Gibbons: I'm sorry, 230.

Thomas Kottke: Got that, 230.

Ray Gibbons: Three-thirty is the readmission rate following heart failure. Two-thirty is acute MI, 30-day mortality.

Thomas Kottke: Right, okay. Well, the Yale group - let's see if I have this right. Sort of caught me unaware here.

Ray Gibbons: Okay.

Thomas Kottke: Well, this is the - Yale did the same thing, correct?

Ray Gibbons: Correct.

Thomas Kottke: Yes.

Ray Gibbons: Tested in California the same way.

Thomas Kottke: Yes, and I went through it, read the document and was impressed that the - there does not seem to be any need to change the variables and that the fit is - I would say, extremely good. And so I thought that it worked well. I didn't have any real questions about it.

Ray Gibbons: Are there any questions from the committee about this measure, AMI mortality extended to broader patient groups other than the Medicare fee for service population? The Yale report points out that the C statistic exceeds 0.7 for both the Medicare fee for service population as well as the

broader population and the difference was - well, it was 0.713 versus 0.725. I think for most of us that would be viewed as cutting hairs.

Andrea Russo: So the - I'm just trying to find it here. So the delay between - so the mortality is being measured by - is it social security death index?

Ray Gibbons: No, this - when they tested in California, and that was the question I asked them about heart failure, they used vital statistics from data from the State of California. Is that correct, developers?

Elizabeth Drye: ((inaudible)), can we confirm that?

Female: I'm sorry, could you repeat the question?

Ray Gibbons: Is the mortality for the patients who are not Medicare was derived from California vital statistics for the California testing, is that correct?

Female: That's correct. It was California vital statistics for everyone 18 and over, Medicare and the younger.

Ray Gibbons: Right. So as I mentioned when I talked about heart failure mortality I think that's at least something of an issue for usability depending on the State and the adequacy of - or the location and the adequacy of the vital statistic data. I'm not enough of an epidemiologist to know whether all 50 States have equally good data on that point.

Thomas Kottke: So Ray, this is Tom. But the issue there is the validity of the California experience because you don't - you're basically judging quality of care or not and mortality, right? Well, but

there's probably not a lot of migration. The big issue is, like in Minnesota it takes us about 18 months to two years to get a...

Ray Gibbons: Yes, right, that's what I mean. How available is this - are these data in the various locations around the country? I don't know but it's best we can do.

Thomas Kottke: Yes, that's for sure.

Elizabeth Drye: This is Elizabeth Drye at Yale and if I can just make one comment. These - we've looked at the issue of 18 and over mortality data for the PTI mortality measure we did. It's also approved by NQF and any - when you look at these ((inaudible)) data sets you are going to have to think about potentially a national source for - State sources because of the issues that you're mentioning.

But we - California actually just connected this, you know, supplied us with the data in this case so we were focused on the question of does the measure work in these data - in this State but if you move towards ((inaudible)) you would need to - those would be issues that would have to be addressed.

Andrea Russo: It suggests, just for my own knowledge, is it the delay that we would expect - it's going to depend on the State but what is the delay for one of the more national sources?

Do we - is it - so if you're using this - I mean should - my only concern is if it's different State by State should it be just - if everyone's using the same measurement or if all the States are within plus or minus, you know, a month but if national sources are a lag of three months - it seems that different States are measuring different things. There might be some issues with that.

Elizabeth Drye: If you wanted we could get back to you with what we found looking specifically at that issue for PCI mortality in the 18 and over age group. I don't have those ((inaudible)) the top of my head.

Ray Gibbons: Tom, you had a comment?

Thomas Kottke: Yes, the delay at the national - what happens is that the death certificates basically get collected, you know, at the - and then at the end of a year they put together a tape or sometime during a year as all the death certificates come back. And then I believe they're submitted nationally. So there's quite a delay. It's not a month or two.

It's, you know, sort of parts of years and I guess for - if somebody can tell me more about usability of this in terms of being concurrent with current practice, I mean where it's meaningful, you know. Can you get the last three months or, you know, are you doing, like, in many epidemiological studies you're talking about something that happened three, four, or five years ago?

Ray Gibbons: Well, maybe we can ask since it sounds like the Yale group looked at this for the PCI measure, if we can ask them to respond to us subsequently with that.

Susannah Bernheim: Well, this is Susannah Bernheim from the Yale group. I'll just say one thing, which is unfortunately, of course, there's also a delay with the administrative data used to calculate these measures. So I think the - when we had looked at this in the past the national death data was not going to be a hold up.

I mean right now when these measures are published - reported, we're reporting on a year earlier and we think we could do the same. You know, if you found a way to get the administrative claims

ready quicker than you might have a problem with the death data but we can get pretty reasonable death data in the same timeframe as we can the administrative claim.

Ray Gibbons: So the real answer is they're all delayed.

Susannah Bernheim: Right.

Ray Gibbons: Okay, that's makes perfect sense.

Elizabeth Drye: I'm sorry, if I could just add, I was just confirming the national death index information and I believe there's a - from the close of a calendar year there's a 12-month delay. So the - all of the death certification information are getting rolled up at the State level, being submitted to the national death index.

Thomas Kottke: That's not so bad then.

Ray Gibbons: Yes, that doesn't sound bad at all.

Elizabeth Drye: Yes, and so by the time the - you know, we're always using - as Susannah was mentioned, we're using data from a lagged period of the CMS records or any other records. And so those would catch up very quickly - be available.

Ray Gibbons: Yes, it won't match social security death index in Medicare but it will be reasonable. Okay, are there other questions about this from the committee?

Okay, I think we then want to move on to Measure 330, which is the all caused risk standardized readmission rate following heart failure hospitalization and as - this deals with not only the measure but also comments that we received in response to our early approval.

(David), you're on.

Female: Is (David) with us?

Ray Gibbons: Is (David) with us?

Female: Oh dear.

Ray Gibbons: We have a problem.

Female: Yes, he didn't say he wasn't joining us.

