

NATIONAL QUALITY FORUM

Moderator: Katie Streeter
June 7, 2011
3:00 pm CT

Operator: Welcome to the conference everyone. Please note today's call is being recorded. Please stand by.

Reva Winkler: Hi this is Reva Winkler at NQF. Thank you everybody for being here.

To our audience participants, we've opened all the lines so we'd ask everybody to put yourself on mute while you're listening. We will have an opportunity for public comment later.

Thanks to everybody for joining us. The agenda today is to wrap up some of the leftover items on the previous agendas, most specifically the issues around what is now being called "reserve" measures. Previously we called them "inactive."

Along with yourselves, NQF's Board of Directors did not like that term either. They liked the concept, not the name so we were trying out different names. Currently right now, "reserve" seems to be the favorite.

After that, I just want to spend some time talking about the ongoing activities, the project and what our next steps are, but I think the first order of business is to do what we need to do for the action on the potential "reserve" measures.

So Mary and Ray, I'll give it to you.

Ray Gibbons: Okay so thank you everybody for taking time out of your schedules yet again for the work of this committee.

We had a very full agenda the last time and did not get to the last section of the agenda. And that is the agenda for today's call. And that was by design, we felt in reviewing the agenda before the previous call that this item could wait if necessary. And indeed it has had to wait.

The agenda that was sent around by email to everybody included a document that is basically a summary by Reva to the committee of the NQF policy on "reserve" measures that's dated May 31. And I think it be pertinent for everybody to have that open or available because as we talk about these, we'll want to make sure we're in compliance with what the NQF guidance of Board of Director's has provided with respect to these.

So these are "reserve" status. I'm going to read directly from that, it's supposed to apply only to highly credible, reliable and valid measures that have high levels of performance due to quality improvement actions rather than problems with specifications.

And the key issue is the opportunity cost associated with measuring processes at high levels of performance rather than focusing on areas where there's a gap. And NQF doesn't want to move in to reserve status measures that are really not needed because they're too far from the desired outcome.

So that's I think the framework for our deliberations and discussion about these. And we do need to make certain that as part of this process the measures have all gotten a full review for the other criteria other than simply the potential for improvement.

And unfortunately because when we first discussed these and they didn't have enough potential for improvement, they were voted down on importance. We didn't fully review two of them for all the other criteria which we are compelled to do as part of this review.

Are there questions about that and what we need to do before we launch in to this?

Mary, any other comments you want to make before we start?

Mary George: No I think you summed it up pretty well.

David Magid: This is David. I just wanted to say that I can only be on the call till - for an hour so if you hear any disconnect at the hour you'll know that...

Ray Gibbons: We will not reprimand you for that.

David Magid: Okay.

Ray Gibbons: And that sets the bar for everybody in discussing these. We want to see if we can do it in that approximate time frame.

So the first measure we're going to review is 0142: Aspirin prescribed at discharge for AMI. And we did not go through this from start to finish initially because it was voted down on importance.

So George, you, I believe, were our original reviewer. Do you want to sort of take us through the highlights of your review of this?

Reva Winkler: George?

David Magid: If George isn't on, I could do it because I had one of...

Ray Gibbons: Well I thought George was on with us, maybe he's on mute.

George, we're not hearing you.

David Magid: This is David. I had a similar measure so I could provide that summary if you'd like.

Reva Winkler: Well we're just trying to figure out why we lost George.

Operator: This is the operator. George's line is connected.

Ray Gibbons: Oh.

Reva Winkler: Okay, I wonder if he got called away from the...

Ray Gibbons: Yes, I wonder if he got called away. Okay, so which one of our volunteers wants to lay claim to this?

David Magid: It's David, David Magid. I'm happy to do it.

Ray Gibbons: Okay, what was yours that was similar?

David Magid: I think it was - mine was not aspirin at discharge, but I think mine was use of aspirin, you know, post-discharge for people who had - in people who had had an AMI.

Bruce Koplan: Who were you looking...

Ray Gibbons: Was that Roger's voice I heard volunteering?

David Magid: No, David Magid.

Ray Gibbons: Okay no, but there was somebody else who volunteered I thought?

Bruce Koplan: Who were you looking for that got called away?

Reva Winkler: George.

Ray Gibbons: George.

Bruce Koplan: Oh nevermind, it's Bruce. I got called away too, that's why...

Ray Gibbons: All right, well okay David, why don't you go ahead then if you don't mind.

David Magid: Sure, so I mean basically the evidence in support of aspirin therapy and patients post-MI is very strong. The - I don't remember all the criteria we had to go through, but you know, the measures didn't properly validate it. It met all of the criteria that we had.

The main issue was that there was very high performance and there was not much differentiating the top quartile from the bottom quartile. And I think we went ahead and - because we used to prove one of the measures just because it had been used so successfully before, but I would say based on the criteria that was outlined for this reserve measure that this could conceivably meet that criteria.

A measure that by all other accounts is a very good measure, but where performance is so high, that perhaps it's better to focus our energies on other measures where there's greater room for improvement.

Ray Gibbons: Okay and somewhere in here I know we have the data. It's on Page 2 right at the bottom, the actual numbers in terms of performance rates. For 2010 First Quarter, 98.5; Fourth Quarter 2009, 98.5; Third Quarter 2009, 98.4; and Second Quarter 2009, 98.3.

So clearly, very high level of performance and we didn't think there was much room for improvement. And that was why this got voted down for importance.

