NATIONAL QUALITY FORUM

Moderator: Reva Winkler
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Operator: Welcome to the conference. Please note today's call is being recorded. Please standby.

Reva Winkler: Good afternoon everyone. This is Reva Winkler at the National Quality Forum. Thank you all for joining us on today's pre-voting webinar for NQF's Cardiovascular Endorsement Maintenance Project.

The voting opened today for 15 days for the 39 measures recommended in this project.

With me on the call, I'd like to introduce the co-Chair of this project who's been working quite diligently with us since early in the year, Dr. Ray Gibbons.

Dr. Ray Gibbons: Hello everyone.

Reva Winkler: And - yes. And our co-Chair Dr. Mary George from CDC is not with us today. She's traveling outside the country. She also has put in a large amount of work supporting this effort.

Has Gail Amundson joined us?

We're expecting Dr. Gail Amundson from NQF Consensus Standards of Approval Committee, though apparently she hasn't joined us yet.

Also from NQF we have the Project Manager Katie Streeter and NQF Vice President Performance Measures for - here at NQF.

So we'll go ahead and get started first by just looking at the goals of today's webinar. This is a process recently instituted in the CDP process when particularly since the voting duration has changed to 15 days. This is an opportunity for members to ask questions about the process, about the project, in preparation for voting. We will bring you up-to-date on the status of the project though in a call like this we really can't rehash all of the details.

So we're going to just provide you the information of what has transpired, the major highlights, and then provide you plenty of opportunity to ask questions hopefully to help prepare you for voting as we go forward.

So to start off, I'd like to ask our Project Manager Katie Streeter to just give us an update on the project and the project status. Katie.

Kathryn Streeter: So for this project, a 19 member Steering Committee was appointed to review a total of 57 candidate standards. Of the 57, 26 were newly submitted measures and 31 were undergoing maintenance review.

Because of the larger number of measures the evaluation process was conducted in two phases. The first phase included coronary artery disease, AMI and PCI, and the second phase included hypertension, heart failure, ACIV and other heart disease treatments, diagnostic studies and interventions or procedures associated with these conditions.

Dr. Gail Amundson: This is - I just want to say this is Gail. I joined the call a few minutes ago. I'm sorry I was a few minutes late. I apologize.

Reva Winkler: Okay. Gail this is - thank you Gail. This is Reva. I kind of started us off with the goals of the webinar.

Is there anything else you'd like to add?

I just want to do this.

Dr. Gail Amundson: I think I caught the last end of that Reva. I appreciate - so I appreciate people being here today.

And this is a new process to make sure that we have better connection with the conversation, the recommendations of the Steering Committee and CSAC so I'm here as your liaison person and I'm all ears.

Reva Winkler: Great. Thanks Gail. All right, well back to Katie to continue on the project status.

Kathryn Streeter: Thank you. NQF received 215 comments on measures during the 45 day comment period. That concluded on August 19th.

All of the comments have been addressed by measure developers and the Steering Committee.

And now voting begins today through October 20th.

You can find all of the comments and responses as well as the draft report on the project page which is on the NQF web site.

Reva Winkler: Great. Okay, thanks Katie. This is Reva again. During this process this was one of the first topic areas to go through NQF's new approach of both endorsement and maintenance of previously endorsed measures.

As Katie mentioned we evaluated the measures in two phases, though because the topic area was so interconnected we combined them all for - in the draft report for the comment phase and now again for voting.

A couple of things about the measure evaluation criteria and the evaluation process that the Steering Committee went through just to let everyone know that none of the measures in this project were eligible for time limited endorsement.

And so testing data for reliability and validity was required on all of the measures. This Steering Committee identified several measures which they felt met all of the criteria with the exception for opportunity for improvement. In other words measures seemed to be topped out.

And they asked is there some special designation we could make for these measures that are good but probably aren't terribly useful going forward but perhaps might be useful to pull off the shelf down the road if we want to check to see if there's been any backsliding or, you know, loss of performance.