Ray Gibbons: Okay, well, I think we can make the statement that this has been studied just as comprehensively because the June 17 report, the 60-page report from Yale included the heart failure readmission measures as well as the heart failure mortality and AMI measures.

I do think it's worth noting that the C index for heart failure readmission is noticeably lower than the C index for heart failure mortality or AMI mortality. I think that's not terribly surprising. But it's more in the 0.6 range as opposed to the 0.68 or 0.7 range for the two mortality measures.

So in terms of the models working and the issues of extending to patients 18 and older, this has been equally well studied in the State of California and would - the same model as that applied to the Medicare fee for service population would seem to work in a more generalizable way in patients 18 and older.

I guess absent more - absent our primary reviewer I think it's reasonable to say that. Are there questions from the committee about this?

George Philippides: Ray, I'm - George Philippides here.

Ray Gibbons: Yes.

George Philippides: Was there an issue about stratification, risk adjustment and ((inaudible)).

Ray Gibbons: Okay, George, thank you. That deals with the comments and I think we - that we've already - that we received and we sort of deferred. So we will now deal with them if that's - let me just ask whether - before we deal with the comments if there's any other questions about the application itself?

Okay, if there aren't then, George, let's move on to the comments. So the comments appear in that same handout. You have to scroll down through Measure 330 and our earlier vote on the Medicare population to find them.

The staff have sort of pasted them in there so it's not - there are comments received in July and August on the original measures. Can I pause for a second and make sure everybody's found those? Because I think the - it's critical to see what the responses were from the developers.

Let's put it this way, is - anyone who has not found them that needs help finding them? Okay, so assuming that everybody's found them, so we've got several comments about exclusions where most of these came from the American Hospital Association.

And they wanted the list of risk adjustment variables that were included in the appendix to be considered as candidates for exclusions. And they wanted us to re-exam the measure for scientific acceptability because they felt the exclusions were too limited and that they should be used as a basis for exclusion.

And the developer has a detailed response that is included in the material we've distributed, which point out that the main reason they views for exclusions is just things that preclude fair assessment of quality of care such as a patient who leaves AMA or is not actually continuously enrolled during the time period.

Whereas if they expanded the exclusions to deal with all the adjustment parameters you'd end up with a very narrowly defined group that would likely not have the same value in terms of quality improvements.

And at least I thought it was a very well put argument about that. They also dealt with the issue of "excluding readmissions" and I think we had this same discussion with respect to why you used all cause mortality.

I, for one, as a clinician would suggest that we do all sorts of things during admissions for heart failure that may lead to subsequent admissions for "other things" but really are related to the treatment of heart failure. You know, for example renal failure or sepsis or syncope and so you have to include all the readmissions to really capture what's going on clinically.

Female: Agreed.

Ray Gibbons: Any concerns about that?

Female: Looks good.

Ray Gibbons: And then there was another - there are other comments about disparities and I think those are really, again, the response from the developer highlights the material that I mentioned in talking about heart failure mortality which is from the grouped hospitals who have a lot of African

Americans or not many African Americans, they by and large see the same spectrum of performance across the hospitals.

There's a slight difference in the spectrum of performance when you look at socioeconomic status but it doesn't really appear to require risk adjustment.

George Philippides: Ray, you're convinced that that means that those two factors don't really play a major role in readmission rates?

Ray Gibbons: I'm sorry?

George Philippides: Is it possible that the hospitals who have high percentage of low SVS patients are a little bit advanced in this process? Could that be another interpretation of that?

Ray Gibbons: Yes, I think so but it's not - it's really not very large. You know, it doesn't look like a huge affect. I mean there are - you know, there are clearly high and low performers in every single group.

And then lastly there was comment saying readmission rates aren't a quality measure because, I guess, there was some data in the BA that people who were hospitalized for heart failure, that there was a tradeoff between readmission rates and mortality rates but the developer responds - appropriately notes that it does look like there are hospitals that succeed in both, that is have lower readmission rates and have lower mortality rates.

So it's not a tradeoff necessarily and that both measures are publicly reported in the belief that they will lead to improvement in both.

So I - I'm sorry we don't have (David) here who had spent more time on it but I did go through the developer's response to each of the comments and I thought they adequately addressed the comments in detailed fashion. I personally didn't have any further concerns. Are there any other questions from the committee about these comments and the responses?

Female: No.

Ray Gibbons: George, you have any other thoughts about the socioeconomic status issue?

George Philippides: And how will that be tracked moving forward, Ray?

Ray Gibbons: I think the - Yale can comment on it. I think they'll - every time they have to, you know, report on the measure they'll track this the same way. Is that true?

Susannah Bernheim: Yes, hi, this is Susannah from the Yale team. Right, I mean obviously we will bring this back to - and ((inaudible)) when the measures come back through but more importantly part of our work with CMS is a contract to do survey ((inaudible)) - a portion of our survey on this work is repeating these analyses and actually looking at it in a couple of different ways to track disparities at the hospital level.

George Philippides: And I'm sorry that I didn't look back at some of the old appendices but do you know if there's anything in there as far as addiction, as far as risk for readmission or psychiatric disease?

Susannah Bernheim: So the psychiatric disorders are in one of the nine groups and I honestly don't remember off the top of my head where they fall in the readmission measure. It looks to me - I'm looking quickly, like, yes. If you - I'm looking at what on my copy is called page 9 where we list the risk adjustment variables for the measure. And you'll see that both drug, alcohol abuse,

dependence psychosis and major psychiatric disorders are included in the risk adjustment variables.

George Philippides: Okay.

Ray Gibbons: Yes, so they're already in the formula.

George Philippides: Thank you.

Ray Gibbons: As opposed to the other socioeconomic status or race. Now I guess one of the questions, obviously, is the accuracy of all of that in actual practice across the country. I suspect it's an approximation at best.

Roger Snow: Hello, Roger Snow has just joined. I apologize for being late.

Ray Gibbons: You're forgiven.

Roger Snow: Thank you.

Ray Gibbons: We're happy to have you.

Roger Snow: Where am I?