Are there other comments or questions about the - this measure and its scientific acceptability?

George Philippides: Ray, George Philippides here.

Male: Ray, this...

Ray Gibbons: Oh George, you're back.

George Philippides: I'm in and out. I'm precepting fellows...

Ray Gibbons: Oh my goodness.

George Philippides: ...and ((inaudible)) patients so I'll be and I apologize.

Ray Gibbons: No, no that's fine. We understand.

George Philippides: The only issue I wanted to bring up - and it's a query more than anything is the fact that there were some disparities there. I think the Hispanics were a little bit lower, 96.5 versus Caucasians, 98.5.

Does that make this measure more intriguing or worth keeping? Or can we just track that even if we have it on sort of the reserve list?

Reva Winkler: Well George...

Ray Gibbons: Reva, you want to just weigh in?

Reva Winkler: Yes. The reserve list means the measures are still endorsed and I think that this is why people are reluctant to totally remove some patient - some measures even though they're topped out because there may be specific uses.

And this might be one, if you were specifically using the measure to look at disparities in a particular population. It might be useful so the measure's still on the shelf. But - so I think that that's a very reasonable kind of potential reserve for it.

George Philippides: Okay, because otherwise it seems to me to fit all the criteria for something that can be put on the side for a while. That was the one issue that I had.

Reva Winkler: Yes, yes. And it's - reserve status does not take away its endorsement. It's just that we're signaling that there's very little room for improvement to use this and there should be sort of specific reasons for using it. And disparities may very well be one of them.

George Philippides: Got it.

Ray Gibbons: Okay, so I think though that this is an important issue that we at least want to all be comfortable with which is, you know, what are the consequences for disparities and how great does the disparities have to be before a measure wouldn't be placed on reserve?

I think we're breaking new ground here.

Reva Winkler: You are.

Ray Gibbons: And I think the point that George has raised is an important one which is: Are we comfortable as a group saying, you know, overall performance is good and good enough that this goes on reserve even though for one important group in the population it's, you know, the failure rate's about double what it is for everybody else.

So I would really welcome comments from other members of the committee about this issue that George has raised.

Mark Sanz: This is Mark Sanz; can I ask you a question?

Ray Gibbons: Sure.

Mark Sanz: Hey, I wasn't at the last meeting so this may have been answered, but I'm interested in how this reserve status works going forward from the time a decision a made.

For instance, is it somehow re-measured automatically in three years so that the status comes back up for review? And that would have implications regarding the disparities issue as well or does it - is it just one step from being put into a closet and then three years from now removed completely?

I mean it's not clear to me what happens...

Reva Winkler: Yes.

Mark Sanz: ...once it goes in to this status.

Reva Winkler: Right. And I think those are excellent questions that were still working out the details and the thinking on, but I think that one of the reasons this particular status was created was so that the measure is maintained, that it is - doesn't lose its endorsed status and that people could use it to periodically measure to be sure that performance continues to be high.

I think those are implementation questions though that actually will be better answered going forward by the people who use the measure. But that's what the rationale for creating the special category is.

Mary George: This is Mary and I just had a question, maybe someone knows. Is this the measure that CMS has proposed dropping, their hospital measure set for AMI?

Ray Gibbons: Do we have somebody from CMS on the phone?

Reva Winkler: I don't think so, hold on a sec. Let - Mary on the - in the materials I sent you for the May call, I had given you some additional information about what CMS was potentially doing. I didn't re-do it and so I can look real quickly.

They have addressed the issue or evaluating the issue of topped-out measures and they had a process for doing it. And they are talking about moving those measures off, but not for another three years.

Mary George: Okay, I thought they had something in the proposed IPPS that came out this spring.

Reva Winkler: Yes exactly and it was also in the value-based purchasing.

Mary George: Okay.

Reva Winkler: And that's what I'm looking to see where I put it, if I find it all.

Ray Gibbons: Okay, are there others who want to comment on this issue of our comfort with the aspirin measure being 96.5 in Hispanics when it's going in to a retired category, given the fact that some of the logistics, as Reva has pointed out, haven't been worked out yet?

Is that a good message for us to be sending I guess is...

Thomas Kottke: Ray?

Ray Gibbons: ...I'm really inviting other people to weigh in on this.

Thomas Kottke: Ray, (Tom) Kottke here.

Ray Gibbons: Yes.

Thomas Kottke: Yes, I keep wringing my hands about this. I'm really seriously concerned that somehow this drops off the radar screen and even if we vote to retire measures or whatever, I think Mark's suggestion that they automatically be revisited periodically once every three years or five years, you know, until - so that we don't have to put Harlan Krumholz with a fantastic paper in New England Journal about how aspirin after MI has, you know, gone into the tank. That kind of stuff.

So it was the same thing ejection fraction for heart failure, you know, in the hospital. I'm really concerned that there even there's some hospitals that are performing at a much lower level than this and it worries me about retiring the measure.

Reva Winkler: Okay this is Reva, just to be clear when you vote you will have the option to keep it as a regular endorsed measure or put it in reserve status, not retire.

Thomas Kottke: Reserve status...

Ray Gibbons: Yes reserve, don't worry Reva we'll get the terminology right.

Thomas Kottke: Yes right.

Reva Winkler: The only reason I'm being explicit is because there actually are group measures that the developers have requested be retired...

Thomas Kottke: Yes.