And so that query was taken to both CSAC and the Board and the concept of the reserve status was created.

And so these are measures that are endorsed and meet all of the criteria with the exception of criteria 1(B) opportunity for improvement.

And in this particular project several measures have been recommended for this reserve status.

Another relatively new process for this Steering Committee was the use of the new guidance for related and competing measures. As you can tell looking at the list of measures there's an awful lot of very similar measures, measure concepts in this group.

And this was a very difficult task for the Steering Committee. A lot of the measures are very similar but they're from different settings of care. Determining the best-in-class was really quite difficult. And the committee struggled with it multiple times.

Harmonization was another issue that was raised over and over again. And we discovered as many other efforts prior to this that harmonization is best done upfront and now when measures have been in play, they have a long track record, there's a lot of investment in the measures as-is, harmonization is difficult to achieve.

Though we are under - we have discussed harmonization with measure developers and we'll talk a little bit about some of the progress that's ongoing moving forward.

And the last thing I just want to let you know about is three of the outcome measures that were evaluated in this project, AMI mortality, heart failure mortality and heart failure readmission. These three measures from CMS were up for maintenance review. The original measure and the initial submission for maintenance only captured patients over age 65, in other words, the Medicare population.

However we certainly heard for quite awhile that stakeholders are looking to see the measures expanded to capture all patients. And so the measure developers had been working on that all along.

And in the middle of the process during the summer they will - were able to provide to the Steering Committee updated testing on a combined all payer data set for these measures, provided the results.

And the Steering Committee has just recently looked at and evaluated revised measure specifications and submission. So these three measures will not be voted on with this group starting today. And in fact tomorrow we are posting them for a 15 day comment period on the revised specifications that include all ages.

So this is a way of really meeting the demand from our audiences to broaden the populations to as large as possible. So just to make you aware that those three measures won't be voted on until after this new 15 day comment period.

So I think those are the main process issues that occurred during this project as we're understanding how the dynamics of these endorsement maintenance evaluation processes work.

So now I'd like to turn it over to Dr. Gibbons.

Dr. Ray Gibbons: Thank you very much Reva. I would like to just depart slightly from the slides posted on the webinar to just comment on the outcome measures that Reva just mentioned. Certainly the committee recognized in reviewing the renewal applications how effective these measures had been and how carefully studied and evaluated they had been and certainly supported the view of many that they needed to be expanded to other patient populations.

So we were delighted to learn that working with CMS, the group at Yale had already been working on that and delighted to review their subsequent careful report on the expansion of those three outcome measures that Reva's already described.

We encountered a number of issues that I think have broad application and multiple measures which we'd like to mention to everyone. The first was disparities.

And we recognized in our initial review of some of the measures that we're reapplying that in fact the section on disparities in the actual application was not always completed to our satisfaction.

And one member of the committee in particular pointed out that we ought to be seeing and reviewing better data on this important issue.

So with the help of the staff we went back to the multiple developers and asked for additional data on disparities.

And we're pleased to see that that was forthcoming because I think all of us recognize the importance of addressing healthcare disparities within the system and the importance of measurement in trying to eliminate those disparities over time.

The second issue that we encountered as already mentioned was measures that demonstrated very high current performance.

And we had a fairly detailed discussion about the potential risk of eliminating measures from view and the possible hazard that things would then worsen with respect to performance regarding those measures.

And that led to the concept of reserve status that Reva has already mentioned. So that these measures don't disappear; they're just put in a separate category and hopefully can be revisited when necessary to ensure that performance is still high.

A third issue was that of conflicting guidelines. We certainly encountered in multiple different blood pressure measures different guidance with respect to targets and age groups. And that was also true in the lipid area.

And we recognize that there are in process hopefully in advance stages new guidelines from the NHLBI on both lipids and blood pressure and multiple developers agreed that they will revise their targets as needed when those new guidelines become available.