Ray Gibbons: We were just completing discussion - we're completing the first of three major agenda items and we're - and it's really discussion of the comments we received about the heart failure readmission rate, our original approval of the Medicare fee for service measure, and we've incorporated into our discussion of the new measure extending this to all patients, age 18 and older.

Roger Snow: I assume it's 330, okay.

Ray Gibbons: Three-thirty.

Roger Snow: Thank you.

Ray Gibbons: Other questions about the comments and the developer's responses? Does the committee feel we need to do anything differently in terms of our original approval of 330, our original approval of heart failure readmission? And is everybody happy with a - that they're going to be able to vote on the 18 and older even though we haven't had a primary reviewer?

Female: Yes.

Female: That sounds fine.

Male: Yes.

Male: Yes.

Female: Yes.

Male: Okay.

Female: Fine with me.

Ray Gibbons: Well, either this group took happy days at the end of - the beginning of the day or we've succeeded in making sure that everybody's comfortable. I hope it's the latter. Okay, so thank you to the group from Yale. I think we're now going to move on so you are hereby excused.

Susannah Bernheim: Thank you very much.

Elizabeth Drye: Thanks so much, take care.

Female: Bye.

Ray Gibbons: Okay, so we're now going to move on the ACCF, AHA, PCPI letter that was part of the discussion briefly at our last call and we felt we wanted to defer it. And it's - the staff have now prepared a summary that's the second attachment to the agenda email. And I'm going to let Mary take over here and lead the discussion of the letter. Mary?

Mary George: Okay, thanks. So just to refresh your memory, that letter was in the September 2 email called ACCF, AHA, AMA, PCPI comments for NQF, see the endorsement maintenance.

So those are their comments. We had briefly started discussing this last time as Ray said and they asked us to review several measures. And Reva and Katie have given us a nice document that they sent on September 7 and that is called MMSC Comments 9/12/2011.

Starting with Measure 65, we've reviewed, I think, at least these first four measures here on two different occasions and we have been asked in the letter to reconsider these measures. And I'll just kind of briefly remind you of our previous discussion since our original discussion, at least on 65, went back to February 15.

And some of the issues with this particular measure, chronic stable coronary artery disease symptom and activity assessment, was that there was no reliability or validity data. There was some discussion about evidence lacking that doing the assessment was related to patient satisfaction, better outcomes, etc. There was some concern with the gap and performance was - and the issue of testing data not provided.

I'm going to just take these in order and then we can come back and you're welcome to add your comments on them because a number of our comments were common on several of these. From heart failure symptom and activity assessment, Measure 77, again, there was a lack of reliability and validity data that was submitted. There was a question of what the evidence was to support this, what the gap was. And you have our voting on the two previous times that we considered ((inaudible)).

The next two measures were blood pressure measures, 1486 and 13 - 1486 for stable coronary artery disease and 13 to adults over 18. And these measures were similar in that they generated a lot of discussion among us because they were looking at prescribing two or more antihypertensive medications.

And our comments were similar in some respects on both of these. There was concern about the lack of evidence for two or more drugs. Apparently there was no testing data and there were new - at least 13 was a new measure with no current performance data. And concern that some patients may need to be given three drugs and yet two would be sufficient to meet the measure.

And so I'll stop there and ask for comments in reconsidering these measures.

Reva Winkler: Mary, this is Reva. I just wanted to mention that for Measure 77, the heart failure symptom and activity, I just looked at the testing results. PCPI put it in a separate document with several other measures and they did provide us with some data for what I think were previously two

separate measures, assessment of symptoms of volume overload and then the assessment of activity level. So we do have some data, testing data, on Measure 77 though not on the others.

Mary George: But not on the others.

Andrea Russo: This is Andrea, just to start on the comments on the two - on the 65 and the 77 in general in terms of symptom assessment and activity assessment.

It'd be interesting to see actually, you know, what the information - what the gap is out there but I think is if you don't ask the appropriate questions it - these are patients centered in many ways because a lot of your subsequent treatment will depend on - for example, for heart failure you knew your ((inaudible)) association functional class, what other therapies you might be a candidate for if you can't assess how - their symptoms and you don't document that.

And it's more than just saying, are you short of breath? You need some functional assessment. So I always think that these are actually very important measures, both of them, and that we should reconsider this for that reason.

You know, and I know I felt that way initially too but, you know, taking those two together because, for example, even I - you know, consideration of, you know, should the patients be on ACE inhibitors, should they be on beta blockers depends on their - you know, not, you know, their EF but also should be considered for ICD therapy will depend on their functional class.

So I think they're both very important measures. And I know by doing my own chart review - you look at charts and people just don't - they may ask it but they don't document it and that's a problem.

Mary George: Other comments on either these symptom...

Leslie Cho: Can I just ask - it's Leslie Cho. I just want to ask, you know, we keep on voting and revoting on these measures and even on the revoting I think it was voted down. How many times do we have to keep on voting on a measure to be voted down to be actually voted down?

Ray Gibbons: Reva?

Reva Winkler: Well, I think that, again, we try and be - have a conversation that's back and forth as much as possible but I would say that, you know, you should look to see if there's really any new information, whether there is - you know, something has changed.

But as a comment that came in we have to respond to it so in that respect, you know, we have to at least address it. But certainly the past history of what you've done certainly can help you - guide you in your response.

(Dion): This is (Dion). I was trying to look back through the materials we received for our meeting and it would help me to see the data because I think I was one of the people that was pretty strong about there are no data so I was questioning why we were even considering the measure in the absence of data given its requirement.

So I think I would need to have a better - I appreciate comments from the committee members from their own experience but, you know - in order to be faithful to the process I feel like I need to see that information.

Mary George: Is that in the email because I actually - I don't see that?

Reva Winkler: This is - actually, it was not embedded in the submission form. It was a separate document, which we did not resend to you but was with your meeting materials from prior meetings.

Mary George: Do you know the date of that email by any chance? You said September 2, I didn't see one that day.

Reva Winkler: No, talking about the meeting in May.

Mary George: A long time ago, okay.