Reva Winkler: ...because they no longer maintain them. So what - trying to keep that differentiation. But if you are concerned enough and particularly around the disparities issue then, you know, perhaps the reserve option is not appropriate and that's really what we're looking to you for that recommendation.

Ray Gibbons: Okay so I think we've heard from George. He's concerned about the disparity. We've heard from (Tom) who's concerned that the whole performance is going to go into the tank. And we've heard from Mark, some concerns about just what are the details of this going forward, will the measures get forgotten in this reserve status or be revisited periodically which is not a stated part of the policy right now.

Are there other concerns that other committee members want to put on the table?

Bruce Koplan: This is Bruce. I have a question, is the 96 point whatever percent - is this a significant difference from - I mean do people feel like in this particular case this represents a significant disparity from the total?

David Magid: Yes, this is David. I was going to add to what Bruce just said. My guess is that in almost any other measure, you're probably going to see wider disparity so we do know that both racial and ethnic minorities tend to be seen at hospitals that perform poorer across all measures than Whites for instance.

And so, you know, this isn't saying that the data we've been provided doesn't really help us differentiate between whether there are true disparities within a hospital.

This really looks at disparities across all patients regardless of where they're seen and I suspect that if you actually adjust it for the hospitals that there were patients were being seen at, that this difference which is, you know, a few percentage points would largely go away.

It probably would persist, but it would probably be on the order of 1 or 1-1/2% so if we apply this criteria for any other measure, then we'll probably never ever put a measure in reserve status which may be okay, but I think you should recognize that the magnitude above the disparity here is probably as small as we're going to ever see it and so that means this category really will never be used.

Reva Winkler: Well, just to maintain the perspective. NQF did not have this criteria, this policy or this status until this committee raised it, question. When you did your initial evaluation of these measures and they were failing, that wouldn't be criteria of opportunity for improvement, but you

were all uncomfortable with the fact of not, you know, endorsing the measures because they're so important processes of care.

So this is in response to the problem you all raised.

Dana King: Ray, I have a comment. This is Dana King.

Ray Gibbons: Yes, please. Another voice to be heard, yes.

Dana King: Thank you. I do not think that if NQF puts a measure on reserve status, that we are sending a measure that something is not important. There are many other organizations that set the standards of care. What we are doing is making a measured and I think appropriate decision about the use of resources and where we get the most bang for our buck.

We are not interested in creating measures for every clinical thing in the universe that can be measured. What we're interested in are high priority items that give us the best return as far as quality improvement for the nation.

And if you put it in that perspective, it is not a good use of resources for something that is 96, or 97, or 98, or 99% already there. There are much better uses. The burden of measurement is not zero, the burden of measurement is quite expensive and so we are actually having a precious resource which is people's time and money and effort to measure things.

That is what we're measuring. We're not saying that this is not important, it is extremely important and might be the most important of all the measures is to give people an aspirin because it's so simple and so important and has such a big impact.

But we're not saying it's not important, we're saying we don't need to measure it right now.

There's better bang for our measurement dollars and buck elsewhere.

Thomas Kottke: Ray, (Tom) Kottke.

Ray Gibbons: Yes.

Thomas Kottke: If I could offer a respect or respectful other opinion that in fact communication is in the mind of the recipient, not of the speaker.

And I'm - I recognize the resource problem, but also going to register that, you know, if this goes in to reserve and, you know, we may actually do - have a better positive effect by keeping it on the agenda and preventing the loss of power from aspirin on discharge than from searching out other indicators - new indicators that have less potential all-around even if they were - even if a gap were closed.

But that's all sort of theoretical.

Ray Gibbons: Okay, well both of you have I think spoken very eloquently to both sides to this issue. I want to make sure that we hear from other committee members who want to express some question about it or some other point about this so please anybody who we haven't heard from that wants to weigh in, please weigh in.

Rochelle Ayala: This is Rochelle Ayala.

Ray Gibbons: Yes.

Rochelle Ayala: And I'm kind of listening and thinking since we have this anxiety about what's going to happen to this measure if we put it on reserve, then and I hear statements like we're going to maybe check on it every couple years. I'm just wondering, how would we check on it if it's in reserve and not really being used, where would we get the data about compliance with this measure?

And, you know, just from an operational point of view, I think of in the hospitals many of the people that control what's measured and how much - the resources to go in to measurement, they're not necessarily clinical people.

A lot of times the administrative people who really don't understand sometimes all of the details that go in to these measures, but they're concerned about their scores and their reimbursement. And so I'm a little bit concerned because a lot of times it's not even the physicians who are controlling the decisions about what a healthcare system's going to measure.

And these measures I've seen as very positive in rallying up the administrative forces and the resources to support evidence-based medicine when many of the physician's might want to do it and sometimes may forget, but there are systems in place with nurses and quality people that are supported by an administrative structure that would not be there had it not been for the fact that this would be a measure and a safer example of CMS set.

Ray Gibbons: Yes, okay. All right, are there other thoughts on this?

Cathy Szumanski: Ray, this is Cathy. It's just a random thought that kind of keeps rattling around in my head.

We talk about current performance being high and yet we've never said what that performance rate needs to be. And if you look at these measures, that there is a variation on where the performance is at, have we ever decided what "high" really means?

Ray Gibbons: Not to my knowledge. If there's somebody with more knowledge about that, please chime in, but I'm not aware of it.