Composites were an important issue for us. As many of you know the importance of composite measures was stressed in an IOM Report a number of years ago. But the reality in terms of the field is that there haven't been very many composites.

The committee certainly recognized this as we discussed specific issues of patient care revolving around percutaneous coronary intervention or PCI or implantable cardio defibrillators, ICDs, and was pleased that the American College of Cardiology responded quickly with two new composites for those specific areas so that we combine them and make sure that patients who are treated in those episodes receive basically all the care that they should.

As already mentioned there are many examples in the portfolio of related and competing measures.

And we struggled as we reviewed all of them to understand where they overlapped and where they were truly competing.

And I think that will remain a challenge moving forward for the whole field of measurement because certainly we did in the end endorse a number of measures that many would see as related.

But when you carefully scrutinize them it's very difficult to say that they are truly competing because of different settings and different measurement data sets that are used.

Harmonization I won't discuss much further other than to say that remains an ongoing challenge and will truly be addressed prospectively before submissions.

And then finally we as a group had a considerable discussion and we had the opportunity to review the pre-2008 measures and the new forthcoming measures about what were the gaps in the cardiovascular portfolio for measure developers to consider moving forward.

And we came up with quite easily actually on the - from the various perspectives of people on the committee a number of categories. And I'd just like to quickly outline them for those of you who are on the call in the hopes that it might inspire some new applications to NQF in the future.

First, outcome measures that assess functional status and symptom control from patient reported data particularly in the outpatient setting where it might reduce visits and admissions through the emergency department and help to improve overall quality of life.

Second, measures of patient education and comprehension of their own care during transitions of care where I think we all recognize there are major problems in the current system.

Third, measures of appropriateness and overuse particularly of procedures. The NQF last year did have a separate committee dealing with imaging that did look at several measures in this area. But several of the people on the panel thought that this concept should be expanded.

Measures of shared decision making because the role of patients in helping to decide their own care is increasingly recognized by everybody.

Measures of appropriate referral and care coordination particularly during episodes of transitions of care, again getting back to the recognized difficulties in these.

Patient safety measures considered I think broadly. Obviously we have an inpatient safety measures that are being applied throughout the country.

But the committee felt that the concept also merited application in terms of reactions to cardiac medications. One primary example being the use of both aspirin and warfarin by millions of Americans who happen to have both coronary artery disease and atrial defibrillation.

Other examples were the upstream use of clopidogrel by patients undergoing non-cardiac surgical procedures. And unusual reactions like angioedema to ACE inhibitors.

And finally we thought there was a clear opportunity for measures for effectiveness and outcomes of cardiac rehabilitation that are not linked to a specific certifying organization.

There were some measures submitted to the committee. But we felt that they had major potential problems and they were not approved. We thought there was a great opportunity for other submissions in this area.

With that, I'll turn it back over to Reva.

Reva Winkler: Okay, thanks, Ray, very much. The audience will have an opportunity to ask some questions in a few minutes.

As we mentioned, we combined the two phases of evaluation into a single report. And the 45 day comment period garnered 215 comments from 23 organizations or individuals.

The themes really reflected the topics that Dr. Gibbons has just gone over. The topped out measures, competing measures. Three were also comments about measures that just look at assessment without a subsequent intervention. There were comments about some of the measures that were not recommended.

Again the Steering Committee has spent two conference calls discussing those comments in a large amount of detail. Their responses are included in the searchable spreadsheet that is posted on the web site so that you can search by measure number, you can search by measure developer, you can search by whoever submitted the comment.

So those are all available for your review to see how the committee and/or measure developers responded to the comments.

The review of the comments caused a couple of changes. The Steering Committee did take the comments quite seriously.

Two additional measures were placed in reserve status. And so several commenters alerted us that CMS had announced that they were stopping data collection on several - on two of their measures because there was really very high performance across the board so the committee agreed that those should be placed in reserve status.