Thomas Kottke: This is Tom. I had voted against this and the reason I did was that, one, I'm not convinced that getting people or making people write down a number is actually quantitative. It's pseudo-quantitative. And I'm not sure that that said it's going to help. A lot of the patients get lost to follow up and it's a matter of follow up systems. We know that non-adherence is a huge problem.

And there's a limited number or limited amount of resources that we can devote to healthcare and to the extent that we divert any from treatment to measurement or the extent that we use them for measurement means we're not using them for treatment.

I think we have to - I mean I recognize that patients are under treated and we've just gone through all of our patients that, you know, we can now do it and ask a question, are we overlooking people who ought to have defibrillators or bi-vents or something like that? But I think that the evidence we all hear is lacking, that what the measure requests will actually change outcomes in patients.

Andrea Russo: Well, yes, I guess I would respectfully disagree with that because if we're not at least identifying patients at high risk, and again, I'll take only because it's out there in the media and - you know, is the ICD issue. If we're not accurately identifying the appropriate patients we know that these devices save lives and there's been multiple randomized trials.

If you don't even identify those patients upfront by assessing the symptoms then I just - you know, I think we will miss people and people will die suddenly when, you know, we could potentially save lives.

Thomas Kottke: But it may be that a much bigger problem is total lost to follow up of patients in that - but making - you know, people say, okay, I'll write down a Canadian or a New York Heart Association class but that means I can't do a follow up program.

And it's - I mean this has been the problem in - for example, in cholesterol when docs were defining cholesterol as over 350 and bypassing all sorts of patients who had cholesterols of 220, 210, whatever, that it may not be the most effective way to get to the patients who need the therapy. And it may divert resources from effective programs that need to be out there like patient tracking programs.

Andrea Russo: But these are people that we're seeing in the - we're writing a note and we're seeing them in the office or, you know, in the electronic health record. So it's just how to quantify that information on paper and, you know - yes, I think that's a huge problem also, patients are getting followed for a variety of reasons.

But I think that's a very separate issue. A very, very important and - as important or more important issue but I think for this particular symptom assessment and activity assessment it does - it is important and I, again, just - we can disagree on the importance of it and if there data there

to show that there is the scab, you know, I think it would be important before we turn it down again, that we at least share that information with the rest of the group.

Reva Winkler: I'll be happy to resend the heart failure testing document from PCPI out to you one more time. Just from - just as a reminder to everybody, these evaluations need to be anchored in NQF evaluation criteria. So important to remember is around opportunity for improvement and evidence. And those should be your rationale for voting however you decide to vote. But that - those are the elements that you need to be considering.

Mary George: Okay, any additional lines of thoughts on those measures before we move on?

Reva Winkler: Mary, this is Reva again. I just wanted to point out that the absence of testing data for reliability and validity is huge and it applies to several of these measures. And without data, numbers, these measures do not meet NQF criteria.

Andrea Russo: That's clear, okay, ((inaudible)).

Mary George: Okay, we'll move on the two blood pressure measures. Any additional comments that people want to make on either of the blood pressure measures? And I think, Reva, we did not have current data on either of these, is that correct?

Reva Winkler: For 1486, no, we did not. And for 13, I'm just renewing, checking myself. There was no data presented for both of those.

Mary George: Okay, any comments from the committee on the blood pressure measures in addition to those that we have made in the past. They're listed on the document for you.

Thomas Kottke: It seems as if there's no data presented then they don't meet criteria, do they? That makes the task a little easier.

Mary George: Okay.

Thomas Kottke: The other question I had, this isn't about that, but the description as percentage of patients 18 and older with a diagnosis coronary artery disease seen in a 12-month period with blood pressure less than 140/90 or with a blood pressure equal to and prescribed two more medications. Is that supposed to be greater?

Ray Gibbons: Yes, that was an error in their original submission that they clarified, greater than or equal to 140/90 and two or more antihypertensives. And that's mentioned, Tom, on page 4 under Item 2 that that was misstated.

Female: All right.

Suma Thomas: Reva, this is Suma. Does ((inaudible)) in their letter for reconsideration say anything about their lack of data and how to address that? Do they mention that?

Reva Winkler: I didn't see anything.

Suma Thomas: Because I swear I don't have that in front of me.

Andrea Russo: I guess in our response, and that seems to be, you know, the overwhelming problem with these measures then is can we give them some recommendations on the amount of data that would be needed to make the specific - you know, maybe it isn't a lot of work to get a small amount of data to show that there is even a gap.

So I don't know if we can give them specifics on the response as it turns out that this is, again, turned down.

Reva Winkler: Well, I think that PCPI specifically has been doing testing for measures. So they are certainly aware of methodologies to do it.

(Dion): This is (Dion). I guess that - I'm confused why the measures were submitted absent the data given that it's reliability of validity testing, given that it's a clear requirement. It's a deal breaker and it's known.

Female: Right.

Reva Winkler: If you recall the - on some of the measures we were promised data up until, like, the night before and ultimately it wasn't sent.

(Dion): Okay, thank you.

Andrea Russo: So let me ask, just in terms of the data that would be, just for my own knowledge here, so if it's a symptom assessment so would it be sufficient to submit data saying that there is a gap in - or do they - because it's going to be hard to prove that that's directly - that that measure, that process measure directly results in a change in outcome.

(Dion): Right, well, you're addressing the evidence question and that is another criteria but the testing is not just results of performance. We're looking for testing of reliability and validity. And NQF has recently done a whole - had a taskforce - created a whole report on appropriate testing. So we can certainly refer to that.

Andrea Russo: Okay.

(Dion): This is (Dion) again, I'm sorry. In fairness to the question about the gap related to the first two measures, I wanted - I've been sitting here scrolling through my various files and I did find the testing data. And the - related to a gap in care, reliability and validity of those two measures, that it was in the pinnacle registry. It was 50% performance rate. So we do have that information.

Andrea Russo: Which is a huge gap and that's in a highly motivated group.

(Dion): Right, so that might cause me to change my mind about the importance question because I'm pretty certain I was one of the no-gos also. But I don't believe we have reliability and validity data for these measures either if I understood Reva properly.