Male: I'd just say that when we look across almost all of our ((inaudible)) that's performance measures, I'm not sure we have higher proponents on any other measure that we've looked at.

So that would be one way to look at it, it's the measure that we have the highest performance of everything that we spent, you know, four days in person looking at. I don't think there was anything higher than this.

Ray Gibbons: Okay, yes.

Cathy Szumanski: And I guess that would raise the question then in the next group that comes in to say, "Our high is not your high." I'm just wondering if that would cause - if we're setting a protocol or a policy, do we need to speak to what "high" means? And I don't know the answer to that question.

Reva Winkler: Cathy, this is Reva. You're not the first group that's looked at that. We've had previous committee's look at current performance rates and determine they were, you know, seriously high and did not recommend measures and what that's generally floating around is, is around the 95th percentile.

Cathy Szumanski: Okay.

Reva Winkler: Or 95%, but there's no rule. And I think it does have a lot to do with the prevalence because, you know, 1% of a small number is a small number of people. 1% of a large number is a whole lot of people so I think there are some relativeness that you may want to factor in to the assessment of really is this measure going to get any better?

Cathy Szumanski: Right and I agree with you Reva. I'm just asking, is that going to be confusing to somebody who's looking at a reserve measure? How did it get there?

Reva Winkler: Well clearly, whenever we do - to give it that status, we'll explain, you know, clearly that we looked at all of this data and we'll just list it out.

Cathy Szumanski: Okay and that makes sense to me.

Ray Gibbons: So I would just raise one issue which I think, at least in my mind is relevant here, and that is if CMS is really talking about a timeline several years from now of truly retiring some of the things on hospital compare, they obviously have their own internal policies and may or may not choose to pay much attention to what this committee does, but I would suspect that if we place things in reserve status that that would make it easier, politically easier for them to pull them off hospital compare.

Reva Winkler: Yes, just I found the document where I had shared with you the CMS announcement and the final rule for value-based purchasing. They had done an analysis of all of the measures on hospital compare because they felt that they just not, would not work in to the formula if you had topped-out measures.

And so they did an analysis of what topped-out measures that was different, but they felt among this group that the measures that were topped out were aspirin at arrival, beta-blocker at discharge and ACE or ARB at discharge, but not the aspirin at discharge, so.

Ray Gibbons: So in a way that accentuates the point that maybe perhaps by putting something else in reserve status, we might be in some way encouraging them to add that measure to that list.

Reva Winkler: Maybe.

Ray Gibbons: Hard to predict.

Are there other comments or questions? Now I would point out that we're going to have to have a vote by email of whether we're going to continue endorsement, move the measure to reserve endorsement, or remove endorsement.

So it's got to be three possibilities...

Mark Sanz: Ray?

Ray Gibbons: ...and this discussion was all provoked by discussing aspirin. Are there more questions or comments about the issue of aspirin?

Mark Sanz: Ray, its Mark.

Ray Gibbons: Yes.

Mark Sanz: With the vote, is it possible to - it would seem to be that much of the concern relates to never measuring again and since the policy is still in flux, if you can vote on reserve with follow-up in two years and four years, it would give impetus for people not to forget this knowing that it's coming back for a review at the hospital level.

Reva Winkler: Okay, yes this is Reva. I think because the policy doesn't have that embedded in it, what you're talking about are two recommendations. One is if you put it in reserve status, you can also then make a recommendation that they be it, you know, that the measurement occur every couple of years to monitor.

Mark Sanz: Basically, it gets rid of the concerns that this will deteriorate over time. It didn't get rid of it, but it means that people will have to pay attention to it.

Ray Gibbons: So are people comfortable if we make, in terms of this vote, if we say that if we move something to reserve status, we're going to make the recommendation to the Board that that be added to the policy? Re-measurement and a set number of years between two and four or something and let the Board decide on the time?

Reva Winkler: Or are we...

Ray Gibbons: Are people comfortable adding that as a qualification?

Dana King: Ray, this is Dana King. I think it would make people more comfortable about moving something off so that the proper message is sent and it's a true, you know, measure of resources kind of thing in time rather than this isn't important, it's just a temporary, you know, status.

Cathy Szumanski: Then I'm still confused about how you force people to measure it if say for example, let's say for example we put in reserve, CMS says, "Okay that's the green light." We can retire it and then three years later, we're recommending okay we test it, but CMS doesn't have to put it back in there set, their indicators, so how do we ensure that it's re-measured?

Reva Winkler: Well I mean, except for the recommendation and the fact that, you know, we work closely with CMS, there are, you know, other folks who will be using it to monitor what's going on anyway.

So I think - I do think there are a lot of open-ended questions of going forward. We know that CMS is likely to be doing something with the set that they're actually measuring and reporting on hospital compare because of these issues.

They've already said so in their rule announcement so, you know, it is somewhat open-ended. I don't think we can be 100% sure that it will be done. It certainly, as with all the NQF, you know, recommendations - that's what they are, recommendations.

Ray Gibbons: Okay, are there other thoughts about this qualification and whether that should be the basis for our vote?

Are there objections to making that as a basis for our vote?

Mary George: This is Mary and I would just say that I think having that qualification, since this is really something new, I think would be worthwhile.

Ray Gibbons: Yes we're breaking new ground so I think - and as Reva pointed out, some of this is in response to the concerns first expressed by this group so I think we can help to, you know, basically mold the policy going forward.