And they also revised their recommendation on one measure, that’s measure 70 for beta blockers after MI use. This is an outpatient measure at the clinician level. During the discussion of best-in-class this measure was compared to a measure of persistence or adherence of use of beta blockers over a six month period after a myocardial infarction.

And while the committee did not change its recommendation from preferring to see measures of adherence as better measures of performance compared to a single point in time they - the

comment submitted that as a clinician level measure clinicians don't have access to the kind of data that it would take to monitor adherence.

And the fact that many patients are now going to discount pharmacies and buying their medications and it's not tracked made the adherence measure problematic for clinicians. And so this measure was recommended as a change from the original draft recommendations.

Dr. Gibbons did you want to have any comments on the discussions the committee had on the comments and changes in recommendations?

Dr. Ray Gibbons: Yes. I think it's important to point out that the comments were taken very seriously. We actually at one point thought we were going to deal with them in one call. And it quickly became evident that to do justice to the thought and suggestions that we received we needed to take two phone calls.

On one of the calls we had one of the measure developers sort of take us through their entire sort of comment and thinking with respect to a measure that was not recommended and I think the committee listened. The revote that took place reflected the fact that at least a few committee members actually changed their vote as a result of that discussion.

But the majority continued to favor not recommending that measure.

But I think we gave - tried to give respectful hearing to all of the arguments that people put forth when they were unhappy with something we've done.

And I think the fact that we made changes actually does reflect the fact that the comments and the whole comment process is worthwhile. The arguments about the two measures that had been reviewed by CMS and they were aspirin on arrival for acute myocardial infarction and use of ACE

inhibitors and angiotensin receptor blockers for LV dysfunction after myocardial infarction the notion - the recognition that CMS was already - had already reached a decision to stop measuring those because of their high performance I think clearly carried weight with the committee and prompted a change in our thinking about those two.

And as Reva has gone through already the issue of measure 0070 on beta blockers and prior myocardial infarction was very - that the argument to continue to endorse that measure was put forward very effectively in a detailed letter from the ACCF, the AHA and PCPI.

And I think the committee found the arguments put forward in that letter very compelling and re-voted and changed its mind.

So I think the comment process does work. And I would hope that those who submitted comments and didn't see a change will at least take some solace in the fact that the comments were carefully reviewed and considered. And we didn't just reject everything that had come in. In fact we made a number of changes.

Reva Winkler: Right. Thank you all, Dr. Gibbons. Ray has really been a great leader for this group as we've had a large amount of work to do, large number of measures to look at, a lot of revisiting, a lot of thorny issues. And so thank you very much for your leadership in that.

Dr. Ray Gibbons: Well thank you Reva. I think we should remind people as you said at the outset that I was helped a great deal by Mary George from the Center for Disease Control who is unfortunately not available today. But she certainly also provided a lot of assistance in this massive endeavor.

Reva Winkler: Right. All right, so I think at this point in time we're ready for questions. So Nicole if anyone out there would like to ask a question we'll be happy to respond.

Operator: Thank you. Ladies and gentlemen, if you would like to have a - ask a question at this time, you may do so by pressing star 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, that is star 1 to ask a question. And we'll pause for a moment to see if there are any questions. Once again, ladies and gentlemen, that is star 1 for questions.

Dr. Ray Gibbons: Somebody needs to be bold.

Operator: We'll take our...

Dr. Ray Gibbons: Any CME Program I've ever done the first question, there's usually a long pause before somebody is bold so.

Operator: Our first question will come from Joseph Drozda.

Dr. Joseph Drozda: Who else Ray?

Dr. Ray Gibbons: Thanks Joe.

Dr. Joseph Drozda: Yes.

Dr. Ray Gibbons: For being bold.

Dr. Joseph Drozda: Yes. And I thought you all just gave a great summary of the process that you've pain snakingly gone through to get to this point.

And just, you know, making certain everyone on the call is aware that - the fact that I am co-Chair of the PCPI, ACCF, AHA Work Group that developed the CAD and hypertension measures that were considered.