Female: Right.

Thomas Kottke: Tom here. Can I ask, Reva, what would reliability and validity be for the blood pressure measure look like? I mean what would we be looking for?

Reva Winkler: Well, you can evaluate reliability either - level of the data elements, which might be a test/retest or you could do it at the level of the measure's score which might be something like signal to ((inaudible)). We don't - we aren't prescriptive but those are the types of reliability assessments that we're looking for.

Female: Okay.

Mary George: So we will be - Reva, correct me if I'm wrong, we will be going back and revoting on these four measures.

Reva Winkler: If that's what you'd like. If that's what the committee wants to do we can do it.

Mary George: Thoughts from the committee on revoting?

Leslie Cho: It's Leslie Cho. I don't want to revote. I mean my vote's going to stay the same which is I'm not in favor of these measures because I think the reliability and validity is not there, which is one of the pillars of the NQF process. And it's been voted twice without any new additional data. What is the point of us voting? I mean we keep on voting. They keep on sending comments. We keep on voting.

Thomas Kottke: I agree with that sentiment.

(Dion): I agree as well.

Mary George: Me too if it matters, (Dion).

Ray Gibbons: I'll agree.

Dana King: This is Dana. I agree.

Suma Thomas: Suma, I agree.

Andrea Russo: And I don't think that revoting, this is Andrea, would make a difference but I guess if we're more specific - and maybe we were but we just - so they know, you know, what specifically we would want to make these measures work.

And I think just saying specifically we recognize there is a gap and you've shown that but, you know, give us some more data and reliability and validity and what that might mean. And so that may not be very hard and they may be able to do that relatively easily.

Mary George: Any other comments on the vote/revote? I'm not sure of how many we have on the line, Reva.

Reva Winkler: Yes, I heard from at least eight different people. We've got 12 on the line. Is there anybody who totally disagrees with not revoting? Okay.

Mary George: All right, so I guess we move on to competing measures. There were some other comments in the letter that addressed some other issues. I don't know, Ray, whether you want to handle all of those now or come back to those after competing measures.

Ray Gibbons: Yes, why don't we - yes, why don't we move on to competing measures because I think there's an overlap in the concepts and it will be helpful to have the discussion of competing measures first.

So if you - if everybody thinks back to when we first tried to deal with this difficult issue of competing measures, staff created a grid for us where all of the measures in question were lined up in terms of description, numerator, denominator, etc. And that was what we used to side-by-side compare them in deciding whether we would endorse or continue to endorse competing measures or whether we would choose a best in class.

And I think on our call on September 2, I think it's fair to say that very few of us could remember that side-by-side comparison. I know I couldn't and then the comments suggested to me that most of you couldn't either. So the staff have now regenerated a version, a more succinct version of that original table we looked at. And it's in that same handout that is labeled MMSC-Comments. And it's at the bottom.

And the two measures that we struggled with on the September - or the two issues that we struggled with on the September 2 call, which are anti-platelet therapy and lipid control, appear on page - I'm scrolling through, page - the discussion of competing measures starts on page 7 and extends to page 8.

And then we have a side-by-side comparison starting on page 8 of the ischemic vascular disease, 0068 NCQA measure on the left, and the chronic stable coronary disease, anti-platelet therapy on the right from the AMA PCPI.

And I think the side-by-side comparison - it's helpful because it outlines some of the issues that, you know, we considered at the time when we originally proposed to continue with both of these, which we couldn't regenerate in our discussion on September 2.

So if you scroll down to the summary on page 11, for example, you will - I think it adequately or accurately summarizes our thinking at that time, which we couldn't all remember in detail on September 2 in discussing these.

So I'm going to sort of open for comments because we've got - I think just before everybody joined the call, as Tom was saying, evidence that these are really overlapping rather than competing and that was one of the reasons that we recommended that we maintain endorsement of both.

But I want to open it up for comments about that issue at this point. And let's start with the aspirin and other antithrombotic measure and the anti-platelet therapy measure.

Suma Thomas: This is Suma. When I looked at these I thought 67, really - you cut this to everything that 68 did except for the titles doesn't encompass what it actually includes because it says chronic

stable coronary disease but then in the denominator it diagnosed the coronary artery disease within a 12-month period.

And then as you look at the - in 68 it's MI created by a past ((inaudible)) intervention and that would be all inclusive within the patients included in 67. But it's just the title that - to me, at least when I looked at these two, was deceiving.

Mary George: Sixty-eight includes all types of ischemic vascular disease including carotid disease and peripheral vascular disease.

Suma Thomas: It says in that description acute MI, CABG, or percutaneous coronary intervention.

Ray Gibbons: Or - it does a comment and then it says or who had a diagnosis of ischemic vascular disease so that's the key, Suma, is the second clause of that long description.

Leslie Cho: It's Leslie. I agree with Tom. I think they are overlapping. I think that, you know, one is chronic patient and the other one is more pseudo-chronic patients because they've been diagnosed with an event within the last year. I think I'm going to vote to keep both of them.

Ray Gibbons: Other thoughts about this? In our discussion on September 2 I think since he's not with us today I - fair to summarize that (Mark Sans) spoke, I think, pretty compellingly to the fact that we should continue to push developers for harmonization because as a practicing physician he doesn't want to have to deal with the consequences of tracking two related but not exactly the same measures.

Suma Thomas: This is Suma. I agree with that. I just think that they're too close and that they could work together and that it is really a burden on clinicians and we really need to work towards the harmonization.

(Dion): This is (Dion) and I - thinking about our conversation last week I understand that argument and support it. I just didn't have enough - and I guess I still don't, have enough of a sense of whether that case is so strong that we should actually reverse our decision and not endorse either measure because neither meets the need and unburden the provider or whether it's better to keep both even though they're far from perfect as two measures. And I would need some guidance from the physicians.