So unless there are objections, I think we will - we'll specify that, the staff will specify in email that if something's going to be moved through reserve, we're going to add that recommendation to the Board.

Reva Winkler: Yes, this is Reva. We'll do our voting as we've done previously using the SurveyMonkey Tool and we will ask you to evaluate all the criteria. And I can - I'll put that in the recommendation, you know, if you choose reserve...

Ray Gibbons: Right.

Reva Winkler: ...you're also recommending.

Ray Gibbons: Okay now I want to point out. We've been discussing this in general terms, but we started out with aspirin and we actually have three such measures.

So are there other specific issues people feel we should discuss with respect to beta-blocker prescribed at discharge?

We don't have the primary reviewer, but we did distribute a document.

Reva Winkler: Yes the Board sent her evaluation on - earlier today.

Ray Gibbons: And it went out at in an email at 10:32.

Reva Winkler: Yes, 11:32.

Ray Gibbons: I'm sorry. So basically she nicely summarizes everything there in terms of again the overall specifications of the measure, the scientific acceptability. Part of the point that David made earlier, that disparities range from 96.3 in Hispanics to 98.3 in Caucasians so pretty close to the numbers for aspirin.

Reva Winkler: Yes.

Ray Gibbons: Are there any other questions or concerns about the beta-blocker measure or anything else we should discuss that people want discussed prior to an email vote on that one?

Okay, I don't think I hear any ground swell of questions.

So the third measure we're going to vote on is the evaluation of LV systolic function or ejection fraction. And that one was completely reviewed at the time of our initial assessment and the agenda includes the actual overall vote. And highlights the discussion we had at that time that the current performance is very high, that we were a little concerned gets potentially misinterpreted so testing's done at every hospitalization which is not actually required.

And that, that might encourage overuse, but again the performance level of that one is also, it's on the top of Page 3. It's very high, 97.2 and 97.3, 97.6, 97.8.

(Cathleen), you were the reviewer on that one, do you have any other comments about our discussion about it?

Cathy Szumanski: No I think that the change in performance over the time period has only been an improvement of .6 because the (Beizer) performance rate is so high. In the disparity arena; however there is some lower levels of performance with Native Americans, female patients and interestingly enough in rural hospitals versus urban hospitals with rural only coming in at 92.6.

Ray Gibbons: Watch out, Mark's on the call.

Cathy Szumanski: I know he is, but the data speaks for itself, what can I say. And there's some disparity by region in the U.S. territory...

Ray Gibbons: Not the region.

Cathy Szumanski: ...but it certainly is a measure that has a high level of performance, but there is some disparity present.

Reva Winkler: Yes.

Ray Gibbons: Well I think we have to give Mark the A opportunity to respond for rural America.

Cathy Szumanski: I would agree.

Mark Sanz: Oh I think the measure speaks for itself if you said the reasons don't however. Once again resources are often not available to either collect or manage this type of - since most of these hospitals do not have Echo - I don't know if the distribution is of size, but one has to be concerned that a true rural hospital doesn't have an Echo machine nor does an Echo on every single heart failure admission as in a large ((inaudible)).

Ray Gibbons: Yes, okay are there other comments or questions about that one? I do think this one has a little bit of a different nuance to it because of this potential misinterpretation issue.

Reva Winkler: Yes.

Ray Gibbons: So there - keeping it alive may actually have a little bit of a downside from that standpoint.

Reva Winkler: Ray, this is Reva. Additionally, I would just point out that the committee's votes on the scientific acceptability ratings really were not high, high, high. There were five - six partial in size minimally and, you know, again to qualify for a reserve status, you really want solid scientific acceptability and there seems to be some sense that perhaps not.

Ray Gibbons: I don't recall, maybe the others can comment. I don't recall the details of this discussion, but it is a bit more of a surrogate.

Reva Winkler: Yes.

Ray Gibbons: It's a bit more of a surrogate than the other things we've been discussing.

Cathy Szumanski: And I think it was also only one step in a process that...

Ray Gibbons: Right, right. That's right (Cathleen), yes.

Yes, thank you for reminding me. I think we did - yes that's not captured in the brief...

Cathy Szumanski: Yes.

Ray Gibbons: ...summary of the discussion, but that was specifically mentioned by several people on the committee.

Are there other comments about the systolic dysfunction measure?

Okay, is everybody - are there any additional issues in everybody's mind so they're going to be comfortable seeing this email directing them to the voting site? Because now is the time for us to all be sure we're comfortable.

I think it's been a good discussion.

Okay, Reva. Do you want to briefly highlight the...

Reva Winkler: What's going on?

Ray Gibbons: What's going on, yes right. Do we take public comment now or later?

Reva Winkler: You know what, for this particular part I think maybe it would be useful, especially since David's leaving and maybe others. The rest is informational so perhaps it would be good to see if there's any public comment at this time.

Ray Gibbons: All right, let's see. Are there any members of the public who want to comment at this time?

Reva Winkler: All their lines are open so...

Ray Gibbons: Okay.

Reva Winkler: ...I think we have to assume that silence is no comment.

Ray Gibbons: Yes, I would presume so. So you're on Reva.

Reva Winkler: Okay, so this is a dynamic process. Lots of things keep happening. A couple of things - because this has gone through in a step-wise process, we're in the process of compiling a table, a giant table actually that sort of puts together all of the decisions you all have made and comes to a conclusion for final recommendation.