And as Ray as you kind of look at this and how - what your committee went through, I'm wondering if you have any feedback with respect to the, you know, the process and how it might be, you know, improved the next time, you know, through. I mean we're - I think NQF has historically always been, you know, self critical and then looking for opportunities to improve process and I'm just wondering if you've had any learning's about this.

Dr. Ray Gibbons: Well Joe that's an excellent question. I think one thing we saw early on and I hope it's going to be conveyed to the world of measurement at large very strongly is the issue of disparities.

I just found it amazing that some of the applications basically thought they didn't have take much care or time in filling out the part of the application that specifically requests that.

And as the Chair I just sort of looked at the first round and say boy, that's kind of not good that people aren't taking the care.

And then one member on the committee at the very first break came forward to me and said, you know, if I'm going to spend my time on this effort I really would like to have some input on something. And I said sure.

And then he said, I have - we just have to do a better job as a country in healthcare disparities and the only way we're going to do this is by measuring and I can't believe that several of the applications didn't do a better job.

And when we subsequently discussed that as a committee there was an overwhelming sentiment in favor of what he had outlined so that's what we asked the NQF staff to do.

So I think that's one example of how the process will be improved. And certainly on the fly this time but hopefully in the next go around people will understand that.

The second thing I think that we do need to recognize is that given all the measures we have out there and I think you and I both as clinicians recognize that clinicians struggle to keep track of all of this, there needs to be a focus going forward on measures that are outcome-based, that are not in the previous time limited endorsement category which have to basically have some data from the get go that show how this measure performs. That it's indeed a - that there is indeed a gap and that there is some link between the measure and an actual significant outcome measure.

So I think in the past at least my perception from my earlier experience is that many measures came forward with an expectation that they would try to qualify for time limited endorsement. I don't think in moving forward as a system we can continue to do that simply because it leads to too much burden on the overall system with too little definite improvement in quality and outcomes.

Those are the things I would sort of cite in answer to your question. But I'd ask Reva if she has other thoughts.

Reva Winkler: Well this group actually was blazing some new ground being one of the first of the E&M Project and this was the group that asked the question, what do we do with good measures that are topped out?

And in response the reserve status was created.

So this - the thing I was most impressed with this committee was the fact that they were problem solving as they went along. And as they encountered issues they would ask and we would try and help them deal with difficult thorny issues that we're trying to tackle as the whole measurement enterprise has evolved and matured.

So I'm very grateful for the expertise and the thoughtfulness of the people on this committee for being willing to raise the issues and pose the questions and help us push things to just a better place to be.

Dr. Ray Gibbons: All right Dr. Drozda has been the bold one. There must be other questions out there.

Operator: As a reminder that is star 1 if you have a question.

Our next question will come from Lisa Grabert.

Lisa Grabert: Good afternoon. I just had a question on when the 15 day additional comment period will begin on the CMS measures.

Reva Winkler: It'll begin tomorrow.

Lisa Grabert: Thank you.

Reva Winkler: Sure.

Operator: At this time, there are no questions in queue. But I'd like to give the audience another reminder. That is star 1 for any questions.

Reva Winkler: Okay.

Dr. Ray Gibbons: Can I just ask Reva? During that 15 day comment period, where do people who might be interested access the backup documents from Yale that we had access to in our deliberation...

Reva Winkler: They are all...

Dr. Ray Gibbons: ...beyond the application itself?

Reva Winkler: All of those documents are posted on the NQF web site. And if you look at the draft document, that's very much a pared down document for just the revisions of the three measures, we've linked those documents. We've referenced them with links that they could hyperlink to those documents because they're all posted on the project web page on the web site.

Dr. Ray Gibbons: So I would urge anybody who's going to comment and look at those particular measures in the applications to look at those backup documents because they're very, very detailed, very complete and some of the comments or questions you have may have already been anticipated by Yale.

