

NATIONAL QUALITY FORUM

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CARDIOVASCULAR MEASURE ENDORSEMENT PROJECT 2014
STANDING COMMITTEE

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FRIDAY
DECEMBER 5, 2014

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The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Mary George and Thomas Kottke, Co-Chairs, presiding.

PRESENT:

MARY GEORGE, MD, MSPH, FACS, FAHA, Co-Chair
THOMAS KOTTKE, MD, MSPH, Co-Chair
CAROL ALLRED, Immediate Past Chair,

WomenHeart: The National Coalition of
Women with Heart Disease

LINDA BRIGGS, DNP, George Washington
University School of Nursing

LESLIE CHO, MD, Cleveland Clinic*
JOSEPH CLEVELAND, MD, University of
Colorado-Denver

MICHAEL CROUCH, MD, MSPH, FAAFP, Texas A&M
School of Medicine

ELIZABETH DeLONG, PhD, Duke University
Medical Center

TED GIBBONS, MD, FACC, FACP, FASE, Harborview
Medical Center; University of
Washington Medical Center*

ELLEN HILLEGASS, PT, EdD, CCS, FAACVPR,
FAPTA, American Physical Therapy
Association

JUDD HOLLANDER, MD, FACEP, Sidney Kimmell
Medical College; Thomas Jefferson

University

THOMAS JAMES, MD, AmeriHealth Caritas Family
of Companies

GERARD MARTIN, MD, Children's National
Health System

KRISTI MITCHELL, MPH, Avalere Health

GEORGE PHILIPPIDES, MD, Newton-Wellesley
Hospital

JASON SPANGLER, MD, MPH, FACPM, Amgen, Inc.

HENRY TING, MD, MBA, New York-Presbyterian
Hospital and Health System*

MLADEN VIDOVICH, MD, Jesse Brown VA Medical
Center; University of Illinois at
Chicago

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer

SHARON HIBAY, RN, DNP, Senior Director

WUNMI ISIJOLA, MPH, Project Manager

KAREN JOHNSON, Senior Director

VY LUONG, Project Analyst

ALSO PRESENT:

ILEANA PINA, MD, MPH, The Joint Commission

ELVIRA RYAN, RN, The Joint Commission

STEVE SCHMATLZ, PhD, The Joint Commission*

ANN WATT, MBA, The Joint Commission

* present by teleconference

T-A-B-L-E O-F C-O-N-T-E-N-T-S

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1 P-R-O-C-E-E-D-I-N-G-S

2 (9:04 a.m.)

3 MS. ISIJOLA: Good morning, everyone,
4 and thank you again for joining us for Day 2 of
5 the Cardiovascular Project. Again, my name is
6 Wunmi Isijola, and I'm joined here by Sharon
7 Hibay, Karen Johnson, and Vy Luong.

8 We have a host of measures that we'll
9 be considering today really being presented by
10 the Joint Commission, and I will turn it over to
11 our co-chairs, Dr. Kottke, and Dr. George to give
12 us a recap.

13 CO-CHAIR KOTTKE: Good morning, thanks.
14 Yes, I think yesterday was very successful. We've
15 just had a chat with ACCF on 1524 CHADS2 and they
16 realized that there's a couple of problems that
17 they have, and so they are not going to put the
18 measure forward at this time. They're going to
19 reconsider whether to propose a totally new
20 measure around anticoagulation rather than have
21 us debate, and debate, and debate and still say
22 not quite adequate.

1 That's all. Otherwise - yes, Judd?

2 MEMBER HOLLANDER: You know, I'm just
3 thinking again that we went through a lot, and
4 that's a perfect example of something where we
5 could give them really good feedback, and they
6 could make the measure much better. And it makes
7 me wonder whether this whole Committee shouldn't
8 function a little more in the journal model,
9 where there's sort of a revise and reconsider.
10 Can we get the stuff earlier before it's
11 finalized? Like now we're voting yay or nay, and
12 that's a bummer because there's some really great
13 ideas that aren't getting through. And if we saw
14 it and had input and could help shape it via a
15 discussion like this earlier, I think the quality
16 in the country would be a lot better. We'd be
17 able to come out with a lot stronger measures.
18 So, I don't know. Again, it's something we can't
19 decide, but it's something that just, you know,
20 to throw back for NQF to think about.

21 CO-CHAIR KOTTKE: I guess, I mean, I
22 would say NQF has been working with them, and

1 this is - I mean, we see it at some point. You
2 can only see it the first time for the first
3 time. And I think they are doing the revise and
4 reconsider, but they're just - we're on this
5 sort of HAS-BLED and CHA2DS2-VASc, and is CHADS2
6 the state of the art anticoagulation decision
7 calculator at this time? And they're going to
8 have to think that through. I think there will
9 still be plenty of people pushing anticoagulation
10 and use of scores, it just won't be an endorsed
11 measure.

12 CO-CHAIR GEORGE: Basically, we'll see
13 this again in a slightly different version later
14 on.

15 MS. HIBAY: Right, and just to be
16 clear, we also just offered, and I know they will
17 take up, ACC Group will meet with the staff from
18 NQF to review. And just in general, as we
19 continue to, you know, being the quality
20 improvement experts that we all are at the table,
21 as we continue to make sure our processes are up
22 to what they need to be, and we're tweaking them.

1 That's the point of the preliminary analysis;
2 we're also encouraging those measure developers
3 to be coming to us as early as possible so we can
4 be successful in getting good measures endorsed.
5 There is a lot of positive energy around this
6 measure so, you know, we'll do our best to work
7 through those details.

8 MS. JOHNSON: And if you don't mind me
9 adding a little bit to it, your role as a
10 Standing Committee is a new role for us. And we
11 have you down as the overseer of the portfolio,
12 and that role, to tell you the truth, is new for
13 us. And we're still trying to learn and figure
14 out what that really means, but I think what
15 you're talking about, Judd, is what we're
16 thinking about in terms of that, being able to
17 offer that advice early on. And developers, I
18 think, are paying attention to that, so when we
19 write that section in the report of, you know,
20 suggestions for future development, we mean that.
21 We put that in there for a reason, so that sort
22 of feedback we definitely want to get documented

1 and get down.

2 MEMBER HILLEGASS: Can I ask about the
3 other measures that were the stress testing,
4 imaging, and all that?

5 CO-CHAIR GEORGE: We have two measures
6 that we are deferring until after public comment.

7 MS. HIBAY: Correct. And 670, if I
8 remember the number correctly, 670 is the measure
9 that we're going to allow because of 671 and 672,
10 we're going to allow the measure developers to
11 bring back information, as well, at the post-
12 comment call, because they're all so intertwined.
13 The concepts are all so intertwined, so we said
14 we would offer reconsideration at that time.

15 MEMBER HILLEGASS: But there was also
16 a discussion about sending this to possibly
17 another committee, like Resource and Cost, and
18 you supposedly told us that Helen was going to
19 tell us whether we could do that or not.

20 MS. HIBAY: Yes. We are going to
21 address that after this meeting is over, after
22 the two days are over, so I don't want you to

1 think that that's fallen by the wayside. We
2 understand that request is still there. Helen is
3 in and out over two days, and so to really give
4 her a substantive review of the concepts that we
5 discussed, we want to be fair to the discussion
6 and the decision, if that's okay.

7 MEMBER JAMES: And just to that point,
8 this is - it's the element of the three legs of
9 the Triple Aim, and some of these measures hit
10 multiple legs. So, that's why we're happier going
11 down another leg than another, but I can
12 understand why it -

13 MS. HIBAY: Yes, correct. Just for full
14 disclosure, so my role before I came to NQF was
15 working with the American Board of Internal
16 Medicine, so I'm really familiar with the
17 concepts of Choosing Wisely. And in my role,
18 there were lots of societies who approached us
19 and asked for measures that fit along the themes
20 of Choosing Wisely. And I guess my head sees,
21 and I think we mentioned in yesterday's
22 conversation that the AUC measures were in part

1 done because of the Choosing Wisely, or to
2 reflect Choosing Wisely.

3 So, you know, that's - these measures
4 may come to many, many condition or disease-
5 specific committees in the future, so I also
6 wonder if there's an opportunity for us to
7 provide additional guidance on how we can improve
8 the - because we're all kind of learning as we
9 go, but try to understand how we can review these
10 consistently across committees, so this will be
11 something that we bring back to Helen as well.

12 CO-CHAIR GEORGE: I just have one
13 question. Are there any concerns or questions
14 about the insufficient with exception option for
15 voting? Okay. Just want to make sure everybody
16 was clear on that.

17 MEMBER CHO: This is Leslie Cho. I just
18 have a quick question. Sorry I couldn't join you
19 afternoon -- yesterday afternoon. Did 1524, the
20 measure developers, are they going to provide
21 CHA2DS2-VASc2 score in the next revision?

22 CO-CHAIR KOTTKE: They'll probably -

1 they have to go back and decide what they're
2 going to do. They will probably come in for round
3 4. Round 3 is in June; round 4 will be later.
4 They don't think they can meet June, so they'll
5 be back. They have to decide whether to retire
6 CHADS2 and just go with CHA2DS2-VASc2 and HAS-
7 BLED. They haven't quite decided exactly what
8 they're going to do, so they have to regroup.

9 So, we'll start this morning with
10 2438. Do we have the developers, this is Joint
11 Commission. Do we have the developers - and the
12 discussants are Henry Ting on the phone, and
13 Kristi Mitchell.

14 While the developers are joining us,
15 who's on the phone? Henry, you're on the phone?

16 MEMBER TING: Yes, I'm here and
17 prepared to present the measure.

18 CO-CHAIR KOTTKE: Leslie Cho is on the
19 phone, and Ted Gibbons is on the phone. Anybody
20 else on the phone?

21 DR. SCHMALTZ: Yes, this is Steve
22 Schmaltz from the Joint Commission. I'm also

1 listening in.

2 CO-CHAIR KOTTKE: Oh, thank you. Okay,
3 developers?

4 MS. WATT: Good morning. I just want to
5 introduce ourselves. My name is Ann Watt, and I'm
6 an Associate Director in the Department of
7 Quality Measurement at the Joint Commission. Turn
8 this one off then. Thank you.

9 Next to me is Elvira Ryan. She is our
10 Clinical Lead for the Advanced Certification for
11 Heart Failure and a member of our technical
12 advisory panel. Ileana Pina, who I think is not a
13 stranger to many of you, worked with the advisory
14 panel that helped us to develop these measures.
15 So thank you for having us.

16 MS. RYAN: Good morning.

17 MS. WATT: Do you want to start with
18 the -

19 MS. RYAN: The introduction.

20 MS. WATT: Okay.

21 MS. RYAN: Okay. Good morning. Thank
22 you for the opportunity for us to be here today.

1 This is a set of six standardized
2 performance measures that were developed to
3 support the Joint Commission's Certification
4 Program in Advanced Heart Failure Care. The
5 measure set was developed with an emphasis on the
6 transitions of care, specifically the transition
7 from inpatient to outpatient.

8 The Joint Commission's standardized
9 systematic process for measure development was
10 employed and initiated for the development of
11 this measure set. And as a part of this process,
12 as Ann mentioned, the technical advisory panel
13 was established to define the scope of the
14 measures and to recommend measures which would
15 address key aspects of care.

16 The Advanced Certification Program was
17 actually implemented in January of this year, and
18 to date we have 58 participating organizations.
19 And in order to participate for the certification
20 process, it is mandatory that they collect all
21 six of these measures and submit data to the
22 Joint Commission.

1 CO-CHAIR KOTTKE: Okay, thank you. Who
2 is - Henry or Kristi?

3 MEMBER TING: Yes, I think we agreed
4 that I would lead the discussion and certainly
5 Kristi would chime in.

6 So, this is Measure 2438, beta blocker
7 therapy, specifically three long-acting beta
8 blockers, bisoprolol, carvedilol, or sustained-
9 release metoprolol for left ventricular systolic
10 dysfunction prescribed at discharge.

11 I just want to make sure everybody can
12 actually hear me okay through the phone.

13 CO-CHAIR KOTTKE: Sounds good.

14 MEMBER TING: The measure steward is
15 the Joint Commission. The level analysis is a
16 hospital facility. I'll start with the evidence.
17 This is a process measure. I felt that the
18 evidence was low to moderate, and the rationale
19 being this is a Class 1 Level of Evidence A
20 Guideline Recommendation from the heart failure
21 recommendations. There is no systematic review
22 provided in the - developed from the measure

1 developers.

2 Also, it's not explicitly stated in
3 the - and it was admitted that this - the
4 empirical evidence includes all studies in the
5 body of the evidence. If we look at the
6 guidelines, which sort of recommended this as
7 Class 1 Level Evidence A Recommendation, there
8 were six trials quoted in the guidelines from
9 1990 to 2003. In the proposal we were given from
10 the measure developers, they quoted four
11 different studies.

12 I would note that these studies are
13 all from 2003 or older, and much has changed in
14 heart failure therapy since that time.

15 The only other concern I had about the
16 evidence is that although this is a Class 1
17 recommendation, the Class 1 recommendation is not
18 for prescription of these three medications at
19 the time of discharge. The benefits of these
20 drugs are actually from long-term therapy and
21 compliance, not for prescribing these medications
22 at the time of discharge.

1 CO-CHAIR KOTTKE: So, Tom here. I guess
2 I have a couple of questions. You imply that
3 maybe by saying that a lot has changed in the
4 last 12 years, so are you suggesting that the
5 prescription of these drugs is no longer -

6 MEMBER TING: I'm suggesting that the
7 studies being used to justify the evidence is
8 from 1999 to 2003, and we all know much has
9 changed since that time. I don't think we know if
10 these drugs have the same relative benefits in
11 the setting of the other medications and
12 therapies we're using for heart failure patients.

13 CO-CHAIR KOTTKE: Are you aware of
14 trials that have been done since 2003?

15 MEMBER TING: I have not done that
16 analyses myself, but that was not provided by the
17 measure steward either.

18 CO-CHAIR KOTTKE: Okay. And the other
19 question is if it's long-term, when would you
20 suggest the drugs be started?

21 MEMBER TING: Well, you know, when
22 these patients are discharged, I could imagine a

1 situation where they're sick enough that you
2 might start them on a short-acting drug so that
3 you can titrate and escalate them, and then
4 convert them over to these long-acting beta
5 blockers. I'm not questioning the benefit of a
6 long-term beta blocker, both for compliance and
7 benefit, but at the time of discharge I could
8 imagine patients potentially being discharged on
9 a short-term beta blocker because you're going to
10 be escalating other therapies and eventually
11 converting them in the next 30 days, two months,
12 or three months to a long-acting beta blocker.
13 Again, this measure is looking at beta blocker
14 prescription of these three long-acting agents at
15 the time of discharge.

16 CO-CHAIR KOTTKE: Okay. Mladen and then
17 Judd.

18 MEMBER VIDOVICH: Well, I probably
19 would want to add to this that I think the
20 evidence is quite strong. Maybe it may not have
21 been presented in the measure, but I think there
22 is - I probably can't quote because I'm not

1 specifically a heart failure specialist, but I
2 mean there's good evidence that if medications
3 are not started in the hospital, they may not be
4 continued. And I think the escalation of
5 medication in the hospital and then continuation
6 has also been shown, I think more than once, to
7 be associated with compliance and good outcomes.
8 So, while perhaps it might have not been
9 presented, I think the data for this is quite
10 overbearingly strong to suggest that this would
11 be an appropriate measure, I think.

12 CO-CHAIR KOTTKE: Okay, thanks. Judd,
13 can I have Ileana make a comment or offer
14 something?

15 DR. PINA: Thank you. Thank you for
16 asking me to come. I really appreciate it. So,
17 first of all, we haven't needed new mortality
18 trials since 2003-2004 because beta blockers are
19 entrenched as part of what we now call GDMT or
20 Guideline Directed Medical Therapy. However,
21 having said that, there's been an evolution in
22 the way that the guidelines have looked at this.

1 There are two studies, one is called
2 IMPROVE HF, and one is called OPTIMIZE, that
3 showed very clearly that if the beta blockers are
4 not started in the hospital there is a high
5 likelihood that at six months the patients will
6 not be on it.

7 In addition, these new guidelines
8 published in 2013 clearly state that the beta
9 blockers and the ACE inhibitors should not be
10 stopped at the time the patient is admitted, so I
11 see this measure as both reinforcing the fact
12 that stopping the beta blockers is not indicated
13 and that most decompensations have nothing to do
14 with the beta blocker. But, again, getting the
15 clinicians thinking that they need to - if they
16 haven't been on it, they need to start it because
17 of that high likelihood.

18 The drugs are lifesaving: 34 percent
19 mortality reduction, reduction in
20 rehospitalizations, and ventricular improvement.
21 I mean, we reverse about a third of our patients
22 with beta blockers, so I think that adding this

1 to the sort of the thinking at the time of
2 discharge to me is like really critical and
3 keeping right with the guidelines.

4 CO-CHAIR KOTTKE: So, are ready to vote
5 on evidence?

6 MEMBER TING: So, just -

7 CO-CHAIR KOTTKE: Go ahead.

8 MEMBER TING: This measure has nothing
9 to do with stopping beta blockers. And the issues
10 that have been brought up about sort of
11 compliance and prescribing this medication at the
12 time of discharge, and compliance of patients
13 afterwards was not anywhere in the proposal. And
14 I'd like to see some evidence about compliance
15 rates on patients who are prescribed at the time
16 of discharge because most studies looking at
17 medications prescribed at the time of discharge
18 and looking at long-term compliance at one year,
19 and two year indicate that close to half of our
20 patients have stopped Guidelines Directed Medical
21 Therapy for most cardiovascular conditions at
22 one year despite being prescribed for them at the

1 time of discharge.

2 We note that the primary non-
3 compliance rate with these medications is
4 probably 20 percent primary, means they never
5 fill it, and about 50 percent at one to two
6 years, meaning they stopped it themselves.

7 CO-CHAIR KOTTKE: Are we ready to -
8 Judd, oh?

9 MEMBER HOLLANDER: Just one question.
10 This - my reading of this and, you know, I
11 haven't read every word. I wasn't one of the
12 primary reviewers. It's just beta blocker
13 therapy. It's not limited to these three long-
14 acting beta blockers. Is that correct?

15 MEMBER TING: No, it's for these three
16 specific long-acting beta blockers at the time of
17 discharge, Judd.

18 MEMBER HOLLANDER: Oh, okay. Thank you
19 for clarifying.

20 CO-CHAIR KOTTKE: Okay. Are we ready -
21 George?

22 MEMBER PHILIPPIDES: I can - let's

1 vote.

2 CO-CHAIR KOTTKE: Okay. Are we ready to
3 vote? Oh, no, sorry, Liz.

4 MEMBER DeLONG: I guess not being a
5 physician treating heart failure, I'm totally
6 confused. I mean, we have Henry saying there's no
7 evidence. We have other people saying there is,
8 but apparently evidence was not presented
9 sufficiently within this application.

10 CO-CHAIR KOTTKE: No. Henry is not
11 saying there's no evidence; Henry is saying
12 there's no evidence since 2003. Ileana says the
13 reason there's no evidence since 2003 is that the
14 evidence before 2003 is so clear that there have
15 been no subsequent trials. The reason that it's
16 long-acting beta blockers is that's what was used
17 in the trials, and so it's specific to the
18 evidence. And there's - I'm not a heart
19 failureologist either, but there's a difference
20 between short-acting and long-acting beta
21 blockers in efficacy for the treatment of heart
22 failure.