As soon as we've done the voting on these last three, I want to send it out to you so you can see and see what you did. And what those final recommendations are that we're going to be incorporating into the draft report.

So that will be coming, but because this has been a process of a lot of measures, a lot of discussion of various aspects, it's hard to keep, you know, a sense of what's going on without the score card so we're compiling a score card and we'll be sending it to you.

The, you know, anybody wants to comment, please feel free. We're interpreting silence as agreement. All right, that might make it easier for everybody. So that's going to be your final action if you will, is the review of that final document.

A couple other things that are ongoing, this morning in the email that Katy sent you, we forwarded a document that we just received.

I think we mentioned to you all that CMS and Yale are continuing work on their mortality measures for AMI and heart failure and the readmission measure for heart failure because there is a huge interest in seeing these measures be more widely applicable beyond the Medicare population into the general population.

And so they've been working quite diligently to try and get us there. And this is the early sort of information that's coming out. We've just gotten it, we haven't had a chance to really look at it.

One of our folks has been having a couple conversations with them over the last week and you'll see the questions that were posed and they responded to, but this is essentially test results of looking at the AMI mortality measure using All-Payer data rather than just the Medicare data to see how well the measure perform in that environment.

And so clearly you have not had time to look at it or digest it or anything, but I think we want to think about how we might want to move forward with this because there is a very, very intense interest in seeing those measures expanded beyond the Medicare population.

So I think we've got a couple of options and I'm happy to hear any suggestions you all have. Certainly if after you've had a chance to look at this, there are additional questions you would want to ask Yale, CMS, the developers, that please let us know and we'll pass those on.

But I think they have provided the results of the analyses they're doing on an All-Payer data set. And (Tom) Kottke had originally presented and discussed this measure. (Tom), I don't know if you've even had a chance to look at it, but if there's any comments you'd like - initial thoughts or comments you'd like to share with the group?

Thomas Kottke: Sure, I can't say I studied it, I can say I read through it between patients. The - basically the bottom line is that the results for All-Payers are nearly identical to the results limited to the Medicare population and unless I'm being fooled somehow, but the problem they had with All-Payers is that they didn't have any access to out-patient data, but this did seem to make any difference.

And so it seems to work well at least for mortality after AMI.

Reva Winkler: So and also we're expecting, if you read the details, they are doing similar testing on the heart failure mortality measure and the heart fail readmission. To be - to give you guys an opportunity to really digest all this and to have them put it in a format that is similar to what you're used to and to evaluate, we'll take a little bit of time and we want to move the rest of these measures forward.

So we're thinking about asking you all to look at these measures, you know, a little bit later and we'll treat them as sort of an addendum if you will to the work you've already done because it is important to really think about the broadest population for the measures, particularly these important outcome measures.

Ray Gibbons: So can I - Reva can you clarify what you mean about that? You have to ask Yale to submit on the standard template?

Reva Winkler: Yes, you bet.

Ray Gibbons: Okay. So I would just point out to everybody that at a 50,000 ft. level, this is a big deal because, you know, it's using another different administrative database and trying to replicate the very careful work that Yale did, published in circulation showing that clinical variables and administrative variables gave the same answers.

So and obviously there's huge interest in this because up until now, the only thing we really have are Medicare patients and several of you in various discussions of the committee mentioned that issue.

So I think this requires careful deliberation on everybody's part and time for everybody to digest it. And I would encourage your - I know you've put a lot of time in to this project, more of maybe than some of you planned, but if you do have some time to look at this and on a basis of your, you know, recent experiences we've looked at other measures, send along comments and questions to the staff that we can direct to Yale or distribute to everybody.

I think that would be helpful adjunct to the process and because I think that at some point if this is really going to fly, it would seem to me this has got to take another conference call with folks from Yale available to answer questions.

Reva Winkler: Yes.

Ray Gibbons: To do this the right way because this is a as they say, this has major consequences.

Reva Winkler: Right.

Ray Gibbons: Other comments about this issue? By the way, I ((inaudible)) and I shared (Tom's) impression, but it's got to take more time than I had today.

Reva Winkler: No, no one expected you to do that.

A couple of things in looking at the timing and, you know, we're coming up over this summer. And then we've got some logistical issues and I know you guys have given us so much of your time.

One thing I want you to put on your sort of calendars to think about is what we're going to do is be putting your recommendations from the - both meetings in to a single report. We're scheduled right now to put that out for a 45 day public comment right after the 4th of July which means we'll be finished in mid-August.

And we'll compile this comment and we'll need to circle back with you guys in a - for a conference call, probably early September so we're going to be asking you for availability to do that to review the comments and the feedback.

That's going to be particularly important because I think some of the recommendations you're making are going to pump comment so I can you just as a preview, it's taken us until just recently to collect all the feedback from the conference call in May.

But the whole issue around the composite-only versus the composite plus the individuals, congratulations you're evenly split. It's a tie, so there is - that's a bit unresolved and we're going to put it out that way, that it's a difficult issue, you struggled with it, there are pros and cons, there are strengths and weaknesses on both sides and we really need to consider the feedback that's going to come back at us and to give you a chance to weigh that in again.

Perhaps we can figure out a way of kind of scheduling a time frame where we do both to look at these revised outcome measures and the comments. I don't know if that's too much, we can talk about it Ray and Mary or perhaps we can, you know, be far enough ahead to schedule something, maybe two calls in September or something to get us past the summer where your schedules may not be totally filled up yet. Perhaps something like that.