So for example one of them is entitled testing 30 day risk standardized mortality and readmission measures in all payer data. It's dated June 17th this year. And it is 59 pages of incredibly detailed information from the group of - at Yale prepared for CMS.

Reva Winkler: Thank you. Operator, any other questions?

Operator: There appears to be no further questions at this time.

Reva Winkler: Okay. Dr. Amundson, did you have any comments or questions?

Dr. Gail Amundson: No. But this is - I guess I don't have any questions. My comment would be that it really strikes me that the committee has done incredibly thoughtful work and wrestled with some of the toughest problems. And I've been participating with NQF for about six years now and I'm impressed that we are maturing very nicely.

And this is good to see and I will carry this message back to CSAC as we start the deliberations around recommending that these measures go forward.

Reva Winkler: Thank you very much. So if there are no other comments or questions out there.

Operator: I have a follow-up question.

Reva Winkler: Oh excellent.

Operator: Your line is now open, Ms. Grabert.

Lisa Grabert: Hi. Thank you. It's Lisa Grabert from the American Hospital Association again. Dr. Gibbons' comment triggered another question for me.

I originally made the comment on disparities and urged the Steering Committee to ask the measure developer, Yale, to provide data on how they stratify the measure to indicate that disparities were not a factor.

Is that data that Yale was able to share with the Steering Committee after the public comment period?

Reva Winkler: They haven't provided us anything additional after the public comment period.

Dr. Ray Gibbons: There is fairly detailed information in the application and I'm not going to do justice to the group at Yale in this summary for sure.

But basically as I recall they carefully looked across a spectrum of hospitals with respect to the percentage of African-American patients that they serve. And it showed that the measures had a similar - very, very similar broad variability across different, I think it was quartile. It may have been quintiles of minority patients. So that was part of the original application.

And again I don't think we want to get into too many details because off the top of my head, I'm not going to do justice to all the work that they did on that issue.

Reva Winkler: Yes. But the committee certainly did look at that. And Lisa the folks at Yale did respond to your comments. So you'll see the responses in the comment table.

Lisa Grabert: Yes, I saw the comments in the comment table.

Dr. Ray Gibbons: I think at least as judged by the members of the committee, the concern about disparities was we felt adequately addressed there compared to some of our earlier concerns which prompted more information from developers. Just - we just didn't feel they had been addressed.

Lisa Grabert: I think that's a very fair point. And I'm glad that you said that. I do think that they probably did have more than some of the other applications that you looked at so that's really helpful feedback for me in terms of the issues that I was raising. Part of why we raised this issue is because it is intended to be used in a payment policy that CMS will be rolling out where inpatient hospital facilities will be penalized using this measure.

And because it's being tied to payment we're extra cautious about making all the proper adjustments for this measure.

Dr. Ray Gibbons: I understand your concern.

Reva Winkler: Are there any other...

Okay. Thank you, Lisa. Are there any other comments from anyone?

Operator: As a reminder, that is star 1.

Reva Winkler: All right. Well it sounds like we've pretty much talked ourselves out for today. I'd like to thank Dr. Amundson and Dr. Gibbons. And we'll - thinking well of Dr. George while she's traveling.

And everybody here at NQF, thank you all for joining us today. We encourage you to look at the documents, look at the comment table and voting closes on October 20th.

So thanks all...

Dr. Ray Gibbons: And if I may just comment that on behalf of Mary George and the rest of the committee I'm sure that they would all agree with my feelings. The NQF staff did an excellent job of supporting this endeavor which as Reva mentioned had some definite frontiers.

And hopefully we addressed them as best as we could. But certainly they were instrumental in whatever we were able to do that was breaking those barriers.

Reva Winkler: All right. So thank you all very much and good afternoon.

Dr. Ray Gibbons: Bye-bye.

Dr. Gail Amundson: Thank you.

Operator: That will conclude today's conference. You may now disconnect.

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