1 DR. PINA: Actually, carvedilol is a
2 short-acting form that's being recommended; it is
3 not the long-acting form. The only long-acting
4 form here happens to be metoprolol succinate
5 because the short-acting form had a negative
6 trial versus carvedilol, which is why we use
7 succinate which is what was done in the trial
8 MERIT-HF. Bisoprolol happens to be a long-acting
9 just pharmacologically, has a long half-life,
10 that's all.

11 MEMBER TING: Let me try again. Maybe
12 I wasn't as clear or effective in my
13 communication. I think the evidence is clear that
14 if you take these three medications long term and
15 stay compliant to them, there is benefit in terms
16 of heart failure mortality. There's no
17 disagreement on my end or with Ileana on that
18 issue.

19 The question that's at issue is, at
20 the time of discharge prescribing these three
21 specific beta blockers, calling them out, is that
22 associated with long-term survival benefit?

1 There's not a single study that says prescribing
2 these three specific medications at the time of
3 discharge improves survival -- no randomized
4 trial. It would be assumptions that prescribing
5 these medications at the time of discharge would
6 correlate to what was done in the trials, which
7 is randomized trials of patients taking these
8 medications long term. I think that's the
9 evidence.

10 CO-CHAIR KOTTKE: Okay, other - seeing
11 nobody sneaking toward their name tag, let's vote
12 on evidence.

13 MS. LUONG: Polling for evidence starts
14 now, one for high, two for moderate, three for
15 low, four for insufficient evidence, and five for
16 insufficient evidence with exception. Evidence
17 passes with 25 percent voting high, 69 percent
18 voting moderate, and 6 percent voting low.

19 CO-CHAIR KOTTKE: Thank you. Henry,
20 performance gap?

21 MEMBER TING: So, the opportunity for
22 improvement was provided by the developers. The

1 data and the literature from 2003 to 2004 found
2 that 78 percent of patients with heart failure
3 were discharged on beta blockers. I don't know
4 whether they mean any beta blocker, or these
5 three beta blockers. That's not specified.

6 During pilot testing of this measure
7 at nine sites involving 878 patients total, the
8 performance varied from 61.5 percent to 100
9 percent. No data was provided by the developers
10 on any disparities in the application.

11 CO-CHAIR KOTTKE: Thank you. Any
12 discussion, any - are we ready to vote on
13 performance gap? I believe we are.

14 MS. LUONG: Polling for performance gap
15 starts now, one for high, two for moderate, three
16 for low, four for insufficient. Performance gap
17 passes with 37 percent voting high, 58 percent
18 voting moderate, and 5 percent voting
19 insufficient.

20 CO-CHAIR KOTTKE: Thank you. Priority?

21 MEMBER TING: So, for priority there's
22 no question congestive heart failure is a

1 national health priority, and it's something that
2 cardiovascular professionals must focus on. My
3 concern is that I'm not sure that this specific
4 measure is a national health priority, and this
5 is a measure using one of these three beta
6 blockers at the time of discharge.

7 Again, I just want to express that my
8 concern is that I don't think there's a body of
9 evidence that measuring this measure prescribing
10 of these three medications at the time of
11 discharge has been correlated or linked to any
12 desired health care outcome.

13 CO-CHAIR KOTTKE: Sure.

14 DR. PINA: So, in both IMPROVE and in
15 OPTIMIZE, the patients who were not on beta
16 blocker at the six-month level and had not,
17 therefore, been started early had a greater
18 number of rehospitalizations, so we do have some
19 link to outcomes by the absence.

20 I also want to point out that there
21 are other beta blockers that have actually had
22 negative trials in heart failure, including

1 bucindolol and metoprolol tartrate, so you really
2 can't expand this and say beta blockers. And the
3 others really haven't been studied.

4 CO-CHAIR KOTTKE: Thank you.

5 MEMBER TING: So, Ileana, that's at six
6 months. Right? That's not at the time of
7 discharge.

8 DR. PINA: Right, right, but the study

9 -

10 MEMBER TING: I mean the measure --

11 DR. PINA: Yes, the study looked at
12 patients being discharged on the drug, and then
13 were they subsequently - that was the question
14 that the Registry asked, is if they were -

15 MEMBER TING: Yes. And I'm just
16 questioning the time - I'm not questioning at
17 all that these drugs are helpful and beneficial
18 if patients take them long term. The question is
19 whether prescribing just these three medications
20 at the time of discharge is an issue for me,
21 because I don't think there's evidence, and I
22 have yet to hear any evidence quoted that

1 discharge for the - on these three medications
2 correlates to any health outcomes.

3 CO-CHAIR KOTTKE: Okay. Gerard, and
4 then Judd.

5 MEMBER MARTIN: I think a question for
6 you. Are you getting at the whole idea that who
7 is - who would be more likely to prescribe this,
8 whether it's the hospital-based physician, or the
9 primary care physician, or outpatient
10 cardiologist? Is that the issue?

11 MEMBER TING: Are you asking me?

12 MEMBER MARTIN: Yes.

13 MEMBER TING: Yes. No, I'm getting at,
14 I think - I want a measure that we're going to
15 hold people accountable for, for improvement for
16 endorsed by NQF to actually reflect actually what
17 the evidence says, which is are you taking these
18 three beneficial medications long term? And
19 creating sort of these interim surrogate measures
20 which we think may be correlated, but we have no
21 evidence thereof, is creating sort of clerical
22 checklists for people to do. And if these

1 patients are just simply discharged on it and
2 never fill it, and there's no mechanism to keep
3 them on it at six months or a year, there's no
4 benefit.

5 CO-CHAIR KOTTKE: Judd?

6 MEMBER HOLLANDER: I'm wrestling with
7 this because I think Henry is right, but I think
8 Ileana is right. I mean, the best time to start
9 the medication is the time of discharge; there's
10 no doubt about that. Every time it's ever been
11 looked at, if you don't start it at discharge, it
12 doesn't get started.

13 On the other hand I talked yesterday
14 about something I feel passionate about, that you
15 can't take data from the outpatient setting over
16 the long term and appl it to the acute care
17 setting. It doesn't work. And, in fact, the ACCHA
18 guidelines on heart failure basically say nothing
19 about the acute management of heart failure.
20 There's not a single therapeutic Class 1A Level
21 of Evidence A recommendation in those guidelines,
22 not one. There's two pages in the 8 million pages

1 of the document effectively that focus on acute
2 care. And I'm afraid of the slippery slope here,
3 and the slippery slope is taking what we know
4 chronic and now applying it to the tail end of
5 the acute care setting, and that's dangerous. The
6 next step would be: everybody needs to get this
7 when they get into the hospital, so it's not -
8 and I agree with you, Tom, it's not exactly the
9 same, but it's getting closer to that.

10 So, I think what we need from an
11 evidence-based point of view is more research in
12 the acute care of heart failure patients and what
13 the right therapies are, and then we could
14 develop the guidelines. So, I'm just saying this
15 is in a funny area where somewhere between what
16 Ileana and what Henry say is at least the way I
17 feel about it.

18 DR. PINA: So, we just reviewed the
19 literature and we have a paper in the American
20 Journal of Cardiology actually this month as a
21 commentary to exactly what you're saying. Most of
22 the acute heart failure trials have only really

1 looked at the first 48-72 hours, and they will
2 really take you to what you do later, but it's a
3 problem because if you don't give the diuretics,
4 if you don't give the ACE, if you don't give the
5 beta blockers, they'll be back, two weeks I
6 guarantee. So, we went through the literature,
7 and actually the paper we are recommending that
8 we need more research into that transition from
9 the very, very acute to sending them home, which
10 is an element of four and a half days. That's all
11 you've got, is four and a half days. And we're
12 encouraging, you know, sponsors of acute trials
13 to really not to stop at their drug, but to take
14 the clinicians to the next step.

15 So I was just looking at the improved
16 data. There's actually a 10 percent improvement
17 in ejection fraction in IMPROVE, which looked at
18 the earlier adoption of beta blockades.

19 CO-CHAIR KOTTKE: Ted, you have the
20 floor.

21 MEMBER GIBBONS: Yes, thanks. This
22 reminds me of an earlier core measure for

1 measuring ejection fraction where although there
2 wasn't any evidence, you have to measure it in
3 the hospital. It was quite efficient to do so, or
4 you had to state that you had a plan to measure
5 the ejection fraction in follow-up. So, it seems
6 that many of the subtleties here may be that
7 there is a plan to begin beta blocker, and if the
8 patient is stable enough from a hemodynamic
9 standpoint you can begin it in the hospital, or
10 make a statement that you will begin it with the
11 first week or two of post-discharge follow-up
12 based on the patient's recovery.

13 So it seems that in terms of how
14 people actually practice, that it makes sense to
15 have it optimal to have it prescribed at
16 discharge, but to have a plan to begin it when
17 the patient is a candidate for it.

18 MEMBER TING: I think that's a great
19 summary of it. This is Henry, again. I think
20 we've seen both sides, and again it's not the
21 evidence that long-term therapy with these three
22 beta blockers improves survival. I don't dispute

1 that at all. It's when you start in when the
2 patient is stable, because we've seen the other
3 side, as well, where, you know, previously we
4 know that with spironolactone/Aldactone that
5 those are beneficial for heart failure, and
6 there's studies that show that they were
7 beneficial for heart failure. And we started them
8 at the time of discharge because everybody
9 thought that's when you had to do it, and then we
10 had more readmissions because of hyperkalemia.
11 So, you know, ideally all of us who are taking
12 care of these type of patients would want to make
13 sure that we're starting the medications that are
14 evidence-based when the patient is able to take
15 them, even acute or subacute outpatient setting,
16 and escalating them, and not just putting them on
17 a single standard dose.

18 So, my only quibble with this is the
19 fact that you're creating a measure that's going
20 to be held for accountability or quality
21 improvement, and it's at the time of discharge as
22 opposed to what has been described as optimally

1 getting these patients on it for the next 12
2 months, or 24 months.

3 CO-CHAIR KOTTKE: So -

4 DR. PINA: Let me just say - I'm
5 sorry.

6 CO-CHAIR KOTTKE: I've been asked to
7 redirect the -

8 DR. PINA: Okay.

9 CO-CHAIR KOTTKE: We voted on evidence
10 already. It's passed evidence. We're discussing
11 priority. Anybody have anything to say about
12 priority? Linda does.

13 MEMBER BRIGGS: So, I think that we all
14 agree that priority of heart failure and heart
15 failure treatment is a very high priority across
16 the nation. There's a large number of patients,
17 it's like the number one reason for admission in
18 the hospital, very high readmission rate, there's
19 20 percent I think or more that was quoted as a
20 statistic in here. It's a high cost, so in terms
21 of priority I think we have good evidence that
22 there's high priority.

1 MEMBER TING: High priority for heart
2 failure which I agree with. Is there high
3 priority for this specific measure, which is what
4 we're being asked to vote on?

5 CO-CHAIR KOTTKE: Right, so that's been
6 raised. Gerard, are you - okay, everybody has
7 their - are we ready to vote?

8 MS. JOHNSON: Can you let me just add
9 in a little bit? I know high priority is a
10 confusing criterion, and as a matter of fact we
11 are seriously thinking about what we're going to
12 do with this, but what we really want you to
13 think about is the priority of the - what the
14 measure addresses overall, so not the details of
15 the measure per se, but basically this is a heart
16 failure measure that is a high priority. So, it's
17 a little bit of a higher level think about
18 priority.

19 (Simultaneous speaking.)

20 MEMBER VIDOVICH: Priority of heart
21 failure, priority of beta blocker are we voting,
22 or priority of those specific beta blockers?

1 Right? I mean, you can split this in several
2 components. Right? Because I think we just
3 dissected this into multiple pieces. Right? It
4 almost seems that yes, giving these beta blockers
5 in setting of heart failure patients makes sense,
6 but are we splitting this into specific beta
7 blockers that we are voting for, or -

8 CO-CHAIR KOTTKE: My understanding from
9 Karen is that it's priority of heart failure,
10 that it's priority of the condition.

11 MEMBER VIDOVIK: Priority of the
12 condition. Okay.

13 CO-CHAIR KOTTKE: Carol, did you have
14 something?

15 MEMBER VIDOVIK: So, not - we're not
16 voting on bisoprolol. Okay.

17 MEMBER ALLRED: Yes. I would just like
18 to add from the patient standpoint, I would
19 consider these a high priority for quality of
20 life.

21 CO-CHAIR KOTTKE: Thank you. Are we
22 ready to vote? It looks like we're ready to vote.

1 MS. LUONG: Polling starts now for high
2 priority, one for high, two for moderate, three
3 for low, and four for insufficient. High priority
4 passes with 58 voting high, 37 voting - 58
5 percent voting high, 37 percent voting moderate,
6 and 5 percent voting low.

7 CO-CHAIR KOTTKE: Thank you. Scientific
8 acceptability and reliability. Henry?

9 MEMBER TING: Sure. So, the numerator
10 statement is patients who are prescribed on one
11 of these three beta blockers for LV dysfunction
12 at the time of hospital discharge. The
13 denominator statement is patients with heart
14 failure with current or prior documentation of
15 ejection fraction of less than 40 percent.
16 There's quite a long list of exclusions from the
17 denominator which is provided by the measure
18 developers. The data source includes electronic
19 clinical data, electronic health records, paper
20 medical records, and pharmacy.

21 With regards to - I'll stop there,
22 that's the scientific acceptability.

1 CO-CHAIR KOTTKE: Issues or concerns,
2 then reliability. Kristi?

3 MEMBER MITCHELL: For the measure
4 developers, I notice that there is quite a bit of
5 detail around particularly the ICD-9 and a
6 crosswalk to ICD-10, but not as much detail
7 around the - the data elements that were
8 captured in the Registry or in electronic medical
9 records. Is there an implementation manual of
10 some sort that could be submitted in addition to
11 this application?

12 DR. PINA: So, Get With The Guidelines,
13 HA has a very large registry, adopted this as a
14 measure even before the guidelines. We had a lot
15 of discussions about this and we adopted it even
16 before the guidelines, so we now have data in
17 there that needs to be mined to see what there
18 is. And I can certainly suggest that to the
19 scientific committee of Get With The Guidelines
20 for us to take a fresh look because we have now
21 thousands, and thousands, and thousands of
22 patients. And now we have a 30-day form that we

1 didn't have before, so we are going to know what
2 happens to those patients at 30 days. And I think
3 that's a great idea.

4 CO-CHAIR KOTTKE: Other issues with
5 reliability?

6 MEMBER TING: Oh, reliability?

7 CO-CHAIR KOTTKE: Yes.

8 MEMBER TING: I thought we stopped with
9 scientific acceptability.

10 CO-CHAIR KOTTKE: No.

11 MEMBER TING: The reliability I have
12 several comments.

13 CO-CHAIR KOTTKE: Okay, fire away.

14 MEMBER TING: Okay. So, reliability
15 testing was done at the nine participating pilot
16 sites. The Joint Commission actually went to
17 visit these hospitals from April to July of 2012,
18 and actually re-abstracted 201 medical records,
19 so reliability was actually tested by what was
20 reported versus what the Joint Commission saw
21 when they sort of re-abstracted the charts.

22 There inter-reader analysis

1 reliability had a kappa ranging from .31 to .77,
2 so with the specific data elements that were
3 extracted the prescription of the three beta
4 blockers at the time of discharge actually had a
5 kappa of 0.72 which indicates substantial
6 agreement. For documentation LV systolic
7 dysfunction less than 40 percent, the kappa was
8 0.77, again, demonstrating substantial agreement.

9 The documentation of reasons why the
10 patient was not prescribed one of these, so
11 exclusions, or documentation why a patient
12 couldn't take one had a kappa of 0.33, which is
13 quite low, and only shows a fair agreement. So,
14 that is a concern specifically with the
15 documentation of why patients had a
16 contraindication or were not discharged on it.
17 And there was quite a bit of disagreement between
18 what was reported from the sample size versus
19 what the Joint Commission found. In fact there
20 was in that sample 25 mismatches for what was
21 abstracted versus what the Joint Commission found
22 on manual review of the charts.

1 CO-CHAIR KOTTKE: Linda?

2 MEMBER BRIGGS: Looking at that
3 section, there is a bullet point that says no
4 reason for the bisoprolol and other drugs that
5 we've been talking about. The sites didn't
6 realize that the documentation of a reason for
7 administering beta blockers was not required for
8 patients with an LV, or systolic dysfunction
9 greater than 40. So, it's, I guess, again,
10 education around the particular measure that was
11 maybe the issue there based on what's reported,
12 anyway.

13 CO-CHAIR KOTTKE: I, frankly, myself am
14 not too concerned about the reason. With multiple
15 providers entering opinions into the chart, it's
16 easy for one abstracter to choose one, and one to
17 choose another. You know, I think the crucial is
18 the ejection fraction and whether or not they
19 were on the drug.

20 MEMBER TING: Well, I think that's an
21 assumption, Tom. I would agree with you if that
22 was the reason. I don't think we were provided

1 that level of detailed granularity as to why. Was
2 it just they chose different ones, or whether
3 there was documentation of exclusions when none
4 existed. You know, because you can imagine
5 patients being documented as being exclusions
6 when they should have been on this beta blocker
7 at the time of discharge. So, I was not given in
8 the proposal the reasons for this low kappa, and
9 where the disagreements occurred, so from a pure
10 reliability perspective I didn't feel like it was
11 sufficient, or it was quite low for that specific
12 reason. Because there's a very long list of
13 exclusions, and I don't know whether it was just
14 because they picked different ones, or whether it
15 wasn't done when it should have been done.

16 CO-CHAIR KOTTKE: Ileana, or anybody
17 have any -

18 MS. WATT: This is Ann. As noted, a
19 large part of the reason for the disagreement was
20 because the abstracters in the hospitals did not
21 have a clear understanding of the specifications
22 with regard to the ejection fraction, so they

1 were looking for reasons where they didn't exist.
2 That's one.

3 The other thing is that what we find
4 is that sometimes the hospitals who are doing the
5 abstraction for these pilots tests, they have --
6 they're clinically savvy people because generally
7 it's done in that service, and a lot of times we
8 find that they infer that, oh, well, obviously it
9 wasn't done because of this, but there is no
10 direct documented link the medical record. And
11 our instructions are that unless there is a link
12 in the documentation between the condition and
13 not doing something that it doesn't count.

14 DR. PINA: There's been some back and
15 forth about the level of 40, 35, and some trials
16 have used 40, and some trials have used 35. There
17 really isn't a heck of a lot of difference
18 between 35 and 40. And if you go even higher up a
19 little bit, 40 to 45, that's really like the gray
20 zone. So, I think that a lot of people interpret
21 40, or interpret 35. I don't think there's that
22 much.

1 MEMBER DeLONG: I'm a little bit
2 concerned that if there is a long list of
3 exclusions that must be because there's potential
4 harm. Is that right? I mean, why a long list of
5 exclusions if it's perfectly fine to give it to
6 all of these people? Are we not worried at all
7 about downside risk of promoting measures that
8 could have an impact on the wrong patients?

9 DR. PINA: I can answer that
10 clinically. It is very rare the day that I can't
11 start a beta blocker. And, for example, below 18
12 we need to exclude because the data in the
13 pediatric population is not as robust as it is in
14 the adult population. And you have to tell them
15 about worsening heart failure. You have to do
16 that because that's part of the labeling of those
17 drugs. But like I said, it's a rare day that I
18 can't start a beta blocker in the hospital.