Ray Gibbons: Well, I'll take a stab at that and then ask Reva to comment. I think the process of harmonization, while it's - it should be encourage, it's difficult and time consuming. So even if these two groups work very carefully I would anticipate we're talking about a 12 to 24-month timeframe. And the question is during that time do you give a message to the country that anti-platelet therapy is temporarily not important.

Suma Thomas: Can we maintain both of the measures in the meantime?

Ray Gibbons: Yes, that's the argument for maintaining them and - as opposed to saying, well, let's push the issue and vote down.

Suma Thomas: We maintain them and then encourage harmonization and have those developed into that because I think as (Mark) pointed out very well was that really the clinicians are at a great burden at this point and it's only going to get greater because quality is going to be paid for and we really need to continue to encourage safety harmonized. Otherwise, it's going to be too great of a burden for clinicians. And I think this is the first start of that.

Reva Winkler: This is Reva, just to say those arguments are exactly those that get put forth for picking one over the other because harmonization is difficult. It takes a long time. And trying to live with

multiple related measures is very, very burdensome. And that is actually the fundamental rationale for NQF best in class policy and goal.

Roger Snow: Yes, this is Roger Snow. I had a couple thoughts. Best in class is kind of hard for me because it depends on what question you're asking and a measure will be not best in class if you're asking a somewhat different question. I'm thinking about the - the second part is I'm thinking about the clinical context here.

The - although 67 deals with an issue that is - as it says here, has very strong evidence for the importance and I expect that an awful lot of people do it routinely in people like that whereas the use of these medications and the other ischemic vascular diseases is less.

I would think that it is more important if you had to pick one to pick 68 because that's where we have more improvement to do. This is not to say that 67 really belongs in the parking lot but if we were picking one that's where I would want to vote.

I think we have to decide if we - you know, whether we're going to give full credence to (Mark Sans)' point, which is a very strong one. I think this is very important.

Mary George: This is Mary and I would just say we are looking at national data on 68, less ((inaudible)) in 50% of patients with IVD are getting antithrombotic medications.

Ray Gibbons: But my problem with 68, if I'm reading it right, it goes away after a year. I mean you have to be hospitalized in the prior year and - otherwise you're not part of the numerator or the denominator.

Reva Winkler: Tom, these are the shortened specifications to keep this document from being too long. If you want to see the full set you can click on the title link and it will take you to the full submission.

Because the details are - for 68 to qualify are not - are the hospitalizations but also a visit - an outpatient visit with that diagnosis.

Thomas Kottke: Okay, so that changes everything then.

Reva Winkler: You can look at the details by clicking on the title.

Ray Gibbons: And it's IT - what the - retard, has just done that and gotten it to work so everybody should be able to get it to work.

Reva Winkler: So that was a way of making it easier to see everything without giving you pages.

Thomas Kottke: So then I guess I would vote for 68.

Ray Gibbons: I do think we need to point out as we - just as part of our original discussion that 68 doesn't allow for exclusions so basic - you know, it's the whole business of if you have atrial fib and coronary disease, what do you need? Sixty-eight basically defines the treatment much more broadly because there's no exclusion for warfarin use.

Mary George: I thought warfarin was an included medication.

Ray Gibbons: Right, so if you have coronary disease and you're on warfarin you're treated by this measure regardless of the indication for warfarin. So I mean it just - I just point out that this issue - in my mind, I've always been bothered by this because, yes, warfarin will work but certainly aspirin's safer, more convenient, and less expensive if you don't need warfarin.

Suma Thomas: And also there's no exclusions then for bleeding or...

Ray Gibbons: No, there's nothing.

Suma Thomas: That is - that part is troubling for me because there are people who are in that category.

Is there any way to ask them to consider exclusions or not?

Ray Gibbons: We did during the meeting if you recall and whoever was present representing the organization gave us an answer that it would be "very difficult".

Reva Winkler: Also, take a look as you follow down the side-by-side, that was a question for the developer and they provided their response, if you go down to page 10.

Suma Thomas: Saying that most exclusions are relative I guess?

Ray Gibbons: Right.

Suma Thomas: Are there many measures that don't have any exclusions? You know, just as a general question.

Reva Winkler: This is Reva. Yes, there are. I think in general the philosophy of that is if indeed there are - they're so uncommon that the number wouldn't really affect the overall outcome then why collect that data and crunch it. But also the idea that the goal is not 100% performance, that's acknowledged.

And so nobody's going to reach 100% but rather just try and reach as high as possible and adding to the burden of data collection for exclusions. So yes, there are measures without any exclusions.

Ray Gibbons: And I hate to keep point out downsides but it was part of our original discussion and it's mentioned in the summary that appears on page 11 that the evidence for aspirin use is very strong for CAD and cardiovascular disease but less strong for PAD.

There is a randomized trial from Scotland showed if your angiobrachial index was abnormal but you had no symptoms of the PAD that aspirin brought no benefit. So the real question here is in terms of the specification as this measure, how often that comes into play.

Mary George: But doesn't 68 require symptomatic PAD?

Ray Gibbons: I don't know. I guess I'd have to question - go back to the original.

Mary George: ((inaudible)) have atherosclerosis. Right, you know, that Scottish study was - there were asymptomatic people. They're upper limit of ABI was, like, 0.99 or 0.95. It was pretty high in the asymptomatic people. So - and we don't have the updated guidelines yet for PAD.

Ray Gibbons: Right.

Dana King: This is Dana. We seem to be left where we were at the beginning. We want them harmonized but they're not and it's not an easy process and we understand that because there are many things to take into account. Neither of them is perfect and neither of them is a compelling choice over the other at this point.

And so we were left with the choice that this is an important thing to monitor and track. We don't want to give the wrong message so we kept them both awaiting a more perfect measure sometime in the future.

Reva Winkler: This is Reva. Just to remind you the reason we're going through this again is there were specific comments that were submitted during the comment period that we're trying to respond to.

Dana King: Absolutely correct, I don't mean to say that we shouldn't. It's - I'm - all I was pointing out was that, you know, I think we did fairly do that and consider all the angles and it just so happens perhaps I should say that we're left in the same place we were. And it's a difficult position. And while the appropriate questions prompted us to reconsider it seems like we're sort of, you know, went full circle, that's all.