Any other thoughts are welcome.

Ray Gibbons: Mary, you want to chime in here at all?

Mary George: This is Mary; I just had a question. Does the committee publicly respond to every comment?

Reva Winkler: Well what we do is, depending on and at times there are large numbers, what we do is staff draft a response to every comment that we share with you and if there are hundreds of comments, I don't - I mean, you know, honestly I doubt you're going to read every single one, but what we do is pull out that common ones, the ones that really challenge some of the recommendations, challenge evidence, challenge the evaluation and ask you to look at them and respond to them.

So we try and draft a response for you.

Ray Gibbons: Well it would seem to me that the notion of waiting till, you know, the summer has passed before we tap everybody for further efforts seems reasonable. I can't imagine that we'd be able to do much in the summer time frame on the basis of past experience trying to do that.

And I think we'll have to see what the volume of public comments is. So I just wanted to point out in case you haven't seen your - looked at your email in the last hour that the voting results from the May call were distributed this afternoon including the 10 to 9 vote that Reva eluded to about the composite vascular disease measure.

Reva Winkler: So...

Ray Gibbons: We had a more clear consensus on other issues.

Reva Winkler: Yes you did. This one is still not. It's okay because this one's very tough. There are really good arguments on both sides of this and I think you've struggled with it and articulated what those issues are and will present them and perhaps the feedback we get during public comment may help you, you know, one way or the other.

But no doubt about it, this one's tough. This is the first time we truly ask the committee to do this much of discussion around competing and related measures and all of that. Just because this topic area has so many similar measures, but it's tough and there's no easy answer, that's for sure.

But perhaps what we'll do...

Ray Gibbons: Okay, are there...

Reva Winkler: Okay.

Ray Gibbons: Are there other concerns or questions about the proposed schedule that Reva has outlined or the comments people want to make about their availability, etc.?

Reva Winkler: Now Ray what I'm thinking is right now since we're three months out, perhaps we'll see if we can nail down two dates in September. If we only need one, grand. But if we need two, we'll have two.

Ray Gibbons: I think we can try.

Reva Winkler: Okay.

Ray Gibbons: We'll see what we can do.

Reva Winkler: Yes, all right.

Ray Gibbons: You know the one issue that September raises, certainly an academic schedule is right after the summer and everybody wants to have their meeting or whatever.

Reva Winkler: Yes.

Ray Gibbons: So there's a flurry of activity, we'll see whether we can identify two dates for everybody.

Reva Winkler: Okay.

Ray Gibbons: Just looking at my own schedule here, it's going to be tough for me.

Reva Winkler: Okay. Yes, no I mean it's a struggle and we really appreciate it so we'll try and work with you as best we can.

I know it'd be good to start, to finish early, but one more topic for you. And I just want to let you know about part of the report will contain a discussion of gaps in the measure - in NQF's

cardiovascular measurement portfolio. And we've taken notes along the way of all your discussions where you've pointed out that we don't measure in X or we don't have the right type of measures in X.

And so I was going to share with you just what that was. And then I would ask you to offer up any other areas that you thought of or something we've forgotten, but briefly - certainly measures of cardiac rehab, all the existential angst experienced in February, that's clearly a gap where greater measure, you know, more measures around that seem to be highly desirable.

Then I think there was a significant discussion about measures around patient-reported information and outcomes around their symptom control and their functioning. Actually using the data the patient provides to assess quality, not just the process of asking the questions, but what were the responses.

You had some good comments around a preference for medication adherence measures rather than measures that just measure a single prescription or a single, you know, event.

Also more ((inaudible)) composite measures for processes of care, particularly like the discharge medications for AMI and heart failure. And I'm sure there are others that would help focus the measurement set and reduce the overall number of measures, but really address issues that are important to patients.

You also talked about expanding denominator population beyond that narrow definition of AMI or heart failure. I remember particularly when you were discussing use of ACE and ARBS in heart failure and AMI, it's you know, all patients will ((inaudible)) ventricular dysfunction regardless of how they got it.

Maybe a better measure to assess the care delivered and then consolidation of measures across settings of care. The number of times you talked about, you know, there's six measures for secondary use - secondary prevention use of aspirin or use of beta-blockers or use of ACE and ARBS and isn't there some way that we can get the single measure that can be applied to whatever sub-population of interest or whatever setting of care of interest.

So those are the kinds of things that would be recommendations to improve the portfolio of measures, the kind of measures, how we move things forward in to the future.

And so I would ask you either now or if you think of it down the road, send me an email. Are there any thoughts about additional types of measures or gaps in the measure portfolio, we certainly want to hear about them from you?

Ray Gibbons: Are there thoughts from members of the committee?

Well while people are pondering, I'll offer one and I recall specifically that it was raised by Dana in one of the discussions.

We have all these measures that by-in-large focus on hospitalized patients although measures in the outpatients here are coming along. But everybody recognizes that keeping people out of the hospital is in fact a desirable, laudable goal and certainly would go a long way to altering the crisis in healthcare expense.

And so we have no measures for maintaining patient stability or preventing hospitalization in our existing portfolio that I am familiar with

Reva Winkler: Right, okay.

Dana King: Thank you, Ray.

Ray Gibbons: Did I state that correctly, Dana?

Dana King: Very good, sir.