19 CO-CHAIR KOTTKE: George?

20 MEMBER PHILIPPIDES: This is mostly to
21 educate myself, Ileana. I've seen cases where
22 patients get started on metoprolol, not the long-

1 acting form, not succinate with the intention
2 that when they get to the next visit outpatient
3 they'll be switched over. By this metric, that
4 would be a bad performance. Is that correct? And
5 I understand there's a comparison between short-
6 acting metoprolol, I believe, and carvedilol, but
7 are saying that metoprolol short-acting is worse
8 than not starting it all in the hospital?

9 DR. PINA: You bring up a great point.
10 So, the true metoprolol tartrate dose for heart
11 failure is actually TID, if you look at the
12 pharmacology of the drug. And we don't have any
13 data on that because even the COMET trial was
14 done on BID, and I think it was obviously stacked
15 up so the carvedilol would look good. And the
16 mortality really wasn't that different, but the
17 hospitalizations rate were.

18 I don't know that I would penalize
19 anybody for starting metoprolol tartrate with the
20 plans to switch them over to succinate at the
21 first visit, but there are side effects to the
22 tartrate, like a drop in heart rate that may be,

1 you know, when the drug peaks, a drop in blood
2 pressure when the drug peaks, and succinate just
3 gives you such a nice even keel absorption and
4 blood level that the patients tolerate it
5 extremely well, and even the blood pressure
6 doesn't drop much.

7 I mean, in our place where I am
8 fighting constantly Guideline Derived Medical
9 Care, patients are going home on like 90 percent
10 beta blocker which is pretty darned good.

11 MEMBER TING: So, Ileana, or maybe the
12 measure developers, since we're discussing the
13 exclusions and Liz brought it up, one of the
14 listed exclusions from the denominator is, and I
15 quote, "Patients with a documented reason for no
16 bisoprolol, carvedilol, or sustained-release
17 metoprolol at the time of discharge." That's it,
18 so there's no further indication that you just
19 have to document a reason, but it doesn't give
20 you the clinically appropriate reasons.

21 MS. WATT: That's correct.

22 MEMBER TING: So what is a clinically

1 valid versus invalid reason to give the checkbox
2 and exclude that patient from the denominator of
3 this measure?

4 MS. WATT: The measure doesn't address
5 what is a clinically valid versus a clinically
6 invalid reason because we - the Joint Commission
7 generally speaking does not establish goodness or
8 badness of reasons because we understand the
9 physicians have a stronger understanding of a
10 patient's particular case. So, if a doctor or
11 nurse practitioner, advanced physician's
12 assistant and so on documents a reason and links
13 it, that counts. I'm doing air quotes here for
14 the purpose of that measure.

15 CO-CHAIR KOTTKE: Yes, this is
16 inferential, but it's - I think it's the reason
17 ACC Guidelines say strongly recommended versus
18 must, just that it's always defer to the
19 individual physician's judgment that they may
20 know something about the patient that we can't
21 predict into the future, but that's inferential.

22 Are we ready to vote on reliability?

1 MEMBER TING: But, Tom, doesn't that
2 become sort of a potential issue of gaming and
3 just documentation, because if my reason is
4 because I want to start short-acting metoprolol
5 with a plan to convert to long acting at, you
6 know, the first medical visit. Ileana pointed out
7 that is an inappropriate reason, I don't want to
8 start the long-acting metoprolol. So, this
9 measure theoretically with any appropriate
10 documentation become 100 percent for everyone.

11 CO-CHAIR KOTTKE: Sure, sure. Yes, any
12 guideline can be gamed. Any time you leave it up
13 to professional judgment can be gamed, but if you
14 eliminate professional judgment you won't get any
15 guidelines.

16 Are we ready - yes?

17 MEMBER MITCHELL: Yes, but I just have
18 to comment. We're talking about measures now and
19 not guidelines, so the concept of gaming the
20 system is incredibly important in this context.
21 So, to Henry's point, I do think we need to
22 better understand what that exclusion criteria -

1 what is it, because I don't think we want to put
2 forth a measure in which we're setting it up to
3 game the system.

4 CO-CHAIR KOTTKE: Anybody else have a
5 comment in response to that? Seeing none, let's
6 vote on reliability.

7 MS. LUONG: Polling for reliability
8 starts now, one for high, two for moderate, three
9 for low, and four for insufficient. Reliability
10 passes with 11 percent voting high, 68 percent
11 voting moderate, 16 percent voting low, and 5
12 percent voting insufficient.

13 CO-CHAIR KOTTKE: Henry, would you like
14 to talk about validity?

15 MEMBER TING: Yes. So, when I looked at
16 validity, the statistics that were done for
17 reliability testing and validity included just
18 nine hospitals. The overall rate was 87 percent
19 with a minimum of 61, and maximum of 100 percent.

20 Because of this rather small sample
21 size, beta blocker therapy was correlated but did
22 not reach any statistical significance in

1 correlating with other measures of heart failure,
2 including discussion of advance directives, as
3 well as post-discharge evaluation of heart
4 failure patients. So, there isn't really I felt
5 sufficient evidence that this measure was - has
6 enough data for validity testing with other
7 measures of heart failure performance measures
8 based on what was provided.

9 CO-CHAIR KOTTKE: Any other discussion?
10 Seeing no action, are we ready to vote on
11 validity and threats? Any other - Henry, do you
12 have any other comments on threats to validity?

13 MEMBER TING: Other than I didn't find
14 evidence of -

15 CO-CHAIR KOTTKE: Okay, let's vote on
16 validity.

17 MS. LUONG: Polling starts now for
18 validity, one for high, two for moderate, three
19 for low, and four for insufficient. Measure 2438
20 passes with 11 percent voting high for validity,
21 58 percent voting moderate, 26 percent voting
22 low, and 5 percent voting insufficient.

1 CO-CHAIR KOTTKE: Henry, would you like
2 to talk about feasibility?

3 MEMBER TING: I'm not sure that I have
4 anything else to say other than what's been
5 stated about feasibility.

6 MEMBER MITCHELL: So, it stated in the
7 proposal that five sites dropped out, but the
8 reason wasn't as clear as to - I think they
9 started with 15 sites in total and they ended up
10 with nine that comprised the sample. What were
11 some of the reasons for the drop out?

12 MS. RYAN: The pilot actually was
13 conducted during the summer months, and that's a
14 time when a lot of the facilities are lower on
15 staff because of vacations. And at the time of
16 the pilot it was more or less having the
17 resources to do the abstraction. Sometimes when
18 the staff turns over they start out with a
19 project with certain lead staff, and the staff
20 turns over mid-project, and then that creates
21 some conflict for the organizations.

22 CO-CHAIR KOTTKE: I have a question. Do

1 you compensate the sites for - you do not
2 compensate the sites for participation.

3 MS. WATT: No, we do not.

4 CO-CHAIR KOTTKE: Okay, thank you.

5 MS. WATT: No, we don't.

6 CO-CHAIR KOTTKE: Okay, yes. So, that
7 - I mean you can tell your Health Partners eager
8 to jump in, you know, we think twice.

9 MS. WATT: We'll remember that.

10 CO-CHAIR KOTTKE: We do do some
11 testing, but it - I mean, it's real, it's a real
12 burden on the organizations to participate and
13 collect these data.

14 Okay. Feasibility, seeing no - oh, I
15 do. Linda?

16 MEMBER BRIGGS: So, I did have a
17 question again about the five sites dropping out.
18 And the other piece is in the feasibility it
19 talks about how much time and cost was computed,
20 30 minutes per measure, \$10.34 to take care of
21 this, but these same statistics are listed for
22 several measures. And while they may have all

1 been done in the same sort of batch, I would kind
2 of posit that different measures require
3 different amounts of time for you to collect that
4 data, particularly since you had developed a
5 tool for a pilot or whatever, but yet said that
6 sites were free to do whatever they want going
7 forward in terms of how - if they want to design
8 their own tool, blah, blah, blah. So, I don't
9 think we have a really good feel for how much
10 each individual measure actually did cost per
11 site, and so I'd ask you to clarify that.

12 MS. WATT: I don't know, is the short
13 answer. The longer answer is because, as Elvira
14 noted, all six of these measures are required to
15 be collected in real life, there's one data
16 collection tool that collects all of the data
17 elements for all of the measures, and it was that
18 whole collection period that you see, you know,
19 the 30 minutes and the \$10 or whatever it was.
20 And I really can't break it out by individual
21 measure because that's just not the way that they
22 abstract. And that's why you see the same number

1 reported because it's for the entire set.

2 CO-CHAIR KOTTKE: Okay. Let's vote on
3 - oh, Judd, sorry.

4 MEMBER HOLLANDER: So, I see this as a
5 reasonably burdensome measure because you can't
6 do it electronically. You need to go into the
7 record to see why somebody did or did not give a
8 drug. I mean, if they give one of these three
9 drugs it's easy, you could probably get that from
10 your EMR, or figure that out easily from coding
11 stuff. But if they didn't get it, then someone
12 really actually has to dig into the chart to see
13 what the documentation is. So, this is a little
14 more complex.

15 I mean, on the opposite side of my
16 argument people managing care transitions for
17 heart failure patients, and there may be somebody
18 that this would be tagged to, but it's actually a
19 real cost. It's not an easy thing to do.

20 CO-CHAIR GEORGE: It's stated in the -
21 I think for all of these measures that they are
22 planning to retool them as e-measures. Is that

1 correct?

2 MS. WATT: This is Ann. That is
3 correct. You know, the problem is, and we've been
4 doing - and I'm sure that you all are involved
5 with this, too, have been doing significant work
6 in trying to re-engineer measures for the medical
7 record, or the electronic medical record. And
8 what we're finding is unless you have these data
9 in standardized fields that you're using
10 structured vocabularies, you can't collect the
11 data. So, unfortunately, at this point anyway,
12 it's very difficult to get complex clinical
13 measures reported via the EHR. We're working on
14 it, we're trying, and that is the goal down the
15 road.

16 DR. PINA: The hospitals have become
17 very aware of this 30-day readmission rate, and
18 the penalties that they're paying which are
19 pretty high this year because it's of the total
20 Medicare charges. So, they've come up with
21 committees and groups to try to do this, so I
22 think a lot of the hospitals are doing this, and

1 they are spending the time. They have a set of
2 abstracters that are actually going into the
3 records to try to find out what is driving the
4 30-day.

5 CO-CHAIR KOTTKE: Okay, seeing no
6 further action, let's vote on feasibility.

7 MS. LUONG: Polling starts now for
8 feasibility, one for high, two for moderate,
9 three for low, and four for insufficient. For
10 feasibility 5 percent voted high, 58 percent
11 voted moderate, 32 percent voted low, and 5
12 percent voted insufficient.

13 CO-CHAIR KOTTKE: Usability and use,
14 Henry?

15 MEMBER TING: So you use and usability
16 is the extent to which potential audiences,
17 consumers, purchasers, providers, policy makers
18 are using or could use these performance results
19 for both accountability and performance
20 improvement to achieve high-quality efficient
21 care for patients of populations.

22 Again, I think the concern as I've

1 already expressed with sort of you can document
2 any reason to exclude them from the denominator,
3 and this is just a prescription of these three
4 medications at the time of discharge, so I felt
5 that was low.

6 CO-CHAIR KOTTKE: Anybody else have -
7 seeing no name tags, let's vote on usability and
8 use.

9 MS. LUONG: Polling starts now for
10 usability and use, one for high, two for
11 moderate, three for low, and four for
12 insufficient information. For usability and use,
13 11 percent voted high, 47 percent voted moderate,
14 42 percent voted low.

15 MS. JOHNSON: This is not a must-pass
16 criteria so we don't really talk about present
17 for this one.

18 CO-CHAIR KOTTKE: So, we're ready for
19 overall up or down.

20 MS. LUONG: For overall suitability for
21 endorsement, one for yes, and two for no.
22 Polling starts now. For measure 2438, 89 percent

1 voted for overall suitability for endorsement of
2 the measure, and 11 percent voted no.

3 CO-CHAIR KOTTKE: Okay, thank you very
4 much. Thank you for your comments, Henry. we
5 appreciate -

6 MEMBER TING: There's actually an issue
7 of competing measures, Tom.

8 CO-CHAIR KOTTKE: Oh, okay, go ahead.

9 MEMBER TING: There are actually two
10 competing measures which are actually more than
11 competing. Measure 0083 for heart failure is beta
12 blocker therapy for left ventricular systolic
13 dysfunction, measure 0615 heart failure is use of
14 beta blocker therapy. So, I think these are
15 actually not just competing, they're conflicting.

16 MS. HIBAY: So, the measure for - the
17 competing measure 0083. Henry, I think that's
18 what you're speaking to.

19 MEMBER TING: And 0615. They both refer
20 to beta blocker therapy for heart failure.

21 MS. HIBAY: Okay. So, 0083 is at that
22 point anticipated to be reviewed the next phase,

1 the next phase of the project, and we will do the
2 competing conversation at that time. It might get
3 delayed to the next one. We're still not totally
4 sure on the phasing because we have so many
5 measures already for the next phase. So, we are
6 - we would like to defer the conversation of
7 competing until the time when 0083 comes up.

8 MEMBER TING: And 0615?

9 MS. HIBAY: I need to look into when
10 the phase comes up for that one, Henry.

11 MEMBER TING: Just in our library that
12 you sent us, so I'm just trying to pick those
13 out.

14 MS. HIBAY: Very good.

15 MEMBER BRIGGS: Is the 0083 an existing
16 measure?

17 MS. HIBAY: I'm sorry, can you ask the
18 question again?

19 MEMBER BRIGGS: Is 0083 heart failure
20 beta blocker therapy for left systolic
21 dysfunction, is that an existing that would be up
22 for renewal rather than a new measure?

1 MS. HIBAY: 0083 is up for maintenance
2 at this point in time for the next phase. We
3 still have to -

4 MEMBER DeLONG: So, it seems as though
5 we should be packaging competing measures
6 together, and that competing measures should have
7 been rolled into the discussion before we got to
8 suitability for use. I'm - I feel not competent
9 enough to vote against this measure, but I do
10 think it creates a slippery slope of gaming the
11 system and imposing a convention on practice that
12 isn't fully specific enough.

13 MS. JOHNSON: So, let me at least
14 address your first question about why aren't we
15 discussing these things in tandem? And, actually,
16 that was our plan originally, and what happened
17 with Phase 1, you guys may not have realized it,
18 but we ended up getting a whole lot more new
19 measures in Phase 1, so these were actually - we
20 were initially planning on talking about these in
21 Phase 1 and all of these together. And we've had
22 to move them because new ones came in the door,

1 so we did try but, unfortunately, we just had too
2 many to be able to do it. So, that's why we're
3 actually going to push the competing of these
4 measures to the next phase so that you guys will
5 be able to look at both in depth, and then make a
6 decision if you need to on best in class or
7 superior.

8 MEMBER DeLONG: But we've already
9 decided on this one.

10 MS. JOHNSON: Right. So, this one --
11 what this one means is is that for now if all
12 goes through, it would be endorsed, you know,
13 again if all goes through. The next time when you
14 do the next one in Phase 3 or 4, wherever it
15 lands, you'll have that discussion for that
16 measure, and then we'll decide then at that point
17 if they really are competing. We would ask you to
18 select the best in class, if you can, or else
19 provide some rationale and justification of why
20 it's appropriate to have more than one measure at
21 that point.

22 MEMBER HOLLANDER: Let's say we have a

1 competing measure that comes up in Phase 3 or
2 Phase 4, but this measure is not there, and we
3 like the competing measure better, what happens?

4 MS. JOHNSON: If you had one in Phase
5 3 or 4 that points back to this one? We will be
6 looking at those, just like we'll be looking -
7 or we'll actually be looking back, so as a
8 matter of fact on your post-meeting call we
9 actually will be seeing that scenario, and we're
10 going to be doing that. So, there was something
11 that was passed in Phase 1 that is directly
12 competing to something that you're looking at
13 right now in Phase 2, so we're actually going to
14 do that scenario in your post-meeting call.

15 CO-CHAIR KOTTKE: Tom?

16 MEMBER JAMES: My understanding had
17 been that the roles of the work groups is to be
18 able to judge the suitability and scientific
19 appropriateness of individual measures, not to
20 make determinations as to prioritization. And I
21 think you're hearing is - and that that body
22 then falls to CSAC and to other users to make

1 determinations and come up with that infamous
2 reduction in - the P word for a small number of
3 measures. Parsimony, yes. Keep thinking of a
4 church mouse, but anyway, but what I think you're
5 hearing is a sense from this body is that we
6 would like to be included in at least previous
7 and prioritization of competing measures.

8 MS. JOHNSON: Yes. And, again, that
9 kind of goes back to your role as overseer of the
10 portfolio, so this kind of feedback is helpful
11 for us as we try to make that more clear.

12 MS. HIBAY: And, Henry, to provide
13 update on 0615, that measure was previously in
14 front of this Committee, and it looks like
15 endorsement was removed from that measure in
16 February of 2014, so that should not be a
17 competing measure unless they would bring that
18 measure again forward at a subsequent phase.

19 But in addition, just to let you know,
20 we do hear the rub there, that you want to be
21 talking about similar measures at the same time,
22 and we're working very hard, and we will take

1 into consideration, you know, hearing the
2 priorities from the Committee. But I think you
3 understand if we don't have it, it's silly to
4 have the conversation right now because we don't
5 even know when 0083 is going to be presented so,
6 you know, if that comes to us in the next phase,
7 we can go through this activity now, but -

8 MEMBER TING: Yes, but if we're the
9 overseers of the measures, you know, all I have
10 is actually a document that lists all the
11 measures in the portfolio, and I can't recall
12 which ones was endorsed, coming up for
13 maintenance, or -

14 MS. HIBAY: That's fine. Yes, that's
15 fine, Henry.

16 MEMBER TING: It's hard for me to -

17 MS. HIBAY: Yes, I just went on the fly
18 right now right into our database to see what
19 was active, and what was up to date. So, when you
20 get a list of the measures in the inventory
21 depending upon what list you're looking at,
22 you're looking at all measures, measures that are

1 not endorsed, and measures that are endorsed, you
2 know. So, you can filter it by those three areas,
3 so you may have the all measure one.

4 CO-CHAIR KOTTKE: Okay. So, Carol has
5 to leave somewhat earlier, so we're going to go
6 to Measure 2440.

7 CO-CHAIR GEORGE: Carol, did you want
8 to start, or do you want me to start? Okay,
9 great.

10 MEMBER ALLRED: Do the developers have
11 anything?

12 MS. RYAN: Hi. This measure looks to
13 see was the care transition record transmitted to
14 a next level of care provider within seven days.
15 And within that, there's also consideration given
16 that the care transition record includes
17 discharge medications, reason - I'm sorry,
18 follow-up treatments and services needed,
19 procedures performed during the hospitalization,
20 reason for hospitalization, and treatments and
21 services provided during the hospitalization.

22 MEMBER ALLRED: Okay. This is a measure

1 that is very closely related to the one Henry
2 just presented. It's the same group, the same
3 hospitals, pretty much the same evidence that we
4 presented in the other one. The nine hospitals,
5 858 patients involved.