Ray Gibbons: Dana, I think that's very well said. So let me get a sense from the committee because we are going to run short on time here. I sense from everybody whether they want to revote on this issue of endorsing both measures or do we simply maintain endorsement. Dana has spoken for maintaining endorsement of both.

Leslie Cho: It's Leslie. I'm going to second Dana's comment.

Thomas Kottke: I'll talk with Dana, no.

Mary George: Well...

Ray Gibbons: Are there others who want to speak to revoting?

Suma Thomas: This is Suma. No, but again, does that mean that we're - because harmonization is difficult we're not going to ask for it?

Ray Gibbons: No, no, we're going to encourage it but we're going to maintain both measures as endorsed.

Suma Thomas: Okay.

Ray Gibbons: We'll keep encouraging it but maintain both methods, I think that's the spirit of what Dana just outlined. We don't have a perfect measure yet.

Mary George: Does it - Ray, let's try this. Does anybody feel very strongly that they want to revote?

Female: No.

Ray Gibbons: Okay, I think we're done with that one. Let's move on to lipids. Again, we've got the side-by-side, 75 is the broader population again. And it requires a complete lipid profile and LDL less than 100. Seventy-four is more narrowly defined, CAD and LDL less than 100 so there's no requirement for a complete lipid profile.

And if you scroll down, again, I think you can see that many of the points out the two were pretty similar that 75 has no exclusion for problems with statins and 74 does. So there's a difference in exclusions, there's difference in the breadth of the population.

Reva Winkler: Ray, this is Reva. I - just to remind you of a comment that PCPI made at the end of the last call with ((inaudible)). On 74 this is patients who - with coronary artery disease who have an LDL less than 100 or who's ((inaudible)) greater than 100 have the documented plan including a statin.

Roger Snow: Right, that's right. Thank you, Reva, for reminding of that. They did point that out. And that's listed in the side-by-side.

Now, Tom, here, I'd go for some of the simpler ones, 74 knowing that we'll take the wrath of the non-HDL cholesterol army with 74. You guys had argue that non-HDL cholesterol is a better indicator of the LDL.

Thomas Kottke: Well, I would point out that in terms of our original votes to maintain endorsement, for 74 it was 14:1. For 75 it was 9:6. So this was at least, at the time of our original discussion, a closer call in terms of maintaining both of them.

So I'm going to sort of - I think the issues here are very similar as you think about these across the two - you know, the aspirin and antithrombotics and the lipid profiles. Slightly different definitions, broader - different populations, issues of exclusions, and in this case flexibility in terms of what meets the criteria.

Roger Snow: You know, I guess as a comment, I don't think we need to measure everything and everybody to get action. And I would think that if we just have an LDL goal and, you know - if in those patients, we all have them who have high triglycerides and we know they have a triglyceride issue or others, we'll pick those up. And I think people will take action on them. I guess I'm an optimist.

The other thing is that the recent - you know, the (Accord) and other trials that suggest that niacin - when you're on a statin, niacin and fibrates really except a certain subgroup lack efficacy of changing outcomes. So LDL with ((inaudible)) of statin appears to be the most important thing.

Ray Gibbons: Okay, can I get a sense from everybody whether you want to revote or maintain endorsement of both measures? Sounds like you want a revote, Tom?

Thomas Kottke: Yes, I think it's worth revoting with an eye towards the simpler measure of simply an LDL and statin.

Ray Gibbons: Other comments on this? Other thoughts?

Suma Thomas: The major category that wouldn't be included in 74, again, would be peripheral vascular disease.

Mary George: And - yes, carotid disease.

Suma Thomas: Which is - includes that right.

Ray Gibbons: Yes.

Thomas Kottke: Yes, but I don't - I'm not the expert on this but, Snow, I don't know that the statins have been successful - as successful in carotid artery disease anyway, have they?

Mary George: Tom, that's true but I think they have been shown benefit in people with peripheral vascular disease?

Reva Winkler: Definitely it's an inpatient measure for ischemic stroke patients and the measure is written in a way that's very similar to 74 with LDL below 100 or discharged on a statin.

Leslie Cho: It's Leslie and I'm going to sound like an orthodox here but, you know, I voted to keep both measures when we met last time because I felt that they were different in subtle ways. I think the one includes a very important population of peripheral vascular disease and the other does not. And that was my reason and I think that's going to continue to be my reason.

Ray Gibbons: Okay, so you don't want a revote.

Leslie Cho: No.

Ray Gibbons: All right, others? I need a sense of whether there's enough sentiment to revote to go through the exercise. Is there anybody who wants to line up with Tom?

Well, my sense of silence is that we're going to maintain endorsement of both of these measures.

Thomas Kottke: Okay.

Ray Gibbons: All right, now if that's the case now can we go back to - can you scroll up here to go back to the issue raised by the ACCF, AHA, PCPI letter, which dealt with the fact that they weren't pleased that we were doing away with 0070. This was a competing measure issue and we basically did not maintain endorsement on this one but instead basically went with 00...

Mary George: Seven-one.

Ray Gibbons: Seven-one, which was the persistence of beta blocker therapy after a MI. And the letter, if you don't have it at your finger tips let me sort of point out that the - basically the letter said although we agree that medication adherence is the desired outcome the current state of data systems makes this extremely difficult to implement at the individual physician level.

When prescribing clinicians do not usually have access to pharmacy data. Furthermore, they can take of patients from multiple insurance plans and it's not easy to merge those data. And patients are often getting inexpensive generic beta blockers from discount pharmacy programs.

And therefore, argued that a measure based on claims data along, which is what we supported, that measure won't give an accurate reflection of what is actually going on in terms of patients filling their prescriptions.

And so they wanted us to reconsider and to recommend both measures for consistent endorsement believing that they're complementary not competing given the different data sources and the difficulty of knowing whether somebody's maintaining therapy.