Ray Gibbons: Okay, you made the point very well the one day. I can still remember it and it really struck a chord with me.

Cathy Szumanski: I think another one that relates to that Ray is the type of instructions or discharge information that's given to patients with these cardiovascular diseases to keep them out of the hospital.

We did have one measure we looked at, but that's another piece of information that the patient needs to have that we really don't have a lot of measures about.

Mary George: And I think that, this is Mary. I think it speaks to sort of evolving need to have transitions of care measures.

Cathy Szumanski: Okay.

Ray Gibbons: All good ideas, are there others?

Reva Winkler: Are there any potential measures that might be considered patient safety measures?

I'm thinking of sort of the big category in the national quality strategy and the national priority partnership.

Dana King: This is Dana again. You make a good point and that is monitoring reactions or admissions to the hospital or serious adverse reactions to cardiovascular medications. They were prescribed for good, but they ended up, you know, in a bad result.

Cathy Szumanski: I think Warfarin is probably the number one drug that falls in to that adverse category, but do you have other measures addressing that already?

Reva Winkler: Well we have the measures that this group looked at and it's, you know, monitoring the laboratories. I think, let me just double check, I had a whole list of them here.

What was it, yes on chronic anticoagulation therapy and assessment of thrombotic risk, but not some - there are some patient safety measures around Warfarin use, but I'll have to go look at them specifically. But that's a good point.

Dana King: This is Dana again. This is Dana again, I was thinking - it seems like we used to admit people to the hospital a lot for, you know, digoxin toxicity and it seems to be replaced in our residency anyway by angioedema from ACE inhibitors. And it's kind of, you know, somewhat unpredictable, but nevertheless with more alternatives coming on the market, ARBS, etc. might be something worth monitoring.

Reva Winkler: Okay.

Ray Gibbons: Well, you know, I would point out that - I mean Mary has mentioned the anticoagulation and that's certainly a complication, but these days in cardiovascular disease we have many people with both coronary disease and atrial fibrillation who end up on a combination of antiplatelets and Warfarin or other anticoagulants.

And the adverse events in those patients are really considerable so it's a further demonstration of the need in that area.

Reva Winkler: Okay.

Ray Gibbons: But we have very little evidence to guide us.

Reva Winkler: Right.

Thomas Kottke: Ray, (Tom) Kottke here.

Ray Gibbons: Yes (Tom).

Thomas Kottke: I don't know how this fits in, but two very interesting reports that came out of the ((inaudible)), one was the problem of PPI's and subsequent re-hospitalization in points in patients with first myocardial infarction.

And the other one was any NSAID in patients with myocardial infarction, both having very significant increase in risk of re-event, but I don't think this has much to do at all with indicators at this time, but until there's good other centers observe that both PPI's and NSAID's increase risk.

So there may be at some point a role for an indicator of patients with known coronary disease on PPI's or on NSAID's.

Ray Gibbons: Yes, another example just of what Dana was talking about, the drugs we use don't always help people. And some of that can be anticipated and some can't.

Are there other thoughts on this one, if not put your thinking caps on when Reva sends this when Reva sends this around.

Reva Winkler: Yes.

Mark Sanz: Ray, this is Mark. Another one which is perhaps too near and dear to my heart because it happened last week is we get all these meta-analyses about there's no problems Plavix upstream and yet when our surgeons will take the patient, there are consequences to be had.

In this case, the patient who had left main disease was given Plavix at another institution, ((inaudible)) and left main closes.

We need to be a little more - you know these trials and meta-analyses exclude the patients who are the sickest of the sick and yet they're the ones that experience the complications.

I just think we need to be more proactive in looking at the sicker patient populations with what we're doing. You mentioned one which I wholeheartedly agree with which is atrial fib coumadin, 2b3a inhibitors, but another one is upstream use of Plavix and what happens when they need surgery.

Reva Winkler: Okay.

Ray Gibbons: And the advantage of widespread management, it does hopefully capture a broader spectrum of patients than captured in the trials.

Mark Sanz: Right, another one would be do EMR's always improve healthcare?

Ray Gibbons: You're getting radical now Mark.

Mark Sanz: You asked for suggestions. Well outside the great mail where we know it always does improve healthcare.

Ray Gibbons: Some of us are skeptical even here Mark.

Mark Sanz: I don't know exactly the structure of such a thing, but it would be wonderful if the brains that exist help us to figure out methodology to look at certain types of EMR-driven healthcare requests than do or don't really improve outcomes and/or may just increase costs.

Reva Winkler: Good point.

Ray Gibbons: Yes, that's very good point. Well Reva, we certainly created a wealth of ideas for you.

Reva Winkler: You certainly have and I appreciate it very much. I can do a lot with that, I'll write paragraphs.

Ray Gibbons: Are there anything else we need to do before we let these folks get back to their lives?

Reva Winkler: I think you covered everything on the agenda and I'm very thankful for the time you've spent sharing your wonderful thoughts.

I think we're finished Ray.

Ray Gibbons: All right, Mary anything we've missed here?

Mary George: No I just really appreciate everyone's time and the comments that you've made today.

Reva Winkler: Yes.

Ray Gibbons: Yes, I think it was this on paper looked like a routine call and the discussion once again was very productive, very high level and I again thank everybody for their involvement and we'll be in touch further.

Reva Winkler: All right, thanks everybody very much.

Ray Gibbons: Bye bye.

Mary George: Bye.

END