6 The measure itself I think is a very
7 good measure because the whole purpose of it is
8 to set up a follow-up appointment transferring
9 the information from the hospital record to the
10 attending physician, and there are five data
11 points that have to be included in that. And it
12 needs to be done within seven days of discharge,
13 the reason for hospitalization, the procedures
14 performed during the hospitalization, treatment
15 and services provided during the hospitalization,
16 discharge medicines including dose and indication
17 for use, and any follow-up treatment or services
18 needed, so it looks to me like that's a wonderful
19 way to transition that care from the hospital
20 back to the private physician.

21 In terms of evidence, I think the
22 evidence is okay. It may be a little bit shy in

1 places, but I don't see anything wrong with it
2 all. So, I would say let's go ahead and vote on
3 evidence.

4 CO-CHAIR KOTTKE: Mary would like to
5 add a little bit.

6 MEMBER ALLRED: Okay.

7 CO-CHAIR GEORGE: So, I will say that
8 the developers did perform a literature review
9 resulting in about 35 different references with
10 evidence-based guidelines, cohort studies, other
11 references. And I think while this process itself
12 is not specifically unique or needs to be unique
13 to heart failure patients, the timing referenced
14 in the measure is probably very specific for
15 heart failure patients.

16 They cited evidence from five
17 citations, rather than empiric studies, and 17
18 references for this pilot measure. So, I thought
19 the evidence was fairly good.

20 MEMBER HILLEGASS: I kind of disagree
21 about the evidence. I don't feel that the
22 evidence is that strong for this whole group of

1 measures specifically. So if you want to go back
2 to Henry talking about the specific beta
3 blockers, if we carry that discussion over here,
4 these are specific things that need to be
5 measured for all patients. It shouldn't be just
6 for heart failure. So I really think it's a
7 valuable measure, but I don't think the evidence
8 supports it, in my opinion.

9 CO-CHAIR GEORGE: I think - and I
10 agree with you to a certain extent on this whole
11 package of transition measures. One of the things
12 that CDC commissioned a study of transition of
13 care for heart failure, for MI specifically, and
14 stroke specifically in 2011 from AHRQ with their
15 evidence-based review process, and there was
16 basically nothing in terms of evidence in the
17 literature. It's because it hasn't been done;
18 people haven't studied it. So, you know, it's one
19 of those things, how - so we fault and absence
20 of the literature?

21 DR. PINA: May I? I think that what's
22 been happening and why there are no more data on

1 the evidence for here is because heart failure
2 care, all care has become so fragmented. And we
3 have seen such a drastic increase in hospitalists
4 taking care of all these patients, and they'll
5 never be seen by that same person in the
6 outpatient. And the outpatient doctor most of the
7 times don't even know that the patient has been
8 in the hospital. And I think some of this may get
9 better as we're moving - I sit on the Electronic
10 Health Initiative, as we're moving with the
11 Office of the National Coordinator to get the
12 EMRs in better shape so that the outpatient EMR
13 talks to the inpatient EMR. And I think that
14 that's what's happened; it's why we don't have
15 any more evidence, because it's been so fast that
16 the fragmentation of care. The Commonwealth calls
17 it a cottage industry, that's what they call
18 health care.

19 CO-CHAIR KOTTKE: So, let's see, Linda,
20 then down the line, Tom, Mladen, Judd, and then
21 George. We'll go around this way. Oh, sorry, I
22 missed -

1 MEMBER DeLONG: Could I just interject
2 that evidence - I'm going to go all the way
3 opposite from what I usually say. Evidence in
4 this kind of a thing where you're looking at care
5 processes is very difficult to get. We have tried
6 to analyze things like a follow-up appointment,
7 and it is so totally confounded with the site
8 that it is very difficult to have firm evidence
9 regarding some of these things. So I wonder about
10 that criterion for something like this. You can't
11 do a trial.

12 MEMBER BRIGGS: I would agree that it's
13 difficult for this type of measure, but the one
14 thing that concerns me about this measure is that
15 there are so many pieces of it. And because of
16 that, trying to make any one piece of evidence
17 match it is difficult in and of itself. So,
18 there's one study that we were given with the
19 packets. Yes, there may be other data, but given
20 the complexity of this measure, I don't think
21 that the evidence really is there to support the
22 full complexity of this measure.

1 CO-CHAIR KOTTKE: Tom?

2 MEMBER JAMES: This week's issue of the
3 New England Journal of Medicine has an article on
4 the handoff, on a standardized handoff process
5 between residents, showing a significant
6 reduction in adverse events at that level. But
7 the question I have has to do with the seven-day.

8 In my past employer, we did a study
9 looking at readmissions with heart failure and
10 several other significant diseases and found that
11 you maximize at three days, 72 hours, and that -
12 to make contact. If you went out to seven days
13 there was a much higher readmission rate, so I'm
14 questioning the seven days as opposed to an
15 earlier time frame for handing off. And goodness
16 knows, we all got our hand slapped if we didn't
17 dictate as hospitalists right away.

18 DR. PINA: I think that what has never
19 come through with our seven-day and our three-day
20 is that there are physiologic reasons why the
21 patients get worse at about seven days. And it
22 has to do with neurohormones. When they get

1 excessively diuresed in the hospital, which is
2 what we all do, there is a rise in aldosterone
3 levels that happen at about a week to 10 days
4 where then they become avid sodium absorbers. And
5 if you don't see the patients then and try to
6 adjust their diuretic and go up on the other
7 drugs, I assure you a readmission. I mean, I can
8 even put the Good Housekeeping Seal on it that
9 they'll be back. So, there are physiologic
10 reasons that I don't think have ever come out in
11 any of these papers, but that's the reason why we
12 have always thought of that seven-day, or that
13 seven to ten day.

14 (Off-microphone comment.)

15 DR. PINA: Right, but if the clinician
16 who's taking over the patient sees the - knows
17 that the patient has been in the hospital they're
18 more likely to act on it. And, obviously, that's
19 the extension that we can't always measure;
20 you're right.

21 MS. RYAN: I think another thing to
22 explain is that this measure correlates with a

1 measure that we haven't yet discussed with
2 respect to the appointment within the seven days.
3 And we're not saying, you know, seven days, but
4 within that seven-day time frame, and the
5 expectation being that by the time the patient
6 has the appointment, the -

7 (Off-microphone comment.)

8 MEMBER HOLLANDER: I'm questioning
9 whether those should be paired measures. And I'm
10 - you know, we're doing an Epic implementation,
11 so automatically we meet this if it's referred to
12 somebody in our system. Right? But that's not
13 really good care; it just means somewhere in some
14 electronic cloud void the record exists. So, it's
15 - you know, I agree with the philosophy. I
16 frankly think it should be the day of discharge;
17 I don't see why we tolerate things going on for
18 weeks. You have to do the damn work anyway; do it
19 when it's best for the patient rather than when
20 it's best for the doctor. But I do question
21 whether we're going to get what we want. We're
22 just going to have it go into a void somewhere;

1 they're going to meet the measure. We're going to
2 sell more EMRs to deal with this because it's
3 going to fit into the ROI on doing that, but it's
4 not entirely clear to me it's going to improve
5 care unless there's an appointment that comes
6 with it. So, if part of the other measure was
7 having an appointment with the care record in
8 hand, that would be really good.

9 CO-CHAIR KOTTKE: Gerard and then
10 Mladen.

11 MEMBER VIDOVICH: First just make a
12 comment, it may sound stupid. But I think it's
13 like, you know, do we need a clinical trial? You
14 know, the famous thing for jumping out with a
15 parachute. Right? This completely makes sense,
16 everybody needs a discharge summary. Right? This
17 is - I mean, this is in your genome. Right? So,
18 I have no problems with evidence here. This
19 essentially says please write a discharge
20 summary, so that's great. No problems there. I
21 don't think anybody needs evidence for this, but
22 I have some problems with - you know, again, the

1 devil is in the detail.

2 Care transition record, what is a
3 record? And I think this is what Judd mentioned,
4 is everybody is going to EMR. Right? You know,
5 the Affordable Care Act talked about EMR
6 integration so maybe one day our EMRs will talk
7 together. What is a record, is it paper, is it
8 electronic, is it implied in some sort of - I
9 think that's a problem that records at this time.

10 Then definition of next level of care.
11 What is next level of care? Is this a nurse
12 practitioner, is this an internist, is it a heart
13 failure specialist? Within seven days. Right? You
14 know, it should be instantaneous. Right? You
15 know, again, if you look at these pure
16 definitions, just semantically I have a problem
17 with that. And then is this a double standard?
18 Right? You know, are we treating heart failure
19 patients with this, and then if you don't have
20 heart failure then you don't get a discharge
21 summary, or you could wait two weeks. Right?
22 That's a question for Joint Commission. Right?

1 The Joint Commission does a great job in
2 standardizing care across many, many hospitals.
3 Right? Is this cool to do this for heart failure
4 and not for pneumonia? I mean, do you have a
5 similar measure for a zillion other conditions
6 that also need a discharge summary?

7 MS. WATT: This is Ann from the Joint
8 Commission, and we have - there is a Joint
9 Commission standard that says that the medical
10 record needs to be completed within 30 days, and
11 that all medical records need to have a discharge
12 summary.

13 I think the reason why, you know,
14 that's a standard, and that's what every -

15 MEMBER VIDOVIK: Thirty days?

16 MS. WATT: - hospital is looked at,
17 or that's actually two standards, but every
18 hospital in the country is looked at those
19 things. I think the reason why we pulled this out
20 for this particular performance measure set was
21 because of the issues related to readmissions and
22 so forth. It seems to have a higher resonance, I

1 think, would be the thing.

2 In answer to your question about what
3 is a care transition record? We have a detailed
4 implementation guide that we've prepared, and
5 there are data element definitions for every one
6 of these things. And in here we state that a care
7 transition record may consist of one document or
8 several documents, which could be considered a
9 care transition packet. The hospital must be able
10 to identify which documents make up the care
11 transition record, and the hospital must identify
12 what specific documents are transmitted to the
13 next level of care provider. It could be in the
14 form of continuing care plan, discharge
15 instruction form, or another patient-specific
16 document contained in the medical record. So we
17 do try to describe very clearly what we're
18 looking for.

19 MEMBER ALLRED: We're still on
20 evidence.

21 MEMBER PHILIPPIDES: So this is just a
22 general question. There are specific things we're

1 asked to look for in regards to ranking the
2 evidence. Did the developer present data
3 supporting the idea that instituting this metric
4 leads to better patient outcomes. Is that right?
5 But sometimes it feels to me that if we like the
6 metric enough, or it feels right, we're willing
7 to forego that threshold and say well, we don't
8 need the evidence.

9 I'm actually okay with that because I
10 like this transition care things. I think they're
11 really important, I think that's where we're
12 moving into the next phase of good health care,
13 but I'm just concerned as to whether that would
14 really - do we need to hold ourselves to what's
15 written there as far as evidence. Because to my
16 knowledge, and correct me if I'm wrong, Mary,
17 that the data suggesting that if we do this, it
18 will lead to fewer admissions or better outcomes
19 is not that robust. I mean, it makes sense. I
20 think it has face validity to all of us, but I
21 don't think there's been data presented. Am I
22 wrong about that?

1 (Off-microphone comment.)

2 MEMBER PHILIPPIDES: So then I'm lost.

3 I don't know whether to follow the guidelines as
4 written and look for that evidence, or to say
5 well, in this particular case we all have a good
6 feeling about it. We think it makes sense
7 logically, let's just pass it. I don't know what
8 to do with that.

9 CO-CHAIR KOTTKE: Ted is on the phone.

10 MEMBER GIBBONS: It strikes me that
11 we're - when we're looking at these six measures
12 that we are at risk of falling into the same trap
13 as yesterday with 670, 71, and 72 where it seemed
14 to me since I was going to present 672 and didn't
15 have the opportunity, that that should have gone
16 first because it was the broadest measure. And
17 then 671 and 672 would have followed thereafter
18 because 672 had the strongest evidence for
19 asymptomatic individuals in general.

20 So, I wonder if what we're doing here
21 is criticizing the limited nature of one measure
22 and hoping that it will follow to the next

1 measure such that if someone gets an appointment,
2 then they get the 72-hour phone call, then they
3 show up to their appointment and they have their
4 discharge summary with the provider. So I wonder
5 if part of this is the way we're presenting the
6 measures, and in what order.

7 CO-CHAIR KOTTKE: I have a rhetorical
8 question. How many people could get that study
9 through the IRB -- the usual care arm of sending
10 the patient home without a discharge summary?

11 MEMBER HOLLANDER: I could guarantee at
12 the two institutions I've been at, that would go
13 through the IRB. It's usual care versus expedited
14 transition. One is the doctor does whatever the
15 doctor normally does. We don't slow it down, but
16 -

17 CO-CHAIR KOTTKE: We normally send a
18 discharge - the patient does not leave a
19 hospital on our system without a discharge
20 summary.

21 MEMBER HOLLANDER: That's a system I
22 want to go to, so move to Philly.

1 (Off-microphone comment.)

2 MEMBER HOLLANDER: Right, so you can't
3 but, you know, I think a lot of the world - I
4 mean, I ask the question now: if the Joint
5 Commission standard is 30 days to send a note,
6 but yet the Joint Commission says we shouldn't
7 have readmissions within 30 days, there's a bit
8 of a problem there.

9 MEMBER VIDOVICH: That's the double
10 standard. You can't have 30-day and a 7-day same
11 for different conditions. That concerns me.

12 MS. WATT: Just a clarification. Number
13 one, the Joint Commission doesn't say anything
14 about readmissions within 30 days; that's CMS.
15 But secondly, what we say is that a discharge
16 summary has to be completed within 30 days. We
17 don't say anything about transmitted or anything
18 else. What we are saying in this measure is that
19 we need to have a care transition record created
20 and transmitted within seven days of discharge
21 for heart failure patients.

22 And in terms of the paired measure,

1 you know, the way - because, as you know, all
2 six of these measures are required for
3 organizations that have the Advanced
4 Certification for Heart Failure, they are in
5 effect paired measures; they don't have a choice.
6 And the intent - the reason why we do measures
7 in sets like that is so that when you look at the
8 results as a whole, it gives you a pretty good
9 indication of the care presented or given to the
10 patient, and that's why we do it.

11 DR. BURSTIN: I'll just make a comment,
12 I'm sorry, just briefly. So we've gone through
13 this a lot in our care coordination projects
14 where most of these transition measures reside.
15 There actually is a fair amount of evidence about
16 transitions. You know, I don't know about the
17 specificity of the seven days, but at times that
18 committee, in particular, and it is certainly
19 within your purview, can go ahead and put forward
20 a measure with the - using the evidence
21 exception if the benefits significantly outweigh
22 the risks. And that's certainly within your

1 purview, to Liz's point earlier. I will point
2 out, though, although it's not in this project,
3 but care transition group also did endorse a
4 measure of a transition record within 24 hours
5 for all patients, so I just want to put that in
6 context.

7 MEMBER ALLRED: The measure also does
8 state that it could be transferred by phone, by
9 email, by various other things, so if you just
10 pick up the phone and calling the attending
11 physician and tell him what's going on, I think
12 that suffices.

13 MEMBER DeLONG: Then there's no record
14 of that.

15 CO-CHAIR KOTTKE: Helen and then --

16 MEMBER HILLEGASS: But for
17 clarification, I think we need to set a bar like
18 we talked yesterday. And we need to make a
19 decision: are we going to constantly bypass our
20 algorithm and do insufficient, you know, with
21 whatever exceptions, or are we going to stick to
22 what we were given, which is look at the

1 evidence, decide on the evidence, rate the
2 evidence. And maybe an exceptional case, and I'm
3 saying this as a devil's advocate because there
4 are five measures that are very similar. We're
5 going to be addressing the same issues because I
6 read all of them. I couldn't just read one; I
7 read all of them. And they're all very similar in
8 lack of evidence, so we need to decide now: are
9 we going to bypass the evidence which is
10 bypassing what we've been told to do, go through
11 our algorithm, or are we going to actually rate
12 the evidence?

13 The reason I say we need to set the
14 bar is there are other groups that these measures
15 could go to. And maybe we need to make a standard
16 as to what comes here and what doesn't come here.
17 And I don't know, maybe I'm talking out of school
18 here, but I do believe that we need to make a
19 decision. Are we going to go by the rules, or are
20 we going to constantly bypass and do five,
21 insufficient, you know, with exceptions. And
22 where do we make that decision as a group,

1 because it's silly to keep arguing this on the
2 next four issues that might have similar lack of
3 evidence. So, I think we need to make some kind
4 of decision here where we go with the evidence,
5 how often we bypass it.

6 We all think these are quality issues.
7 We think these are - we all believe in 24 hours
8 you should have this care transition. Where do we
9 set the bar with this group?

10 MEMBER DeLONG: Helen hit the nail on
11 the head. Is there any risk - I mean, if it's
12 hard to get evidence and you've got a measure
13 that you can't imagine a risk does the evidence
14 criterion have to really be strict? I mean, I
15 would say on the first one I had doubts about
16 risk. On this one, I'm having trouble imagining
17 any risk.

18 MEMBER HILLEGASS: And you're talking
19 about bypassing our algorithm and writing a new
20 algorithm. Correct?

21 (Simultaneous speaking.)

22 MEMBER HILLEGASS: Making a lot of

1 these fives.

2 DR. BURSTIN: Except, just to be clear,
3 the exception is part of your algorithm. We put
4 that there intentionally when the evidence tests
5 were submitted several years ago. So, it's not
6 going outside the algorithm. I will say, though,
7 we do view it as an exception. It is not
8 something you want to invoke constantly, but in
9 the right instances for the right kinds of
10 measures where evidence is weak, certainly not so
11 much on the clinical side, but I think more of a
12 crosscutting side we see it more invoked than
13 usual.

14 MEMBER HILLEGASS: But we have five
15 measures - and you're saying we need five
16 exceptions.

17 DR. BURSTIN: No, I'm not saying that.
18 I'm just offering to you that that is -

19 MEMBER HILLEGASS: Just throwing it out
20 there.

21 DR. BURSTIN: - certainly a
22 possibility, and that you should really be

1 weighing - this is when your expertise comes
2 into hand. Does the benefit of having that
3 measure in the portfolio significantly outweigh
4 any risks for patients?

5 CO-CHAIR KOTTKE: Well, I can tell you
6 our primary care docs do not ask rhetorically;
7 they ask how do you expect me to treat this
8 patient when I don't even have an idea they were
9 in the hospital? I mean, you know, does a tree
10 fall when there's no forest?

11 CO-CHAIR GEORGE: And I was going to
12 bring up what Helen mentioned about the NQF was
13 the preferred practices and performance measures
14 for reporting care coordination. And this is one
15 of the preferred practices in that NQF document.
16 Also recommended in the transitions of care
17 consensus policy statement from American College
18 of Physicians Society of General Internal
19 Medicine, and Society of Hospital Medicine,
20 American Geriatric Society, and the American
21 College of Emergency Physicians, and the Society
22 of Academic Emergency Medicine, so it's evidence

1 that's recommended from many, many different
2 societies in NQF.

3 CO-CHAIR KOTTKE: Gerard.

4 MEMBER MARTIN: So, again, new to NQF,
5 not new to quality improvement, it seems to me
6 that we're arguing over something that's pretty
7 silly. There are two aspects to evidence. There's
8 evidence where you're saying I want to do Drug A,
9 which has this outcome, and a new drug. And we're
10 going to try to impact survival, quality of life,
11 blah, blah, blah, where we say wow, to do that
12 there's a lot of risk involved. And we're going
13 to go for a randomized double blind study.