Dana King: This is Dana. I mean they may have a point. I mean with statins, you know, now inexpensive, \$4, you know, \$10 for 90 of them. I mean you don't need to - you certainly don't put in an insurance claim for \$4 most of the time. If it does it's below your co-pay.

And so there may be going forward, you know, more problems with the size of claims data. Claims data is usually very good and we've seen some analyses here at NQF on this committee where they were very good and comparable to other kinds. But in this particular case they may have a point.

Ray Gibbons: Other thoughts on our earlier decision to remove endorsement of Measure 0070 in favor of 0071?

Not a lot of comments so I'm going to have to force the question. Do we want to revote on our removal of endorsement for 0070? I think Dana's just made the case that we probably - it would be worth a revote.

That doesn't necessary - got to change our minds but it says that we've listened to this argument about the administrative data limitations and maybe there's some merit in having this other measure, which we, by the way, had originally approved 17:4.

(Laura): This is (Laura). I think we should revote it. I think the arguments make sense.

Ray Gibbons: All right, two for revoting. Are there others?

Leslie Cho: It's Leslie. I think we should revoke.

Ray Gibbons: Three. There's a groundswell.

Roger Snow: Snow here, I'll go along with voting.

Ray Gibbons: Okay, I think I've heard enough to know there's a fair sentiment to revoke and that's what we should do in response to the concerns raised in the ACCF, AHA, PCPI letter regarding Measure 0070.

Staff, are we doing all right here?

Reva Winkler: You're doing fine. We can do that.

Ray Gibbons: Okay, are there other questions that anybody wants to - is everybody comfortable that we're going to be able to revoke? Staff, I think we at a minimum want to send the letter out again from AHA - ACCF, AHA, and PCPI. And we probably - if you can reconstruct the side-by-side comparison of 70 and 71 that we looked at originally, I think that would be helpful to everybody.

Reva Winkler: Okay.

Ray Gibbons: Are there other things that people would want to help them in the revoting process other than those two documents?

(Dion): I think it might be helpful just to give a little synopsis. I mean just one sentence or two sentences why we recommend the revoting.

Reva Winkler: Okay.

Ray Gibbons: Okay. I think Dana said it very well and regarding the issue of insurance claims. Personally I find this argument about people falling through the drug programs, which we I think did mention somewhere in our discussion one of those days, at least in my practice is increasingly the case.

(Dion): I definitely concur looking at our retiree population, 100%.

Ray Gibbons: And that being the case then wow, what do we know from the administrative claims data because I think Dana's is right there. No one's going to fill out all the paperwork for \$4.

Reva Winkler: This is Reva. Just as a question, this is a beta blocker measure and not - this is where specific beta blockers are specified, the ones that are evidence based. Are they typically the beta blockers that you captured in the \$4 program?

Ray Gibbons: Yes.

Reva Winkler: Okay.

Ray Gibbons: Carvedilol is perhaps the most widely used, that's now available. And help me, I think Extended Release Metoprolol is also available but not in all of them.

Reva Winkler: Okay, thanks.

Ray Gibbons: Is anybody - Tom, are you familiar with that?

Thomas Kottke: I just going to make a wisecrack, if you can get a hold of extended release. This is America. I mean there's drug shortages.

Ray Gibbons: Right, and that's the one where they shut down both the manufacturers in the same six months and you were probably dealing with the same barrage of phone calls that I was dealing with.

Thomas Kottke: Exactly.

Ray Gibbons: All right, so I think believe it or not we are on time. Good job, group. And we now want to get public comments.

Reva Winkler: Correct. So Operator?

Operator: Yes, if you would like to ask a question, please signal by pressing the star key followed by the 1 on your telephone keypad. If you are using a speakerphone, please make sure your mute function is turned off to allow your signal to reach our equipment. Once again if you have questions at this time, please press star 1. We'll pause for just a moment to allow everyone an opportunity to ((inaudible)) signal.

Once again, star 1. At this time, we don't have any questions in the queue.

Reva Winkler: Well, okay.

Ray Gibbons: So to summarize, staff will get out the necessary email to all of us. We will be voting on the revised AMI heart failure mortality, heart failure readmission Measures 229, 230, 330 that we discussed in the first part of the call.

Reva Winkler: Right.

Ray Gibbons: We made a decision that we would not revote on the heart failure stable angina or blood pressure measures that were detailed in the ACCF, AHA, PCPI letter.

For competing measures we did agree to revote on the beta blocker issue that was mentioned in the ACCF, AHA, PCPI measure - letter, sorry. Getting my letter and measures mixed up. And we decided not to revote but to maintain endorsement of both the lipid profile and the aspirin and antithrombotic measures. Did I miss anything, Reva?

Reva Winkler: I think that's what I have.

Ray Gibbons: Mary, did I miss anything?

Mary George: No, that's what I had written down.

Ray Gibbons: Okay, are there other questions or concerns or comments from the committee? I know you'll be sad to hear this but we may be approaching the end of our work.

Reva Winkler: We're getting there.

Mary George: This is Mary and I just really want to thank everybody for these late afternoon calls and all the time that you've put in.

Ray Gibbons: Likewise.

Reva Winkler: Yes, this is Reva. Everybody here at NQF really appreciates all of your time and effort and thoughts on this and the participation through what has been a long and fairly intense project. So you guys have been terrific hanging in there through it all.

Ray Gibbons: And I appreciate in particular that I think that we've learned a lot from one another and that, at least I - I feel that we have proceeded throughout this whole process in the spirit of mutual respect. And I think compared to our first hour together people have been much more willing to express their thoughts and raise questions. And I think that's critical because that makes the whole greater than the sum of the parts. So I thank everybody for that throughout this endeavor and look forward to hopefully completing our final votes.

Reva Winkler: Great. Okay, we'll let you know as your votes conclude and we go through the last steps of the process. We'll keep you posted.

Female: Okay, thanks.

Ray Gibbons: And we're actually done early.

Reva Winkler: Thank you everybody, have a good evening.

Thomas Kottke: Thank you.

Ray Gibbons: Thanks a lot everybody, have a good evening. Bye-bye.

Roger Snow: Bye.

END