14 Someone in the quality improvement
15 realm, and I don't know still what NQF is, I'm
16 learning, there is a - I don't want to say a
17 lower bar, but there is a different risk
18 involved, where you're looking at - and I'm
19 sorry, I think from my hospital we've learned
20 that hand-offs are critically important. And if
21 you don't do hand-off well, even if it's inside
22 the hospital, you're in trouble. So, the idea

1 that you don't hand-off outside the hospital is
2 unbelievable. Okay?

3 To Tom's point, I can get this through
4 my IRB. I have through a National Quality
5 Improvement collaborative looking at single
6 ventricle patients, and part of - one of the key
7 drivers was a better handoff to the outpatient
8 world. And we left it blank, because we didn't
9 know what the strategies were going to be, and we
10 looked for best practices within hospitals.

11 So, if this is about quality, and this
12 is a hand-off, I think the evidence, and whether
13 you want to use the exception thing, then great,
14 use the exception thing because hand-offs are
15 important, and this shouldn't be a randomized
16 double blind study; it should be does this make
17 sense, and is this the right thing to do?

18 The only point I would take is, you
19 know, with Joint Commission is it probably
20 shouldn't be heart failure; it should be every
21 discharge. And it's only because, you know, this
22 is that whole thing about you're coming to the

1 cardiac group, that it's with us, but this should
2 be part of Joint Commission telling every
3 hospital to do this within seven days for
4 everyone that leaves.

5 CO-CHAIR KOTTKE: Thank you. Leslie, on
6 the phone you had a question or comment.

7 MEMBER CHO: Yes, my comment: I totally
8 agree with the previous speaker. There will never
9 be a randomized controlled study versus, you
10 know, care transition versus no care transition.
11 But I still think this is such a good and
12 important thing, that even if we don't have the
13 randomized controlled study from the New England
14 Journal, it should go forward. And I advise the
15 NQF staff again, evidence the way you guys have
16 put it in that algorithm is very difficult unless
17 it's like a randomized controlled study of drugs.
18 And I really think that for many of these
19 measures where it really makes logical, pragmatic
20 sense, that algorithm is really not that helpful.

21 CO-CHAIR KOTTKE: Carol, was that you,
22 or is that George?

1 MEMBER ALLRED: Yes, I was.

2 CO-CHAIR KOTTKE: Okay.

3 MEMBER ALLRED: I just wanted to make
4 a comment about the discussion. Yesterday we got
5 hung up on evidence, and we were talking about
6 new measures and the lack of evidence. And it
7 looks to me like this is the same thing. Are we
8 going to say the evidence isn't good because it's
9 not there, or are we going to figure out how to
10 deal with new measures that improve quality?

11 CO-CHAIR KOTTKE: So, Kristi, Judd, and
12 then back to Liz.

13 MEMBER MITCHELL: My question isn't so
14 much about the evidence; it's about the bar that
15 we need to establish for accountability. So, I
16 think in the context of quality improvement, this
17 is all good. This is motherhood and apple pie.
18 Right? But I think when we're talking about
19 dollars and cents, and incentivizing hospitals
20 and providers, individual attribution around
21 accountability, then the question becomes clear
22 to me that we have to figure out what we're going

1 to do around evidence. So, I just put that out
2 there because I think that those concepts get
3 conflated in our discussions. So, quality
4 improvement and accountability are not the same.

5 MEMBER HOLLANDER: I agree with all
6 these sentiments, and I'm all fine with this
7 going forward. I guess what I'm questioning is,
8 this is a proxy outcome for something where we
9 already have a hard outcome, and we now have a
10 whole series of proxy outcomes for heart failure
11 where we're measuring, you know, the more
12 important thing which is, you know, 30-day
13 readmissions or 30-day quality of care framed as
14 readmissions. So, I wonder if we're not better
15 off having one composite measure that looks at
16 the things that would get us there.

17 So, I think we can all agree you have
18 to have the record transmitted, but if you just
19 have an institutional-wide electronic medical
20 record you meet this criteria. That really does
21 nothing for care. Okay? You need to have an
22 appointment at some period of time. There's not

1 great evidence whether it could be seven days, or
2 14 days, there are some unintended consequences
3 if you get people who don't need an appointment
4 to have an appointment and block people who need
5 it from it, but we all agree at some point in
6 time you need the appointment. And maybe it
7 really should be a composite measure that you do
8 the three, or four, or five things that get you
9 to the likelihood of decreasing 30-day outcomes.
10 There's a great paper in the STEMI world that
11 Elizabeth Bradley wrote years ago that has like
12 seven things that you should be doing at your
13 institution to improve your STEMI outcomes. And
14 we've seen composite measures here, and I'm
15 raising the question. I know it's not the measure
16 in front of us, but we have a whole group of
17 measures. Maybe we should have them come back
18 framed as a composite because this one measure is
19 not going to help anybody on an EMR; it's not
20 going to do anything to their institution that's
21 already being done. It's in the record and may be
22 ignored, but the next step might actually be

1 really useful at that institution with that
2 patient. And if it's put together that's just one
3 way where I think we're really improving quality
4 rather than layering on a bunch of proxy measures
5 where we already have the outcome measure in the
6 portfolio.

7 CO-CHAIR KOTTKE: Liz?

8 MEMBER BRIGGS: I just want to
9 reemphasize - sorry, I'm going in a different
10 direction, but what Leslie said was if it makes
11 sense, the evidence isn't as important. I think
12 there are a lot of things that make sense offhand
13 and have been shown in trials to not work. I
14 think it has to pass a different bar, and that is
15 absolutely minimal risk. And if it feels good,
16 and it's minimal risk, and risk includes cost,
17 then maybe the evidence bar is too high.

18 CO-CHAIR KOTTKE: Okay. Does anybody
19 have anything new to say, new plus relevant, two
20 attributes. Seeing nothing, let's vote on
21 evidence.

22 MS. LUONG: Voting for evidence starts

1 now: one for high, two for moderate, three for
2 low, four for insufficient evidence, five for
3 insufficient evidence with exception. And this is
4 for Measure 2440.

5 Measure 2440 did not pass with 22
6 percent voting moderate, 6 percent voting low,
7 and 72 - oh, it did pass. I'm sorry, with
8 exception. So, Measure 2440, 22 percent voted
9 moderate, 6 percent voted low, and 72 percent
10 voted insufficient evidence with exception.

11 CO-CHAIR KOTTKE: Thank you. Carol, do
12 you want to talk about performance gap?

13 MEMBER ALLRED: There's definitely a
14 performance gap. I think the statistics were less
15 than 40 percent of the people are actually
16 getting the transmitted record within a timely
17 basis. And that's not within the seven-day time
18 period. So, there's a definite room for
19 improvement there.

20 CO-CHAIR KOTTKE: Disparities?

21 MEMBER ALLRED: Disparities, yes. There
22 are disparities in care, but none of the studies

1 on this particular group of five actually
2 designated the disparities, so they went to the
3 literature and actually are showing that white
4 Anglo Saxons have a better rate of getting that
5 first review out than minorities do.

6 CO-CHAIR KOTTKE: Does anybody need to
7 dispute what Carol just said? Okay, let's vote on
8 performance gap.

9 MS. LUONG: Polling for performance gap
10 starts now: one for high, two for moderate, three
11 for low, and four for insufficient. Performance
12 gap passes with 56 percent for high, 44 percent
13 for moderate.

14 CO-CHAIR Kottke: Priority?

15 MEMBER ALLRED: Priorities. Obviously,
16 heart failure is a major problem; it's a high-
17 cost, high-risk disease, so I think it is a high
18 priority.

19 CO-CHAIR KOTTKE: Looks like everybody
20 wants to vote.

21 MS. LUONG: Polling starts now for high
22 priority: one for high, two for moderate, three

1 for low, and four for insufficient.

2 CO-CHAIR KOTTKE: Even I can pick up
3 the subtle bodily motions that -

4 MS. LUONG: Priority passes with 66
5 percent voting high, 22 percent voting moderate,
6 and 11 percent voting no.

7 CO-CHAIR KOTTKE: Scientific
8 acceptability and reliability.

9 MEMBER ALLRED: Okay. Scientific
10 acceptability, the numerator statement and the
11 denominator statement I think are good. The
12 exceptions there, exclusions from the denominator
13 are limited to left ventricular assist devices
14 and heart failure, which makes perfect sense to
15 me. So, I would say the scientific acceptability
16 is good.

17 Reliability, the data points are
18 easily extracted from the electronic record or
19 paper record.

20 CO-CHAIR KOTTKE: I just have a
21 question of why do you exclude patients with
22 LVADs, with transitions?

1 DR. PINA: They are usually in the
2 hospital a lot longer, and the VAD coordinators
3 are all over them, so it's really part of the
4 expected care of LVADs. But yes, I mean, if
5 you're in a place where nobody has seen you in a
6 few days, you're in trouble.

7 MEMBER CLEVELAND: I guess I would just
8 - Tom, if I could make I guess a comment as a
9 VAD surgeon; I would actually like to see the VAD
10 patients. I'd advocate that they put into this,
11 too, because particularly the increase in the
12 rate of thromboses with Heart Mate 2 pumps, et
13 cetera, et cetera, INRs that - bleeding, I think
14 that it's critical they be seen within a week and
15 have a proper discharge. So, I actually think
16 that we should include, not exclude, VAD
17 patients. I can understand excluding heart
18 transplant patients. That's a different kettle of
19 fish, but I would ask that the VADs be placed in
20 there.

21 CO-CHAIR KOTTKE: Have we heard about
22 reliability?

1 MEMBER ALLRED: Yes. I thought I did
2 reliability, but the data again seems to be
3 accurate data points to have in.

4 CO-CHAIR KOTTKE: Okay, ready to vote
5 on reliability?

6 MS. LUONG: Polling starts now for
7 reliability: one for high, two for moderate,
8 three for low, and four for insufficient.

9 MEMBER ALLRED: Usability? Feasibility,
10 I would say the only thing about feasibility -

11 MS. LUONG: Reliability passes with 17
12 percent voting high, 72 percent voting moderate,
13 and 11 percent voting low.

14 CO-CHAIR KOTTKE: Validity.

15 MEMBER ALLRED: Validity. I think the
16 data points are valid; I think they're the right
17 ones to use.

18 CO-CHAIR KOTTKE: Judd?

19 MEMBER HOLLANDER: I'm just going to
20 reiterate my comment before that if you're in a
21 health system-wide, enterprise-wide electronic
22 medical record then sort of it loses its face

1 validity of getting it to the primary care
2 provider because there's no evidence that they'll
3 ever see it or put it in a file.

4 CO-CHAIR KOTTKE: Other comments? Ready
5 to vote on validity?

6 MS. LUONG: Polling for validity starts
7 now: one for high, two for moderate, three for
8 low, and four for insufficient.

9 MEMBER ALLRED: Okay, feasibility?

10 CO-CHAIR KOTTKE: Feasibility?

11 MS. LUONG: Yes.

12 MEMBER ALLRED: I think we talked all
13 around feasibility for this particular measure.
14 One of the things I'd like to raise is that there
15 is a part of this that suggests a care
16 coordinator, which would certainly add to the
17 cost of doing the procedure. And as everybody has
18 talked about, can the institution get the records
19 out in the seven-day time frame without it being
20 an undue burden? Other than that, I think it's
21 feasible.

22 CO-CHAIR KOTTKE: Seeing no action,

1 let's vote on feasibility.

2 MS. LUONG: Before we vote on that, the
3 results for validity testing: 83 percent voted
4 moderate, and 17 percent voted low.

5 CO-CHAIR KOTTKE: Helen noted that it's
6 feasibility of the measure, not feasibility - so
7 feasibility of collecting the data about the
8 measure, not the feasibility of sending out the
9 discharge summary.

10 MS. LUONG: Voting for feasibility
11 starts now: one for high, two for moderate, three
12 for low, and four for insufficient. For
13 feasibility, 39 percent voted high, 50 percent
14 voted moderate, 6 percent voted low, and 6
15 percent voted insufficient. It passes for this
16 criteria.

17 CO-CHAIR KOTTKE: Usability and use?

18 MEMBER ALLRED: Usability and use,
19 those are suggestions they made was internal use
20 for the hospitals, using it for health care
21 plans, things like that, but this is a new
22 measure so usability is really not proven.

1 CO-CHAIR KOTTKE: Ready to vote on
2 usability and use?

3 MS. LUONG: Polling starts now for
4 usability and use: one for high, two for
5 moderate, three for low, and four for
6 insufficient information. Usability and use
7 passes with 22 percent voting high, 56 percent
8 voting moderate, 6 percent voting low, and 17
9 percent voting insufficient information.

10 CO-CHAIR KOTTKE: So, overall vote?

11 MS. LUONG: Polling for overall
12 suitability for endorsement starts now: one for
13 yes and two for no. For Measure 2440, it passes
14 with 89 percent voting yes for endorsement and 11
15 percent voting no.

16 CO-CHAIR KOTTKE: So, Sharon or
17 somebody, we're running considerably behind, but
18 we haven't had a morning break. Are we going to
19 competing measures, I - yes.

20 MEMBER HILLEGASS: Does this new
21 measure add something that's not already measured
22 by 0648?

1 MS. JOHNSON: So, that is a discussion
2 that we're going to table until the post-meeting
3 call. And, also, Ann brought this to my
4 attention, and I apologize for the confusion, but
5 these measures as a group when they originally
6 put their submission in, they were planned for
7 use in the Joint Commission programs, but those
8 went into play January 1st, 2014. So, these are
9 actually in use at least in the Joint Commission
10 Programs. Do I have that right, Ann?

11 MS. WATT: That's correct.

12 CO-CHAIR KOTTKE: Break until 11:15.

13 (Whereupon, the above-entitled matter
14 went off the record at 10:58 a.m., and resumed at
15 11:13 a.m.)

16 CO-CHAIR KOTTKE: We are going to
17 start with 41 and 42 because they're very closely
18 related to 40.

19 CO-CHAIR GEORGE: We'll be doing them
20 separately beginning with 2441. I'm sorry.
21 We're just taking things all out of order today.
22 Any introductory comments from the developers?

1 MS. RYAN: Sure. 2441 is for
2 discussion for advance directives and 2442 is for
3 advanced directive executed. We would just like
4 to explain that initially this was a combined
5 measure, but during the pilot process the
6 facilities had indicated that with the measure
7 being combined it was hard for them to tell was
8 the measure passing because they had discussion
9 with the patient as opposed to the advance
10 directives being executed. And the priority for
11 the facilities was to make sure that the
12 directives were executed. So they had actually
13 requested that these two measures be separated
14 out. And that's why it went from one to two.

15 CO-CHAIR GEORGE: All right. So we
16 have Linda, Tom and George.

17 MEMBER JAMES: This is the 2441. Make
18 sure I'm on the right page. Let me just do a
19 quick summary for the evidence, because this is
20 another one where the scientific evidence is not
21 fair, in my estimation, for a discussion of
22 advance directives leading to a definitive

1 outcome. However, as somebody who has spent time
2 in areas working with patient-centered care and
3 patient-focused care, this is one of those
4 measures that gets into the heart of that.

5 Making sure that patients are -- or the intention
6 is the patients are engaged and help direct their
7 care.

8 Problem for me with this particular
9 measure: It's a discussion by any health care
10 professional. And we all know about the times
11 that a nurse comes in to sign the pre-ops sheet
12 for patients and gets consent. And that counts
13 as a discussion of the operative procedure. This
14 is end-of-life discussions and it should not be
15 passed off. It should be by somebody who's
16 really caring for the patient. And I would like
17 to have seen that rather than just any health
18 care professional.

19 Secondly, this is for patients --
20 an exclusion is patients less than 18 years of
21 age. The portion of me that's a pediatrician
22 recognizes that children and their families

1 should be very much engaged in this kind of
2 discussion, so I'm a little uncomfortable about
3 that.

4 I understand why discharge to a
5 hospice. That means that -- the suggestion is it
6 means we've already that discussion, so it would
7 improve your ratio for including it.

8 So this is one where the balance is
9 lack of scientific evidence, so I would recommend
10 a five on this versus the patient-centered focus
11 that this is still an indirect measure of what
12 the patient should be engaged in a meaningful
13 discussion.

14 CO-CHAIR GEORGE: Go ahead, Gerard.
15 And then Joe.

16 MEMBER MARTIN: So as the pediatrician
17 I guess it depends upon the type of heart
18 failure. Ninety percent of our patients with
19 heart failure have a structural heart defect,
20 which is readily amenable to either cardiac
21 surgery or interventional cardiology and with
22 survival rates that are over 98 percent. And so,

1 if it's advanced heart failure, I couldn't agree
2 more where they're moving on towards heart
3 failure. But if it's -- I mean to having that
4 type of discussion. But just for age itself, it
5 would have to be defined by kind of the -- what
6 type of heart failure.

7 MEMBER CLEVELAND: I guess if I could
8 ask a point of order, too, and clarification from
9 the developers, because as I understand it our
10 program went through Joint Commission
11 certification for an LVAD center and one of the
12 metrics on that was that there had to be an
13 advance directive discussion to be approved as
14 the Joint Commission over that program. And here
15 we have a denominator exclusion that excludes
16 LVAD patients. So I think that exclusion should
17 probably be moved, otherwise we've got a measure
18 that directly conflicts with something that's a
19 process for Joint Commission certification.

20 MS. WATT: I think that's the reason
21 for the exclusion, because it is included for the
22 LVAD and we know that everybody who is certified

1 for LVADs has to have our certification.

2 MEMBER CLEVELAND: Okay.

3 MS. WATT: So it's like a mutually
4 exclusive thing.

5 CO-CHAIR GEORGE: Is that Kristi?

6 MEMBER MITCHELL: Clarification. When
7 you say "all heart failure," we're including
8 patients who have pulmonary hypertension as well?

9 (Off-microphone comment.)

10 MEMBER MITCHELL: So, okay. Just
11 making sure I'm clear on that.

12 CO-CHAIR GEORGE: George?

13 MEMBER PHILIPPIDES: And then there's
14 no differentiation between obvious systolic
15 dysfunction inpatients who have heart failure on
16 the basis -- with normal LVEF, is that correct?

17 DR. PINA: This should include, if I'm
18 correct, half N, half for F, both.

19 MEMBER PHILIPPIDES: Okay.

20 DR. PINA: Low EFs and high EFs.

21 MEMBER PHILIPPIDES: Because I've just
22 generally considered the patients with the very

1 low EFs -- that this discussion is sort of more
2 urgent than patients who had their first heart
3 failure presentation and their EFs are 65
4 percent. So this groups them all together?

5 DR. PINA: Yes, because even those
6 patients are older and they have a lot of
7 comorbidities and many of them we keep doing
8 things to them that really haven't changed much
9 their outcome. So I would include this as a
10 conversation that I have with mine. And they get
11 so edematous and they just -- their pulmonary
12 functions get worse, their kidneys get worse. So
13 whether the mode of death is cardiac or the mode
14 of death is from one of the comorbidities, the
15 discussion I think should be had. I don't know
16 that we specified.

17 MEMBER PHILIPPIDES: Okay. I'm not
18 sure I understand what you're saying, but I think
19 that could lead to some discussions with some 30-
20 year-old folks that might not be as important as
21 the older folks with bad LVs.

22 CO-CHAIR GEORGE: Judd?

1 MEMBER HOLLANDER: Yes, I actually
2 agree 100 percent with what George is saying, but
3 I think I'm a little more afraid of the concept
4 of a one-time discussion with somebody who comes
5 in with A-fib and a little bit of heart failure.
6 The A-fib is totally fixable or it's related to
7 drinking too much the night before and now having
8 a discussion about end-of-life planning with a
9 32-year-old that is otherwise really fine, that
10 has no difference in mortality as compared to an
11 advanced heart failure patient regardless of the
12 injection fraction.

13 And so, I think in the end for a lot
14 of these measures we're stuck between low or with
15 exception, and I think the fact that this
16 includes a whole bunch of people that I frankly
17 think might be inappropriate to go near an end-
18 of-life discussion, and it's overly concerning
19 and overly broad, I have trouble in my mind
20 making this with exception. I think it's
21 problematic.

22 CO-CHAIR GEORGE: I have just a

1 question for the developers. Did this come up
2 with any of your pilots?

3 MS. WATT: No. Actually no. I'm --
4 no, is the short answer.

5 DR. PINA: I think probably in the
6 context of this is a together measure from Get
7 With the Guidelines, that is in Get With the
8 Guidelines. Get With the Guidelines concentrates
9 more on the low EF patients, because that's where
10 we have the evidence for the care and we don't
11 have great evidence in HEF F as to what to do.

12 CO-CHAIR GEORGE: Tom?

13 CO-CHAIR KOTTKE: Yes, I'll take a
14 diametrically opposed position from Judd that any
15 adult should have an advance care directive, and
16 the short form can simply be if you're unable to
17 make a decision about care, who is it that is
18 your proxy? And that's enough. And you don't
19 know when you're going to slip on the stairs here
20 at NQF and -- of course if you take the elevator,
21 you won't slip on the stairs, but you could get
22 stuck and starve to death.

1 MEMBER PHILIPPIDES: I'd like to be
2 resuscitated, for the record. I just wanted to
3 --

4 (Laughter.)

5 MS. HIBAY: Good news, George. That
6 made the transcripts.

7 MEMBER DeLONG: I think there's a
8 difference between what everybody should do and
9 what we should impose as criteria for endorsing a
10 measure that could cause some psychological
11 distress. I don't know that it's our position to
12 promote that sort of thing.

13 MEMBER VIDOVICH: My question for
14 developers is again similar to the previous
15 measure. It's how does this compare to other
16 Joint Commission standards in a place for advance
17 directives for all patients admitted to the
18 hospital?

19 MS. WATT: I'm sorry. I'm not
20 familiar enough with the standards to answer
21 that. I'm sorry.

22 CO-CHAIR GEORGE: Any other comments

1 on the evidence? If not, we'll vote.

2 MEMBER PHILIPPIDES: Actually I have
3 one comment. I think that this is another case
4 where there's not a lot of sort of hard evidence
5 showing that if you have this discussion that
6 down the road there are significantly better
7 outcomes or money saved. I think this is another
8 one that we all know that to be the case. If you
9 have better communication and avoid intubations
10 and all those kind of things that it makes sense.

11 I just wanted to make sure Tom and
12 that we all agree on that in reading through this
13 protocol.

14 CO-CHAIR GEORGE: Linda, did
15 you --

16 MEMBER BRIGGS: I was just going to
17 say that there is again very little evidence
18 there, and what we do have is very old. There
19 was part of a study -- the Krumholtz group in
20 1998. One of the issues that they found -- they
21 actually interviewed patients at three days and
22 six days, between three and six days of

1 enrollment in the support study and then two
2 months after discharge, and a large number of
3 those patients actually changed their minds about
4 what they wanted. So I mean, that's a whole
5 other issue to be dealt with.

6 So when you talk about a one-time
7 discussion, you have that discussion with that
8 setting in the acute care area where the person
9 either does or doesn't think they're going to
10 live, and then quality of life changes again two
11 months out. And what you really want to know is
12 what's going to happen to them in the long run.

13 So I would agree that there's
14 insufficient evidence, but based on what we've
15 said about the fact that there could be some
16 psychological harm to certain groups because this
17 is in all heart failure rather than our low
18 ejection fraction group of people, that there is
19 some degree of harm that we could consider in
20 this. So I would not consider this insufficient
21 with exception. I would consider it
22 insufficient.

1 CO-CHAIR GEORGE: Any other comments?

2 (No response.)

3 CO-CHAIR GEORGE: All right. We'll
4 vote on the evidence.

5 MS. LUONG: Polling for evidence
6 starts now. One for high, two for moderate,
7 three for low, four for insufficient evidence,
8 and five for insufficient evidence with
9 exception.

10 For evidence 6 percent voted high, 17
11 percent voted low, 33 percent voted insufficient
12 evidence, and 44 percent insufficient evidence
13 with exception. It's in the gray zone.

14 CO-CHAIR GEORGE: So we'll continue.
15 So comments on the performance gap and
16 disparities?

17 MEMBER JAMES: If we're looking
18 strictly at the measurement of reported advance
19 directive, there is clearly a performance gap.
20 There is no measurement of what is the person's
21 input, the patient's input into the decision
22 making. That would be a better measure, but

1 there's no way to get that. This becomes a
2 surrogate measure and this surrogate measure does
3 show a performance gap and significant
4 disparities.

5 CO-CHAIR GEORGE: Any other comments?
6 George?

7 MEMBER PHILIPPIDES: I think that what
8 they cited was just sort of low rates of having
9 these discussions in heart failure groups. I
10 don't know that they cited performance gap
11 between commissions or between entities. And as
12 far as disparities, they cite disparities in
13 heart failure care, not in asking or having a
14 discussion about advance directives. So again,
15 it's very little and it really focuses more on
16 heart failure treatment in general and I think
17 less on this particular metric.

18 Any thoughts, Linda?

19 MEMBER BRIGGS: I agree with that. I
20 think that there is -- the disparity issue in
21 particular was not really addressed in terms of
22 this indicator. It was related to -- in-patient

1 care of heart failure patients was the disparity
2 quote that we were given.

3 CO-CHAIR GEORGE: Any other comments
4 on performance gap disparities?

5 DR. PINA: So, even though it's not
6 directly related to advance directives, there's
7 an offshoot of this, which is the ICD
8 conversation, whether to put it in ICD or not,
9 which does have to do with dying if you don't
10 have the ICD. There is an NIH study going on
11 right now called WISDOM that is looking at the
12 conversations around the ICD. And hospitals have
13 randomized to either be the conversation or talk
14 to the patients who already have an ICD and see
15 if the conversation was had by someone else about
16 this.

17 So hopefully we're going to have a
18 little bit more data when the trial is over.
19 It's at least halfway done. I know we're
20 enrolling, and it's a very interesting study.

21 MEMBER JAMES: Actually, just to that
22 point, there are those studies that have shown

1 the incidence of discordance between patients
2 wanting the ICD turned off and that doctor's
3 actually doing it. That's another measure that
4 should be --

5 DR. PINA: It's a scary one.

6 MEMBER JAMES: Yes, it is.

7 CO-CHAIR GEORGE: Linda?

8 MEMBER BRIGGS: Oh, I don't have
9 another comment. I'm sorry.

10 CO-CHAIR GEORGE: All right. We'll go
11 ahead and vote on performance gap.

12 MS. LUONG: Polling for performance
13 gap starts now for Measure 2441. One for high,
14 two for moderate, three for low, and four for
15 insufficient.

16 For performance gap 6 percent voted
17 high, 24 percent voted moderate, 24 percent voted
18 low, and 47 percent voted insufficient. Does not
19 pass.

20 MS. JOHNSON: And so for this one I'd
21 like to get from the Committee just so that I
22 understand it as we write the report -- can

1 someone just help me understand why those of you
2 who said insufficient did?

3 MEMBER JAMES: Let me just throw out
4 what I think may be our view, and that is the
5 intention of the measure is excellent and there
6 is a real need. The issue comes in what is being
7 measured and whether that directly relates to
8 what the need is. And that I think is reflected
9 in this vote.

10 MS. JOHNSON: Thank you, Tom. I do
11 appreciate that. Go ahead, Linda.

12 MEMBER BRIGGS: So I would say that
13 also because it really didn't speak to disparity
14 issues directly related to the group of patients
15 that were being potentially asked this one time
16 discussion issue. That was part of my reason for
17 choosing insufficient.

18 MS. JOHNSON: Okay. So, and, Judd, go
19 ahead and then remind me to come back to that,
20 Linda.

21 MEMBER HOLLANDER: Oh, go ahead. Go
22 back to that first.

1 MS. JOHNSON: I just want to make sure
2 that everybody's clear, and maybe everybody
3 isn't. With the disparities question we are
4 interested in disparities, but we think of
5 disparities as helping to inform whether or not
6 there's a gap.

7 So there's three ways really that you
8 can talk about having a gap in performance. One
9 is if everybody just is doing poorly across the
10 board. Right? Another is that some folks are
11 doing well and maybe some folks aren't, so you
12 have wide variation in practice. And then the
13 other way that you can demonstrate a gap is
14 having certain sub-populations have poor
15 performance.

16 So having the disparities is a way to
17 demonstrate a gap, but if the developer does not
18 show disparities, that doesn't mean that there's
19 not a gap. There's a couple other ways that a
20 gap may be demonstrated. So hopefully that's
21 more clear now.

22 But, Judd, go ahead.

1 MEMBER HOLLANDER: So I was going to
2 say this says less than optimal performance
3 across providers, and I think we just had a
4 pretty robust discussion about what is optimal
5 performance, that not everybody with heart
6 failure should have the discussion. So my vote
7 is that I don't believe it should be 100 percent.
8 I do believe that they documented it's 50
9 percent. I think 50 percent might actually be
10 the ideal number. I don't know. So it's hard to
11 go forward.

12 And I'll just add to this just in case
13 the developer is going to resubmit, when you look
14 ahead to reliability, which we haven't gotten to,
15 a kappa of 0.18 is probably kind of a fatal flaw
16 in the whole process, too. So I'd just throw
17 that out there. When people are thinking about
18 the effort, I think we would have gotten stopped
19 there had we not gotten stopped here anyway.

20 MS. JOHNSON: So with my explanation
21 about disparities not necessarily being able to
22 kill the gap piece, let me ask with a show of

1 hands does anybody feel like that they would like
2 to re-vote or is everybody happy with where this
3 has landed, that it stops here?

4 (Show of hands.)

5 MS. JOHNSON: Okay. I see no hands
6 saying that they want to continue, so the measure
7 stops here, correct?

8 (No audible response.)

9 MS. JOHNSON: Thank you.

10 CO-CHAIR KOTTKE: Okay. 2442. That's
11 Mike and Ellen. And do the measure developers
12 want to offer any preliminary comments?

13 MS. RYAN: As I mentioned earlier,
14 this one correlates with the 2441, and this
15 measure looks at where the advance directive is
16 executed.

17 CO-CHAIR KOTTKE: Mike, are you the
18 guy?

19 MEMBER CROUCH: Ditto.

20 (Laughter.)

21 MEMBER CROUCH: It's the same issues.
22 The kappa of 0.18. The reliability is terrible.

1 I'm in favor of the concept of advance directive
2 for patients with heart disease, which is what
3 this is targeted to. There's good evidence that
4 it's not happening often enough, that a very
5 small percentage of patients have had a chance to
6 express their wishes to the doctor or had a
7 discussion with the doctor. Ten percent are
8 confident that their doctor understands that.
9 It's a problem. I don't think the measure as
10 comprised is likely to fix that with the
11 methodology of the measure.

12 But the other problem is that they
13 say, well, we have this pilot, too. I looked at
14 the pilot too on the Website and there's no
15 operationalization of what an executed advance
16 directive is and how the chart orders are
17 supposed to know that an advance directive has
18 been executed, what that means to be executed,
19 how much discussion went into the process prior
20 to whatever execution is. It's something that
21 really needs work, but it's a messy area and very
22 difficult to deal with given the state of

1 searchable data fields and current medical
2 records. So I don't think it's a practicable
3 measure at this time.

4 CO-CHAIR KOTTKE: Ellen?

5 MEMBER HILLEGASS: I would totally
6 agree. I think this is going to get stopped
7 along the way if it's not stopped in the
8 beginning because it doesn't have any
9 reliability. It has a lot of red flags
10 throughout it with minimal to no evidence. Same
11 thing with performance gap. We can go through
12 each one and vote as we go along, but I don't
13 think there's any strength in this proposal.

14 CO-CHAIR KOTTKE: Anybody else care to
15 jump in the water before we vote on evidence?

16 (No response.)

17 CO-CHAIR KOTTKE: Okay. Let's vote on
18 evidence.

19 MS. LUONG: Voting for evidence starts
20 now for Measure 2442. One for high, two for
21 moderate, three for low, four for insufficient
22 evidence, and five for insufficient evidence with

1 exception.

2 For evidence 19 voted low, 56 percent
3 voted insufficient evidence, and 25 percent voted
4 insufficient evidence with exception, so this
5 measure does not pass.

6 CO-CHAIR KOTTKE: Okay. Karen, do you
7 want to ask or inquire?

8 MS. JOHNSON: Yeah, I think it's
9 probably worth having in the transcript so that
10 we make sure that we write our report accurately.
11 So maybe just make sure that I understand your
12 thinking here a little bit more. Technically
13 we're not supposed to say it would fail on
14 reliability. So this should be the evidence
15 vote.

16 MEMBER HOLLANDER: I did not see a
17 single piece of evidence in the summary that
18 suggested people do not follow advance
19 directives. Right? That's what this measure
20 was. It was about executing the advance
21 directive. It was silent on that.

22 MS. WATT: Sorry. I just wanted to

1 clarify: This measure doesn't have to do with
2 whether or not what the patient asked for in the
3 advance directive was carried out. It has to do
4 with whether or not an advance directive was
5 actually created.

6 MEMBER HOLLANDER: Then explain to me
7 how that's different than the last one.

8 CO-CHAIR KOTTKE: One was just a
9 discussion. Was there a one-time discussion
10 about advance directives. This one was that it
11 executed. That is what Sharon pointed out. It's
12 a legal term.

13 Okay. Oh, Leslie is on the phone and
14 would like to offer a comment.

15 MEMBER CHO: Yeah, that's exactly what
16 I was going to ask, about the execution part,
17 because that does seem like a -- it's a legal
18 thing, isn't it, that's totally different from
19 the previous measure we voted down. So if a
20 patient brings in an advance directive, it's
21 whether that advance directive got executed at
22 the hospital.

1 MS. WATT: Okay. So this is Ann from
2 the Joint Commission, and I would love to say yes
3 you're absolutely right, but really the intent of
4 the measure is that whether or not an advance
5 directive was created after the discussion that
6 happened in last measure.

7 MEMBER CHO: Okay. So that's totally
8 confusing, because to me when I saw this I
9 actually thought what I first said about
10 execution.

11 My second point is is these are re-
12 endorsed measures. How is it that we are voting
13 all these down when it was initially passed with
14 the same criteria, either the same algorithm, the
15 same thing from the Cardiovascular Committee
16 initially? I'm asking the NQF staff, actually.

17 MS. JOHNSON: This is actually a new
18 measure, so this has not been looked at before.

19 MEMBER CHO: Oh, okay. Thank you.

20 CO-CHAIR KOTTKE: Linda, Ellen and
21 then Mike.

22 MEMBER BRIGGS: Okay. So we have a

1 little more clarification from the Joint
2 Commission about what executed means. And if you
3 actually do go back to their documents related to
4 the advanced heart centers, yes, I have that
5 page. So anything -- and there's a whole list of
6 things that qualify for that -- would include an
7 advance care plan, an advance decision making,
8 advance directive. The MOLST form, the POLST
9 form, a personal directive, a power of attorney
10 for health care would all be considered documents
11 that would apply to that. So there is definition
12 in that sense.

13 That being said, in terms of the
14 evidence to support the particular measure
15 itself, I still think that there's not enough
16 evidence.

17 CO-CHAIR KOTTKE: Ellen?

18 MEMBER HILLEGASS: All of the evidence
19 says it should be done. But if you read the
20 evidence, there's no evidence to say it actually
21 has been done. So we're voting on a should
22 versus a -- we're voting on the fact that they

1 say it should be done, and this is saying that it
2 is done. So I don't think that there is evidence
3 to say that this is done, to show that.

4 I think it's a valuable measure and I
5 think it should be done. I don't see that
6 there's any evidence saying that one of the
7 outcomes is to decrease anxiety. I'm trying to
8 look at the specific. It was reduces -- it
9 becomes transitioned to focus on palliative care.
10 There's no evidence on that. And there's no
11 evidence that it decreases anxiety, etcetera.

12 So we could call it insufficient, but
13 I just don't think there's evidence to support
14 it.

15 CO-CHAIR KOTTKE: Mike?

16 MEMBER CROUCH: One of the biggest
17 problems is there are 11 different data sources
18 in the record, or potential data sources in the
19 record, all the ones that she enumerated and some
20 others. And that's why the kappa was so low,
21 because the chart order is going through. We're
22 looking through progress notes, HPIS, looking for

1 evidence of these other -- a power of attorney,
2 an order by the doctor that there was do not
3 resuscitate orders, all these potential things.
4 And the more data sources that you look through
5 to try to find something, and you're not even
6 quite sure what you're looking for, the
7 reliability and validity both are very suspect.

8 So conceptually I agree that it ought
9 to be done, but there are tremendous problems
10 with it being done this way and holding anybody
11 accountable for whatever this is.

12 CO-CHAIR KOTTKE: Anybody else care to
13 weigh in?

14 MS. JOHNSON: So what I'd like to ask
15 you guys to do now that the developer has cleared
16 up whether or not these documents, some of these
17 documents were created, not fulfilled, I would
18 like us to just do this vote one more time so
19 that everybody is extremely clear about what
20 we're voting on. So thank you for humoring me on
21 that.

22 MS. LUONG: We will re-vote on

1 evidence for Measure 2442. Polling starts now.
2 One for high, two for moderate, three for low,
3 and four for insufficient.

4 So for Measure 2442 for evidence 6
5 percent voted moderate, 41 percent voted low, 41
6 percent voted insufficient evidence, and 12
7 percent voted insufficient evidence with
8 exception. So this measure does not pass.

9 MS. JOHNSON: No, it does not pass.

10 CO-CHAIR KOTTKE: Okay. So we're back
11 to the last two measures, 2439 and 2443.

12 CO-CHAIR GEORGE: Any comments from
13 the developers on 2439?

14 MS. RYAN: 2439 is a measure looking
15 at post-discharge appointment made for the
16 patient before discharge or at hospital
17 discharge, and it basically looks at was there an
18 appointment made within seven days of discharge.

19 CO-CHAIR GEORGE: And our discussants
20 are Ted and Ellen.

21 MEMBER GIBBONS: Yeah, I'd be happy to
22 discuss this. And I want to thank the Joint

1 Commission for putting this forth because I think
2 it really does reflect what the Heart Failure
3 Society of America wants to push forward on the
4 agenda, but I think it still needs some work.

5 Now, just to clarify with the
6 description, this to my reading was that the
7 appointment for location, date and time for an
8 office or home health visit is scheduled within
9 seven days post-discharge. So it's actually the
10 appointment must be within seven days post-
11 discharge, not that the scheduling was done
12 within seven days. Is that correct?

13 MS. RYAN: Yes, that's correct.

14 MEMBER GIBBONS: Good. Okay. Thank
15 you.

16 So this is a new measure. Its level
17 of analysis is at the facility level. It's a
18 process measure. And if we go to the evidence,
19 the evidence is based primarily not on a
20 systematic review, but quoting some well-written
21 guidelines that come from the ACC from 2013 and
22 the Heart Failure Society of America in 2010,

1 which are guidelines, as well as the Joint
2 Commission's diagram of optimal care, which by
3 itself is not evidence, but a trajectory for care
4 coordination.

5 The only study that is relatively
6 pertinent to this is the often-quoted Hernandez
7 study from JAMA in 2010, which was an
8 observational study following up patients after
9 discharge for acute decompensated heart failure
10 where it was demonstrated that there was a
11 reduction of readmissions if the patient actually
12 saw a caregiver within the time period of
13 observation, which was around seven days. So it
14 wasn't the making of the appointment. It was the
15 actual appointment showing up and that there was
16 about, by my recollection, about a 20-percent
17 reduction in readmission for that population.

18 The time frame for that particular
19 study was 2003 to 2006, so it's fairly old data.
20 And the evidence that making the appointment
21 separate from keeping the appointment is not
22 there. So this is an indirect measure where this

1 making of the appointment may influence outcomes.
2 Obviously if you make the appointment and show
3 up, the two appear to be linked, but it's not
4 been proven by the evidence.

5 So in the spirit of our previous
6 discussions, I can I think truncate it to say
7 that I would say that this is a valuable part of
8 the care transition, but it's insufficient
9 evidence with exception from my standpoint.

10 MEMBER SPANGLER: So, I know we'll get
11 to this later because it's a competing measure,
12 but we had this same discussion with 2455 in
13 Phase I.

14 MEMBER GIBBONS: Right, yes.

15 MEMBER SPANGLER: And I don't know if
16 we're going to come out differently or not,
17 because it's the exact same issue that we've
18 discussed previously today, that we discussed in
19 Phase I as well.

20 MEMBER GIBBONS: Yes, right.

21 MEMBER SPANGLER: So it doesn't seem
22 to be any different than before.

1 MEMBER GIBBONS: The only difference
2 in the measures that I saw was that 2455 does not
3 state seven days and this one does, and the 2455
4 was based on registry data from ACC, and this is
5 a Joint Commission --

6 MEMBER SPANGLER: Right, and I think
7 you're exactly right. I'm not comparing the two
8 measures. I'm just saying the issue of the
9 evidence with both measures --

10 MEMBER GIBBONS: Right.

11 MEMBER SPANGLER: -- is the same
12 issue.

13 MEMBER GIBBONS: Correct. Correct.
14 Well, and I think you could argue both ways, that
15 it's insufficient evidence overall or it's
16 insufficient evidence with exception. As someone
17 who is a heart failure doctor in a public health
18 hospital I can tell you that each of these six
19 measures from the Joint Commission are ones that
20 we already have in place and which probably
21 account in part for the fact that our readmission
22 rate for our indigent population has fallen from

1 39 percent to 16 percent.

2 So I think that there is value in each
3 of these, and the question is whether we support
4 the care coordination measures that are in the
5 spirit or that the measures as they are written
6 don't give correct instruction about -- we give
7 to an institution about how to implement them.

8 MEMBER SPANGLER: And if I recall
9 correctly, the last time we endorsed this
10 measure, but I thought it was insufficient
11 evidence with exception and we moved on. Is that
12 correct?

13 MEMBER GIBBONS: Yes. I
14 thought --

15 (Simultaneous speaking.)

16 MEMBER GIBBONS: Yeah, it did move on,
17 right.

18 MEMBER HILLEGASS: I'd like to discuss
19 the evidence a little further. I do think that
20 it's important in this measure to not only put in
21 discharge appointment, but I think that since the
22 evidence supports that the patient actually has a

1 visit, I think that's a key component of this
2 measure, that it shouldn't be just an
3 appointment. Because your evidence talks about
4 good support when there's a visit and not just
5 the appointment. So I'd like you to re-look at
6 the evidence and really look at the evidence
7 talking about the visit and not the appointment.
8 So my recommendation --

9 MEMBER GIBBONS: Could you make the
10 distinction what you mean by a visit?

11 MEMBER HILLEGASS: Well, that the
12 patient --

13 MEMBER GIBBONS: A face-to-face?

14 MEMBER HILLEGASS: -- was actually
15 seen by someone. And I'd have to go back and
16 look at the research for -- they looked at a
17 post-op evaluation, so I think an evaluation
18 would be more important than a seven-day
19 appointment. I think the evidence does not
20 support appointment. I think the evidence
21 supports a visit.

22 MEMBER GIBBONS: Yes.

1 MEMBER HILLEGASS: And so I think we
2 need to distinguish between the two, because I do
3 think there is evidence to support a visit.

4 MEMBER GIBBONS: Well, I think we need
5 to be clear about what a visit is, because I
6 think you're absolutely right that the evidence
7 dating back to 2000 would support an interaction
8 within seven days has just as much of an effect
9 as a face-to-face visit. So I think a visit
10 would mean an interaction, whether it's on social
11 media or email or a phone call, but I agree with
12 you that that's where the most compelling
13 evidence is.

14 MEMBER HILLEGASS: Well, so I think
15 there is sufficient evidence for an evaluation or
16 an interaction.

17 CO-CHAIR GEORGE: Judd?

18 MEMBER GIBBONS: That's not what the
19 measure says.

20 MEMBER HOLLANDER: Yes, so we talked
21 yesterday exactly about the points that are being
22 outlined here. This is actually one of the very

1 few things where there's evidence that remote
2 monitoring and telemedicine can actually decrease
3 visit and decrease costs. So I would argue that
4 a visit should include that.

5 But again, as we're rolling out more
6 and more measures, I'm pretty sure you can't
7 actually get a visit without an appointment. And
8 we have another measure coming up that's about
9 evaluation, so to me this seems unnecessary,
10 because if I make an appointment and I don't make
11 arrangements for the patients to get there and
12 they can't access the appointment, this is just
13 silliness.

14 So I think in the absence of evidence
15 this doesn't rise to the insufficient with
16 exception because although it is the first step
17 in getting an appointment, we need them to have
18 the appointment or the visit or the evaluation.
19 And this is a short-term proxy for a proxy for an
20 outcome. So I could live with skipping this one
21 since there's no great evidence.

22 CO-CHAIR GEORGE: Mladen and then Tom.

1 MEMBER VIDOVICH: Yes, the only things
2 I want to say is if the patient -- you know, and
3 working in an inner city hospital with a lot of
4 indigent patients, they may get an appointment,
5 but they don't show up. You can't penalize the
6 hospital for the patient not showing up, although
7 they made every effort of scheduling the
8 appointment, right? So this measure looks at
9 making every best effort to send them home with
10 an appointment and beta blockers and, hey, say if
11 they don't show up because -- I can name a
12 laundry list of reasons, you're penalizing a
13 different entity here, right? So I don't know.

14 MEMBER HOLLANDER: Can I kick back on
15 that; it's directly related to my comment, before
16 Tom? So we give them an appointment between 9:00
17 and 5:00. That's what we do now. I think that's
18 unacceptable for some patients. So the question
19 is do we want to have patient-centered measures?
20 There's many other times they can be seen. We
21 could send people to their house if they want.
22 We could give them appointments to come in. We

1 could do telemedicine. I think just giving an
2 appointment in a non-patient-centered manner
3 probably isn't the best way to decrease 30-day
4 readmissions. So I would kick back on that a
5 little bit.

6 CO-CHAIR GEORGE: Ileana?

7 DR. PINA: Yes, let me respond to
8 that. The problem is that if you don't even make
9 the attempt to make that appointment before they
10 go out the door, I assure you that they won't
11 have an appointment if you just hand them a piece
12 of paper that says here's the number to call on
13 Monday. So, yes, it would be best if we could
14 document the appointment, but the appointment may
15 be in their primary care, which may be out of the
16 system. Could be anywhere.

17 In our numbers, I can tell you that
18 since I've been looking at this; and we just had
19 an abstract at the American Heart, about 50
20 percent of the patients that are given the
21 appointment do not show up for lots of reasons.
22 Mostly transportation. And now I'm trying to

1 target those reasons. But if they hadn't gotten
2 that, they wouldn't have been seen. Of the ones
3 that do get seen, my numbers are very similar to
4 the Hernandez paper. The readmission rate is
5 very, very low, if they get seen.

6 And obviously we need to expand it to
7 a bigger population. But I think it's our
8 attempt to get at that business of at least put
9 it there, because if you don't, then you're
10 totally at the mercy of them calling. And they
11 have been in the hospital for four-and-a-half
12 days where they haven't absorbed much of anything
13 and they're certainly not totally diuresed, as we
14 know how we send them home. So I think this is
15 our attempt to do that. Not perfect.

16 CO-CHAIR KOTTKE: Yes, I think one of
17 the assumptions we're making here is that the
18 patients are seen in the system. And Ileana
19 mentioned this, that there are patients who are
20 seen in the hospital and they are not -- come
21 from 150, 200 miles away. And we've had other
22 discusses particularly around cardiac rehab where

1 we just couldn't even -- we were very concerned
2 about double-dinging doctors for little minor --
3 for being accountable for asking patients if they
4 had been in cardiac rehab. Now we're saying even
5 if the patient is out of system from a long way
6 away, that the hospitalizing organization is
7 responsible to make sure that patient is actually
8 seen.

9 And I mean, maybe that's right, but I
10 just to point out that -- take May Clinic
11 Rochester. Are they -- patient comes from Dubai.
12 Are they responsible for making sure that patient
13 is seen in Dubai within seven days?

14 MEMBER HILLEGASS: I want to point out
15 some data. There's a study done by COPD
16 patients, and they knew the patients wouldn't
17 follow up in the seven days. So what they did is
18 is they hired an individual who would go out to
19 the homes and visit the patient within three days
20 and made a huge difference in re-hospitalization.
21 That's a visit. That's a visit.

22 So I think we need to be looking at

1 more than an appointment. If you know your
2 patient population is 50 percent not going to
3 show up, then you hire somebody to do that visit
4 for you. I don't think the appointment is well
5 documented for any kind of evidence. And I think
6 outside the heart failure range -- realm we have
7 other evidence that shows that visits make a
8 difference, or interactions. However you want to
9 define that.

10 CO-CHAIR GEORGE: Ann?

11 MS. WATT: In our data element
12 definition the question is was a follow-up
13 appointment for an office or home health visit
14 for management of heart failure scheduled within
15 seven days. And it has to have a documented
16 location, date and time. And then in our notes
17 to the abstractors we say a follow-up appointment
18 is an appointment with a physician, APN/PA in a
19 physician office or ambulatory care clinic, or a
20 home health visit with an RN/APN for professional
21 nursing services that occurs within seven days,
22 blah, blah, blah. So we did try to capture that

1 in the definition for this measure.

2 MEMBER GIBBONS: This is Ted Gibbons.
3 You know, I agree with Ileana's experience that
4 in order to operationalize this you have to have
5 the subsequent measure, too, 2443, because what
6 happens with our patients is that they are
7 overwhelmed with the ability to take care of
8 themselves and the follow-up telephone call,
9 which we have also instituted, reinforces the
10 fact that they have a visit, however you want to
11 define it, available to them and that the
12 principles of that visit, the reasons and the
13 time and date are reinforced.

14 Now, how that subsequent one is
15 operationalized is a matter of debate, but the
16 appointment can't exist in isolation from its
17 follow-up. So I guess that is a difficulty in
18 more concepts than the fact that this particular
19 measure doesn't provide value.

20 CO-CHAIR GEORGE: Tom?

21 MEMBER JAMES: Well, I think that the
22 next measure answers what Ellen is looking for.

1 With this particular measure I'd like to be able
2 to refer to a similar measure in the mental
3 health community, and that is the experience with
4 a measure that says a patient discharged from a
5 psych hospital needs an appointment within seven
6 days. That has done a great deal to reduce
7 psychiatric readmissions. I would guess the same
8 would hold here.

9 CO-CHAIR GEORGE: Any further
10 discussion on the evidence?

11 (No response.)

12 CO-CHAIR GEORGE: If not, we'll vote
13 on the evidence.

14 MS. LUONG: Voting for evidence for
15 Measure 2439 starts now. One for high, two for
16 moderate, three for low, four for insufficient
17 evidence, and five for insufficient evidence with
18 exception.

19 For evidence, 24 percent voted
20 moderate, 24 percent voted low, 18 percent voted
21 insufficient evidence, and 35 percent
22 insufficient evidence with exception, so the

1 measure proceeds.

2 CO-CHAIR GEORGE: We'll move onto a
3 discussion of the gaps.

4 MEMBER GIBBONS: Just as in the
5 previous discussion the gap is a bit indirect,
6 although the developers do quote the fact that
7 from old billing data there was a 52 percent lack
8 of follow up. So that there's a significant gap
9 there.

10 I think the same issue arises for the
11 perceived gap in non-white populations in that it
12 may be the gap in heart failure care in general.
13 But I don't think that diminishes the fact that
14 there is a gap and need to fulfill this
15 coordination of care need.

16 DR. PINA: As a matter of fact, in the
17 Hernandez paper that everybody quotes where the
18 visit actually happened, 34 percent only of the
19 programs had a scheduled visit at 7 days in their
20 planning. In other words, that that was part of
21 their processes of care. So, and we recently re-
22 looked at this in Get With the Guidelines, and

1 it's gotten a little bit better, but not great.

2 MEMBER GIBBONS: Right, and that was
3 in 2003 to 2006 from Hernandez. I think people
4 have gotten a little bit better, but it's only
5 with a tremendous amount of effort and clinical
6 decision support data that we review on a monthly
7 basis that allows us to improve. It's a lot of
8 work.

9 CO-CHAIR GEORGE: Any other comments
10 on performance gap?

11 MEMBER BRIGGS: I just wanted to say
12 that it's pretty obvious that there is a
13 performance gap because what you see in the rates
14 of re-hospitalization. The problem is the data
15 you present is old, so I would vote it more a
16 moderate level for this rather than high.

17 CO-CHAIR GEORGE: Shall we vote on
18 gap?

19 MEMBER GIBBONS: The data is old from
20 Hernandez, but the developers present data from
21 when they did their chart review that was from
22 April to July of 2012, I believe. So even that

1 showed that there was a significant gap at that
2 point, so I would still as it's high.

3 MS. LUONG: The polling for
4 performance gap starts now. One for high, two
5 for moderate, three of low, and four for
6 insufficient.

7 For performance gap, it passes with 18
8 percent voting high, 71 percent voting moderate,
9 and 12 percent voting low.

10 CO-CHAIR GEORGE: Priority?

11 MEMBER GIBBONS: For priority based on
12 the fact that there's a gap in an important
13 management issue, I would list it as high
14 priority.

15 CO-CHAIR GEORGE: Any discussion about
16 priority?

17 (No response.)

18 CO-CHAIR GEORGE: All right. We'll
19 vote on priority.

20 MS. LUONG: Voting for priority starts
21 now. One for high, two for moderate, three for
22 low, and four for insufficient.

1 For high priority, 65 voted high, 24
2 percent moderate, and 12 percent voted low. It
3 passes.

4 MEMBER HILLEGASS: Do you want to go
5 through the numerator versus denominator?

6 MEMBER GIBBONS: Sure.

7 MEMBER HILLEGASS: The numerator is
8 for any patient with a follow-up appointment
9 including location, date and time for an office
10 or home visit for management of heart failure
11 scheduled within seven days post-discharge.

12 And then the denominator is certain
13 ICD codes, all heart failure discharged from a
14 hospital inpatient setting to home or home care.
15 Those seem appropriate.

16 MEMBER GIBBONS: Yes, so the data
17 extraction was similar to the previous measure
18 where there are 201 records that were looked at,
19 both paper and EMR. And this was, as mentioned
20 before, a four-month review from April to July of
21 2012 of nine hospitals after a number of other
22 hospitals dropped out.

1 The hospitals were small to moderate
2 in size, and in 5 cases greater than 400 beds.
3 Interestingly enough, the re-admission rate even
4 at that point seemed to be fairly high because
5 there were 878 patients with 1,372 admissions. I
6 wonder if Joint Commission could tell us what the
7 re-admission rates were per 30 days.

8 But the exclusions were still
9 troublesome to me because 37 percent of the
10 patients were excluded based on the listed
11 exclusions including LVED and length of stay
12 greater than 120 days. I would assume, but
13 please correct me if it's not correct, that the
14 exclusions were based on the previous discussion
15 about LVED enrollment. Is that correct?

16 MS. RYAN: Yes, that's the same.

17 MEMBER GIBBONS: Okay. One of the
18 other exclusions was that documented patients
19 with no documented reason for no post-discharge
20 appointment within seven days. What's the
21 rationale for that?

22 MS. RYAN: There are some

1 circumstances where patients might be from out of
2 state or even out of country, so it is not within
3 the purview of the caring provider to be able to
4 make that appointment. So there was
5 consideration given for that.

6 MEMBER GIBBONS: Okay. But it's less
7 than optimal, but that's a reasonable exclusion.
8 Okay.

9 So the specifications seemed
10 reasonable and it was done by direct JCAHO
11 extraction of records from the sample of records
12 taken. So it seems an acceptable approach.

13 CO-CHAIR GEORGE: Ellen?

14 MEMBER HILLEGASS: So with the
15 specifications though they only looked at whether
16 there was a documented appointment. So again, I
17 want to go back to talking about they only
18 documented an appointment and not whether the
19 patient was seen by someone.

20 MEMBER GIBBONS: Right, but that's not
21 within this measure.

22 CO-CHAIR GEORGE: George?

1 MEMBER PHILIPPIDES: Do we know how
2 often they use the patients with a documented
3 reason for no post-discharge appointment within
4 seven days? Was it used often or was it mostly
5 the other exclusionary criteria that dinged them?

6 MEMBER GIBBONS: It's mostly the
7 others.

8 MEMBER PHILIPPIDES: Okay.

9 MEMBER GIBBONS: I think it was less
10 than three percent that was no post-discharge
11 appointment. It was uncommon.

12 MEMBER HILLEGASS: And I wanted to
13 talk to the reliability testing. It was a little
14 concerning to me that five hospitals withdrew
15 from testing due to lack of resources to complete
16 the project.

17 MS. RYAN: That was commented on
18 earlier with respect to the timing of the pilot
19 testing, and some of the hospital leads for the
20 project had some turnover.

21 CO-CHAIR GEORGE: Judd?

22 MEMBER HOLLANDER: I actually hadn't

1 picked this up the first time through, but I have
2 real concerns about the exclusion and being
3 somewhat subjective and not contained where you
4 could just say I can't get an appointment done.
5 I understand that out-of-the-country thing. I
6 kind of get that. I don't really get the I-live-
7 200-miles-away. Someone could get on the phone
8 and make that appointment. That's something we
9 should be able to do.

10 I would also like to see; just and
11 sort of a friendly amendment; doesn't impact my
12 voting, that telehealth is clearly defined as a
13 visit, because a telephone call is. And so I can
14 easily imagine some payer saying, oh, telehealth
15 doesn't count as a reason to ding people because
16 it's not considered a phone call and has an
17 entirely different regulatory structure. So I
18 would like to see as this goes forward that that
19 gets built into the measure.

20 But one can imagine today that if this
21 is a pay-for-performance measure somebody has a
22 note saying they were discharged at night. The

1 office was closed. Couldn't make an appointment.

2 And that's not acceptable to me, but it would

3 fall as an acceptable exclusion criteria here.

4 CO-CHAIR KOTTKE: Yes, I'll change my
5 prior comment. I mean, I think wherever in the
6 world you ought to be able to pick up the phone
7 and call somebody and say this patient needs to
8 be seen. Being responsible for them being seen
9 is a different story.

10 MEMBER HOLLANDER: But don't you think
11 that's the whole point of the measure? I mean, I
12 get calling Dubai may be a little more difficult,
13 but if somebody refers somebody to the Mayo
14 Clinic, then the Mayo Clinic has a obligation, I
15 believe, to get them an appointment. And I would
16 say that the Mayo Clinic should then set them up
17 for a telemedicine visit or a telephone consult,
18 which would meet the criteria, to tide them over
19 to the time that they could get that appointment.

20 So I think within the language of this
21 there's plenty of opportunities for people to
22 provide care during that care transition period

1 if they can't get an appointment. And I think
2 that that's going to improve the care of these
3 patients.

4 CO-CHAIR GEORGE: Any other comments
5 on reliability? If not, we'll vote.

6 MS. LUONG: Polling for reliability
7 starts now. One for high, two for moderate,
8 three for low, and four for insufficient.

9 For reliability it passes with 76
10 percent voting moderate, 18 percent voting low,
11 and 6 percent voting insufficient.

12 CO-CHAIR GEORGE: Okay. We'll move on
13 to validity.

14 MEMBER GIBBONS: In terms of validity
15 the same type of analysis was done and appealed
16 to comparison to other heart failure transition
17 measures, but they found that the overall
18 percentage of patients who had a follow-up
19 appointment was only 14.9 percent with some --
20 one center I think approaching 90 percent.

21 And the correlation that didn't meet
22 statistical significance was that medical record

1 transmission was 56 percent and a post-discharge
2 call was 35.5 percent. So I think this
3 accentuates the gap, but it still appeals to what
4 we consider to be an appropriate definition of
5 appointment as has been discussed before. But
6 certainly the extraction method seemed to support
7 the fact that this was reasonably valid.

8 CO-CHAIR GEORGE: Comments on
9 validity?

10 MEMBER HILLEGASS: I'm just going to
11 say for the record again that this is only
12 measuring appointment. And so, I think it would
13 be a much stronger valid testing done and valid
14 information if we were looking at some sort of
15 interaction with a health care provider, a visit
16 or something.

17 CO-CHAIR GEORGE: Other comments?

18 (No response.)

19 CO-CHAIR GEORGE: We'll vote on
20 validity.

21 MS. LUONG: Polling for validity opens
22 now. One for high, two for moderate, three for

1 low, and four for insufficient.

2 Validity passes with 71 percent voting
3 moderate and 29 percent voting low.

4 CO-CHAIR GEORGE: All right. We'll
5 move on to feasibility.

6 MEMBER GIBBONS: Again, I think that
7 feasibility was questioned by the fact that
8 several hospitals dropped out, but I think we had
9 a reasonable explanation for that that over four
10 months that there were perhaps under-staffing,
11 but I don't know that we've completely understood
12 why that should be the case. But nonetheless,
13 the simplicity of just documenting whether
14 there's an appointment does not seem to be
15 burdensome, so I would say it's feasible.

16 MEMBER DeLONG: This is basically a
17 check box, right?

18 MS. WATT: The measure requires that
19 the appointment be made. That requires an action
20 on the part of the hospital staff to get that
21 appointment made.

22 MEMBER DeLONG: How does JCAHO find

1 the data?

2 MS. WATT: In the medical record.

3 Chart abstraction.

4 MEMBER DeLONG: Chart abstraction?

5 MS. WATT: Correct.

6 MEMBER DeLONG: So this involves a
7 fair amount of work to determine whether somebody
8 actually wrote make a follow-up appointment, or
9 whatever?

10 MS. WATT: All of these measures are
11 chart abstracted. And as we discussed earlier,
12 all of the data elements for all of the measures
13 are generally abstracted at the same time, yes.

14 CO-CHAIR GEORGE: Linda?

15 MEMBER BRIGGS: I just wanted to point
16 out that in this chart abstraction for the
17 appointment made, it's actually three components
18 to say yes. They actually have to a location,
19 they have to have the date and the time. So in
20 order to say yes there's three different pieces
21 that have to go in that. I just wanted to add
22 that.

1 CO-CHAIR KOTTKE: Well, it actually
2 should be pretty easy to find this in the
3 discharge summary if a hospital has its act
4 together. It's not like looking for family
5 history or some other things that could be
6 anywhere.

7 CO-CHAIR GEORGE: Other comments on
8 feasibility?

9 (No response.)

10 CO-CHAIR GEORGE: We'll vote on
11 feasibility.

12 MS. LUONG: Polling starts now for
13 feasibility. One for high, two for moderate,
14 three for low, and four for insufficient.

15 For feasibility it passes with 6
16 percent voting high, 88 percent voting moderate,
17 and 6 voting low.

18 CO-CHAIR GEORGE: Usability?

19 MEMBER GIBBONS: Based on the comment
20 before, it sounds like the Joint Commission has
21 enacted this part of the advance certification on
22 heart failure beginning in January. So at some

1 point I suppose it will be reported. It's
2 intended as an e-measure. And I was wondering if
3 the developers could tell how that is going.

4 MS. WATT: We're breathlessly awaiting
5 the endorsement decision before we move forward
6 with the e-specifications.

7 MEMBER GIBBONS: But as far as the
8 advance certification are people reporting this
9 in a usable number?

10 MS. WATT: Oh. Oh, yes. Sorry. It's
11 a requirement. There are close to 100 hospitals
12 now reporting for the advance certification for
13 heart failure and every one of them is reporting
14 on this measure. They have not rebelled yet.

15 MEMBER GIBBONS: Okay. Thank you. So
16 I would say that if there's feasibility, then
17 usability would allow the follow-up that would
18 then inform 2443.

19 CO-CHAIR GEORGE: Any comments on
20 usability? If not, we'll vote.

21 MS. LUONG: Polling starts now for
22 usability and use. One for high, two for

1 moderate, three for low, and four for
2 insufficient information.

3 For usability and use, 24 percent
4 voted high, 65 percent moderate, and 12 percent
5 voted low. It passes.

6 CO-CHAIR GEORGE: So we'll move on to
7 the overall vote.

8 MS. LUONG: Polling starts now for
9 overall suitability for endorsement. One for
10 yes, and two for no.

11 For Measure 2439 for overall
12 suitability for endorsement 82 percent voted yes,
13 and 18 percent voted no. It passes.

14 CO-CHAIR GEORGE: Any competing
15 measures?

16 MEMBER GIBBONS: We've talked about
17 that before. 2455 presented by ACC and voted on
18 before doesn't specify that the appointment be
19 within seven days. And it's a registry rather
20 than an EMR. Interestingly, if you look at their
21 submission, again they actually presented data
22 showing an improvement that was significant

1 between 2011 and 2012 based on the registry. So
2 it would be interesting to see what happens with
3 this from JCAHO.

4 MS. HIBAY: This is a measure that the
5 related and competing discussion will be hosted
6 at our post-call meeting on the 19th of December.

7 CO-CHAIR GEORGE: Okay. And I believe
8 we're going to do public comment.

9 MS. ISIJOLA: Operator, can you open
10 the lines and see if there are any public or
11 member comments?

12 OPERATOR: Okay. At this time if
13 you'd like to make a comment, please press star
14 then the number one on your telephone keypad.

15 (Pause.)

16 OPERATOR: At this time there are no
17 comments.

18 MS. ISIJOLA: Okay. So, having no
19 comments, we have one additional measure left.
20 And I see people that need to catch their flights
21 and travel, so we'll table this last measure,
22 Measure 2439 for our post-meeting call and we'll

1 work with the Joint Commission to ensure that
2 they're available for that call. Oh, is it?
3 Measure 2443, we'll make sure that that's
4 available for the post-meeting call.

5 MS. JOHNSON: Can we just get a show
6 of hands? We're a little confused here. How
7 many people could stay another half hour, 45
8 minutes to finish this up? Half hour at most.

9 MS. HIBAY: How about the developers?
10 Okay.

11 MS. JOHNSON: This is the Joint
12 Commission. Okay. So how many has to leave?

13 MS. HIBAY: How about on the telephone
14 as well? Are you able to hang for a half hour?

15 MEMBER CHO: Yes.

16 MEMBER GIBBONS: Yes.

17 MS. HIBAY: Okay. We'll proceed with
18 reviewing measure 2443.

19 CO-CHAIR KOTTKE: Okay. Developers,
20 anything you need to say?

21 MS. RYAN: Sure. This measure looks
22 at a post-discharge evaluation for heart failure

1 patients within 72 hours. And within this
2 evaluation we're looking for an evaluation of
3 symptoms or if the symptoms are worsening, if the
4 patients are able to adhere to their medication
5 regimen and also how they're doing with their
6 activity levels.

7 CO-CHAIR KOTTKE: Okay. Linda, you're
8 the discussant.

9 MEMBER BRIGGS: Okay. So the measure
10 is patients who received this evaluation in 72
11 hours. And so that would be the numerator for
12 this.

13 And then the denominator is very
14 similar to others that we've looked at. The
15 denominator being that it's heart failure
16 discharged. This time it is patients going to
17 home, home care or leaving against medical
18 advice. There are exceptions that we had again
19 as before. So in the evidence the same evidence
20 was cited as previously for the appointment,
21 which is the one non-randomized observational
22 study from Hernandez. And the discordance here

1 is that the time interval is seven days there,
2 and in the measure it's three days.

3 Now, there are two clinical guidelines
4 that the developer cites and both of those say
5 preferably within three days is reasonable,
6 reasonable from the American Heart Association,
7 and that's a Class 2-A recommendation with a
8 level of evidence being B. And that was just
9 citing the Hernandez study. And the Heart
10 Failure Association is recommending a visit in
11 three days, and that strength of evidence was C,
12 which was expert opinion only.

13 So I would say the evidence for this
14 particular measure is insufficient. But it
15 doesn't cause harm to anyone, so I would say it's
16 insufficient with exception.

17 CO-CHAIR GEORGE: And I would just add
18 I think some of the evidence -- there was a 2012
19 Cochrane review of 25 clinical trials on post-
20 hospital interventions that was cited when we
21 reviewed the measure in Phase I about making the
22 appointment, but it covered various interventions

1 including early post-hospital follow-up to reduce
2 readmissions. And I think that evidence is
3 somewhat relevant to this discussion, but it
4 wasn't cited by the developers.

5 MEMBER JAMES: I think the practical
6 experience that that's been held by many health
7 plans is that for those people who are discharged
8 with higher level degrees of heart failure; New
9 York Class 3 and 4, that this has been a game
10 changer as far as the ability to reduce
11 readmission rates. Right? I think that's the
12 only issue, is it's separation as to those people
13 who have mild failure, first time systolic
14 dysfunction versus somebody who's got known
15 disease.

16 CO-CHAIR KOTTKE: Okay. Anybody else
17 urged to comment?

18 (No response.)

19 CO-CHAIR KOTTKE: Ready to vote on
20 evidence?

21 MS. LUONG: Polling for evidence
22 starts now. One for high, two for moderate,

1 three for low, four for insufficient evidence,
2 and five for insufficient evidence with exception
3 for Measure 2443.

4 For Measure 2443 on evidence, 7
5 percent voted high, 36 percent moderate, 7
6 percent voted low, and 50 percent insufficient
7 evidence with exception. This measure passes.

8 CO-CHAIR KOTTKE: Performance gap?

9 MEMBER BRIGGS: So, there is a gap.
10 The performance gap cited by the developers is
11 that of the nine test centers that reported the
12 minimum group of folks that complied with this
13 measure was actually 0 and the maximum was 37.8.
14 So there's a huge, huge area where there could be
15 improvement in having this evaluation done.

16 CO-CHAIR KOTTKE: Anybody urged to
17 comment?

18 (No response.)

19 CO-CHAIR KOTTKE: Let's vote on
20 performance gap.

21 MS. LUONG: Polling for performance
22 gap starts now. One for high, two for moderate,

1 three for low, and four for insufficient.

2 For performance gap, 71 percent voted
3 high, and 21 percent voted moderate. It passes
4 this criteria.

5 CO-CHAIR KOTTKE: Priority?

6 MEMBER BRIGGS: I think we've
7 discussed this a number of times, that heart
8 failure is a high priority.

9 CO-CHAIR KOTTKE: Seeing no motion,
10 let's vote on priority.

11 MS. LUONG: High priority polling
12 starts now. One for high, two for moderate,
13 three for low, and four for insufficient.

14 High priority passes with 93 percent
15 for high, and 7 percent for moderate.

16 CO-CHAIR KOTTKE: Scientific
17 acceptability and reliability. Linda?

18 MEMBER BRIGGS: Okay. So, they did
19 inter-rater reliability. They only reported on
20 one data element itself, which was the actual
21 conducting of the evaluation. There was 95
22 percent agreement and the kappa was 0.75. So

1 that's strong agreement. Usually again
2 numerator, denominator and exclusions are what
3 the Committee wants, but they did report on the
4 one.

5 CO-CHAIR KOTTKE: Thank you. Judd?

6 MEMBER HOLLANDER: Just one comment,
7 and I'm not sure where the right place to say
8 this is, but I think every time we hear heart
9 failure and admission or discharge, we need to
10 think admission and observation. We're seeing a
11 huge shift to put these patients in observation.
12 And I can kind of interpret the language either
13 way, but it says inpatient somewhere, and
14 observation is strictly outpatient in
15 terminology. And I think it should be included.
16 So I don't know if there's a way to amend it.

17 Ileana and this group discussed that
18 on the last round. I think it's really
19 important. Otherwise, we're taking patients who
20 really -- we all know this. We're taking
21 patients who warrant inpatient admissions,
22 squeezing them into observation. Their inpatient

1 stay is less quality care. And now we're going
2 to send them without the same transition
3 mechanisms. That's a really bad thing to be
4 doing.

5 CO-CHAIR KOTTKE: Mladen?

6 MEMBER VIDOVIICH: Yes, fantastic
7 point, because at the VA we have like a chest
8 pain unit. Fantastic point.

9 CO-CHAIR KOTTKE: Okay. So ready to
10 vote on reliability?

11 MS. LUONG: Polling for reliability
12 starts now. One for high, two for moderate,
13 three for low, and four for insufficient.

14 Reliability passes with 14 percent
15 voting high, and 86 percent voting moderate.

16 CO-CHAIR KOTTKE: Validity?

17 MEMBER BRIGGS: This is the section
18 where I think this measure stumbles a little bit,
19 and it might be easily rectified by changing the
20 evaluation time frame to that within seven days.
21 Because the evidence that is cited from the very
22 beginning is the study that has to do with

1 evaluation within 7 days, not the 72 hours, even
2 though there are clinical guideline
3 recommendations for shorter time periods. So
4 again, I would say that that's a validity issue
5 that those things don't reflect the same
6 information.

7 Do you want me to speak to the
8 validity as well? Okay. In this case they used
9 comparison or correlations with similar types of
10 sampling that they were doing with other
11 indicators within the center's data set and they
12 did beta blocker and post-discharge appointment.
13 Interestingly enough, the correlation with the
14 post-discharge appointment was poor. So even
15 though they might have had an appointment, maybe
16 the re-evaluation never occurred. Who knows?

17 Neither one of these actually reached
18 statistical significance. The beta blocker
19 therapy one was -- the correlation was 0.512.
20 The sample sizes were relatively small even
21 though we're talking about 800 patients that were
22 actually in the sample that they looked at.

1 CO-CHAIR KOTTKE: Mladen, do you still
2 -- No? Okay. Ready to vote on validity.

3 MS. LUONG: Polling for validity
4 starts now. One for high, two for moderate,
5 three for low, and four for insufficient.

6 Validity passes with 7 percent voting
7 high, 64 percent voting moderate, 21 percent
8 voting low, and 7 percent voting insufficient.

9 CO-CHAIR KOTTKE: Usability and use?
10 Did I miss feasibility? Sorry.

11 MEMBER BRIGGS: No, we're good. So
12 feasibility, we were quoted the same statistics
13 as before, because it's the same data set
14 basically.

15 CO-CHAIR KOTTKE: Okay. No other
16 comments?

17 (No response.)

18 CO-CHAIR KOTTKE: Let's vote on
19 feasibility.

20 MS. LUONG: Polling for feasibility
21 starts now. One for high, two for moderate,
22 three for low, and four for insufficient.

1 For feasibility, 14 percent voted
2 high, 79 percent voted moderate, and 7 percent
3 voted low. It passes this criteria.

4 CO-CHAIR KOTTKE: Now usability and
5 use.

6 MEMBER BRIGGS: Okay. So this is a
7 new measure. There is a desire to use it in the
8 data set. And you say you're actually
9 implementing that as we speak, essentially.

10 CO-CHAIR KOTTKE: Okay. Seeing no
11 cards up, we'll vote on usability and use.

12 MS. LUONG: Polling starts now for
13 usability and use. One for high, two for
14 moderate, three for low, and four for
15 insufficient information.

16 For usability and use it passes with
17 29 percent voting high, 71 percent voting
18 moderate.

19 CO-CHAIR KOTTKE: Overall?

20 MS. LUONG: Polling starts now for
21 overall suitability for endorsement for Measure
22 2443. One for yes, and two for no.

1 For overall suitability for
2 endorsement of Measure 2443 100 percent voted yes
3 for endorsement. This measure passes.

4 CO-CHAIR KOTTKE: Competing measures?

5 MEMBER BRIGGS: I would say the main
6 ones were discussed.

7 CO-CHAIR KOTTKE: Okay. So that's it.
8 Oh, we'll open it one more time for public
9 comment.

10 MEMBER BRIGGS: For Judd this one does
11 say telemedicine.

12 CO-CHAIR KOTTKE: Minor victories.

13 MS. ISIJOLA: Operator, can you open
14 the lines again for public and member commenting
15 once more?

16 OPERATOR: Okay. Once again, to make
17 a comment please press star, then the number one.

18 (Pause.)

19 OPERATOR: Okay. There are still no
20 comments at this time.

21 DR. BURSTIN: And just one comment.
22 I know you had a discussion about some of those

1 overused measures yesterday. So those typically
2 do go to the clinical committees if they're
3 clinically-related to overuse. We're happy to
4 get input if you'd like from the Cost Resource
5 Use Committee chairs, but they are really dealing
6 with cost measures. We very much consider these
7 within your purview, so you'll have an
8 opportunity to get back to those at a later date.

9 MS. HIBAY: I just want to make one
10 more comment related to any competing measures of
11 the measure we just did, which is 2443. They
12 will be held on the post-call meeting on December
13 19th.

14 CO-CHAIR GEORGE: I'd just like to
15 thank everybody for all your hard work and great
16 comments. Thank you.

17 CO-CHAIR KOTTKE: Same. It's obvious
18 you've given a lot of serious thought and the
19 developers appreciate it, and I think we're
20 improving care in America. Thank you. And happy
21 travels.

22 DR. BURSTIN: And thanks to our Co-

1 chairs as well, and all of you.

2 MS. ISIJOLA: Thank you all again for
3 attending. We'll definitely send you information
4 for next steps, particularly for the post-meeting
5 call. And please have lunch on your way out.

6 Thank you everyone who joined us
7 online as well.

8 (Whereupon, the above-entitled matter
9 was concluded at 12:43 p.m.)

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Project 2014 Standing Committee

Before: NQF

Date: 12-05-2014

Place: Washington, D.C.

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